UTAH STATE BULLETIN

OFFICIAL NOTICES OF UTAH STATE GOVERNMENT
Filed July 16, 2009, 12:00 a.m. through July 31, 2009, 11:59 p.m.

Number 2009-16
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Kenneth A. Hansen, Director
Nancy L. Lancaster, Editor

The *Utah State Bulletin (Bulletin)* is an official noticing publication of the executive branch of Utah State Government. The Department of Administrative Services, Division of Administrative Rules produces the *Bulletin* under authority of Section 63G-3-402.

Inquiries concerning the substance or applicability of an administrative rule that appears in the *Bulletin* should be addressed to the contact person for the rule. Questions about the *Bulletin* or the rulemaking process may be addressed to: Division of Administrative Rules, 4120 State Office Building, Salt Lake City, Utah 84114-1201, telephone 801-538-3218, FAX 801-538-1773. Additional rulemaking information, and electronic versions of all administrative rule publications are available at: http://www.rules.utah.gov/

The information in this *Bulletin* is summarized in the *Utah State Digest (Digest)*. The *Digest* is available by E-mail or over the Internet. Visit http://www.rules.utah.gov/publicat/digest.htm for additional information.

Division of Administrative Rules, Salt Lake City 84114

Utah state bulletin.
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SPECIAL NOTICES

Health
Health Care Financing, Coverage and Reimbursement Policy

Notice for September 2009 Medicaid Rate Changes

Effective September 1, 2009, Utah Medicaid will adjust its rates consistent with approved methodologies. Rate adjustments include new codes priced consistent with approved Medicaid methodologies, potential adjustments to existing codes, and nursing home rate changes to case mix components consistent with adopted payment methodology. It is not anticipated that these rate changes will have a substantial fiscal impact. All rate changes are posted to the web and can be viewed at: http://health.utah.gov/medicaid/stplan/bcrp.htm

End of the Special Notices Section

NOTICES OF
PROPOSED RULES

A state agency may file a **Proposed Rule** when it determines the need for a new rule, a substantive change to an existing rule, or a repeal of an existing rule. Filings received between July 16, 2009, 12:00 a.m., and July 31, 2009, 11:59 p.m. are included in this, the August 15, 2009 issue of the *Utah State Bulletin*.

In this publication, each **Proposed Rule** is preceded by a **Rule Analysis**. This analysis provides summary information about the **Proposed Rule** including the name of a contact person, anticipated cost impact of the rule, and legal cross-references.

Following the **Rule Analysis**, the text of the **Proposed Rule** is usually printed. New rules or additions made to existing rules are underlined (e.g., example). Deletions made to existing rules are struck out with brackets surrounding them (e.g., [~~example~~]). Rules being repealed are completely struck out. A row of dots in the text between paragraphs (**. . . . . .**) indicates that unaffected text from within a section was removed to conserve space. Unaffected sections are not printed. If a **Proposed Rule** is too long to print, the Division of Administrative Rules will include only the **Rule analysis**. A copy of each rule that is too long to print is available from the filing agency or from the Division of Administrative Rules.

The law requires that an agency accept public comment on **Proposed Rules** published in this issue of the *Utah State Bulletin* until at least September 14, 2009. The agency may accept comment beyond this date and will indicate the last day the agency will accept comment in the **Rule Analysis**. The agency may also hold public hearings. Additionally, citizens or organizations may request the agency hold a hearing on a specific **Proposed Rule**. Section 63G-3-302 requires that a hearing request be received by the agency proposing the rule "in writing not more than 15 days after the publication date of the **Proposed Rule**."

From the end of the public comment period through December 13, 2009, the agency may notify the Division of Administrative Rules that it wants to make the **Proposed Rule** effective. The agency sets the effective date. The date may be no fewer than seven calendar days after the close of the public comment period nor more than 120 days after the publication date of this issue of the *Utah State Bulletin*. Alternatively, the agency may file a **Change in Proposed Rule** in response to comments received. If the Division of Administrative Rules does not receive a **Notice of Effective Date** or a **Change in Proposed Rule**, the **Proposed Rule** lapses and the agency must start the process over.

The public, interest groups, and governmental agencies are invited to review and comment on **Proposed Rules**. *Comment may be directed to the contact person identified on the* Rule Analysis *for each rule.*

Proposed Rules are governed by Section 63G-3-301; and Rule R15-2, and Sections R15-4-3, R15-4-4, R15-4-5, R15-4-9, and R15-4-10.

The Proposed Rules Begin on the Following Page

Health, Epidemiology and Laboratory Services, Environmental Services
R392-302
Design, Construction, and Operation of Public Pools

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 32839
FILED: 7/23/09 3:59 PM

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of the rule is to incorporate the anti-entrapment requirements of the Virginia Graeme Baker Act (15 USC 8001 sections 1401-1404) into the state swimming pool rule, Rule R392-302.

SUMMARY OF THE RULE OR CHANGE: The rule changes modify the required drain cover or grate standard from ASME A112.19.8M to ASME A112.19.8a - 2008. It also reduces the required spacing between double outlet grates from 4 feet to 3 feet. The rule changes require the installation of a drain cover or grate to meet the safety "use" markings on the grate. The proposed changes mandate that a drain sump be present on all suction drains, and specifies the required design. Additionally, the proposed changes require only one certification, either ASME or ASTM for safety vacuum release systems. Both are currently required in the present rule. A notification system will now be required for safety vacuum release systems. A gravity drain and an unblockable drain are added as alternative anti-entrapment systems. Skimmer equalizer ports are now required to be covered with an anti-entrapment cover. Other methods have been added as alternatives as a means of compliance to the requirement of having an equalizer port. A date for pools to complete the necessary corrective measures to become rule compliant with requirements of single main drains and drain covers is set in the rule. The date is 12/19/2009.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 26-15-2 and Virginia Graeme Baker Act 15 USC 8001 1401-1404

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: There will be no fiscal impact on the state budget. Rule R392-302 is administered through existing state funds. There are not costs or savings to the state budget as the state does not have the responsibility to perform inspections.
♦ LOCAL GOVERNMENTS: There are no additional costs or savings to local health departments. The inspections will be made using existing fees and budgets. There will be costs to local governments who own swimming pools to make the required changes. There are approximately 270 swimming pools in the state owned by local governments. The range of cost for each pool would be $300 (1 drain) to $15,000, depending upon which compliance alternative is chosen by the pool owner. It is estimated that approximately one half of the pools in the state are not in compliance. The minimum aggregate cost of local government-owned pools will be $162,000 (270 x $300 x 2 drains per pool) for approved grates. Of the 270 local government-owned pools, approximately one half are not in compliance. It is estimated that the maximum aggregate cost would be $2,025,000 (135 x $15,000). The Virginia Graeme Baker Act is a federal law with which all public pools must comply.
♦ SMALL BUSINESSES: There are approximately 2,456 nongovernment-owned swimming pools in the state. The range of cost for each pool would be $300 (1 drain) to $15,000, depending upon which compliance alternative is chosen by the pool owner. It is estimated that approximately one half of the pools in the state are not in compliance. The minimum aggregate cost of nongovernment-owned pools will be $1,473,600 (2,456 x $300 x 2 drains per pool) for approved grates. Of the 2,456 nongovernment-owned pools, approximately one half are not in compliance. It is estimated that the maximum aggregate cost would be $18,420,000 (1,228 x $15,000). The Virginia Graeme Baker Act is a federal law with which all public pools must comply.
♦ PERSONS OTHER THAN BUSINESS: There are approximately 2,456 nongovernment-owned swimming pools in the state. The range of cost for each pool would be $300 (1 drain) to $15,000, depending upon which compliance alternative is chosen by the pool owner. It is estimated that approximately one half of the pools in the state are not in compliance. The minimum aggregate cost of nongovernment-owned pools will be $1,473,600 (2,456 x $300 x 2 drains per pool) for approved grates. Of the 2,456 nongovernment-owned pools, approximately one half are not in compliance. It is estimated that the maximum aggregate cost would be $18,420,000 (1,228 x $15,000). The Virginia Graeme Baker Act is a federal law with which all public pools must comply.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The National Recreation and Park Association estimates that the cost per pool would range from $300 to $15,000 per pool, dependent upon whether the pools were already in compliance with certain aspects. Pools that are already in compliance with the current state rule will cost approximate $300 to $400 per drain for new grates. It is estimated that approximately one half of the pools in the state currently are not in compliance. Pools that are not in compliance with the current state rule could incur additional costs from $1,000 up to $15,000 or more dependent upon which alternative is chosen: main drain conversion from single to dual main drain (most expensive), or installation of a safety vacuum release system, or other anti-entrapment protection (least expensive). The Virginia Graeme Baker Act is a federal law with which all public pools must comply.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Federal law mandates the changes to this rule that will have a fiscal impact. The changes to the drains are intended to avoid a person being trapped by the pull of the drain in the pool.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HEALTH
EPIDEMIOLOGY AND LABORATORY SERVICES,
ENVIRONMENTAL SERVICES
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY, UT 84116-3231
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO: ♦ Ronald Marsden by phone at 801-538-6191, by FAX at 801-538-6564, or by Internet E-mail at rmarsden@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 5:00 PM ON 09/14/2009

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2009

AUTHORIZED BY: David Sundwall, Executive Director

R392. Health, Epidemiology and Laboratory Services, Environmental Services.
R392-302. Design, Construction and Operation of Public Pools.
R392-302-18. Outlets.

(1) Each pool shall have a minimum of [~~either~~]two [~~grated outlets, two anti-entrapment outlets, or two anti-vortex type~~]outlets. All pool outlets shall [~~that~~]meet the following design criteria:

(a) The grates or covers of all submerged outlets in pools shall conform to the standards of ASME A112.19.8a-2008.[~~Outlets shall have a suitable protective grate or cover securely fastened in such a way that the use of tools is required to remove it. A pool shall not operate with broken, damaged or missing drain grates or covers. Protective grates or covers smaller than 24 inches by 24 inches, 61 centimeters by 61 centimeters, shall meet the requirements of ASME/ANSI A112.19.8M.~~]

(b) The outlets must be constructed so that if one of the outlets is completely obstructed, the remaining outlets[~~(s)~~] and related piping will be capable of handling 100 percent of the maximum design circulation flow.

(c) All pool outlets must connect to pipes of equal diameter.

(d) The outlet system must not allow any outlet to be cut out of the suction line by a valve or other means.

(e) At least one of the circulation outlets[~~The outlets centered~~] shall be located [~~in~~]at the deepest [~~area~~]point of the pool and must be piped to permit the pool to be completely and easily emptied.

(f) [~~There must be one main drain outlet for each 30 feet, 9.14 meters, of pool width. To prevent body entrapment, ~~]The center of the outlet covers or grates of multiple main drain outlets shall not be spaced more than 30 feet, 9.14 meters, apart nor spaced closer than [~~4~~]3 feet, [~~1.22~~]0.914 meters, apart.[~~The outermost main drain outlets must be located within 15 feet, 4.57 meters, from a side wall.~~

~~(g) If an outlet discharge pipe is 8 inches, 20.32 centimeters, or greater in diameter it shall have an additional device that shall prevent the passage of a sphere greater than 6 inches, 15.24 centimeters, in diameter. Such a device shall be designed by the designing architect or engineer and may not alter the required flow design characteristics.~~

~~(h) Devices or methods used for draining pools shall prevent overcharging the sanitary sewer.~~]

([~~i~~]g) Multiple pumps may utilize the same outlets only if the outlets are sized to accommodate 100 percent of the total combined design flow from all pumps and only if the flow characteristics of the system meet the requirements of subsection R392-302-18(2)[~~(a)~~] [~~or~~]and (3)[~~(a)~~].

([~~j~~]h) No feature or circulation pump shall be connected to less than two outlets unless connected to an anti-entrapment outlet system that the operator demonstrates to the Department as being effective in preventing entrapment.

(i) There must be one main drain outlet for each 30 feet, 9.14 meters, of pool width. The centers of the outlet covers or grates of any outermost main drain outlets must be located within 15 feet, 4.57 meters, of a side wall.

(j) Devices or methods used for draining pools shall prevent overcharging the sanitary sewer.

(k) No operator shall allow the use of a pool with outlet grates or covers that are broken, damaged, missing, or not securely fastened.

[~~(2) Grated Outlets.~~

~~(a) The designing architect or engineer shall ensure that outlet grate openings in the floor of the pool are at least four times the area of discharge or provide sufficient area so the maximum velocity of the water passing through the grate will not exceed 1.5 feet per second.~~

~~(b) The openings in a grate shall have a minimum width of 0.25 inches, 0.635 centimeters, and a maximum length of 1.5 inches, 3.81 centimeters. A grate opening that is neither square nor rectangular in shape, may not be greater than 0.75 inches, 1.905 centimeters., measured in any dimension along the exposed surface of the grate.~~

~~(3) Anti-vortex or anti-entrapment drains.~~

~~The total velocity of water through the open area of an anti-vortex or anti-entrapment drain shall not exceed the manufacturer's recommended maximum velocity or a maximum of three feet per second through the open area of the drain, whichever is more restrictive.~~

](2) Notwithstanding Section R392-302-3, all public pools must comply with Subsections R392-302-18(2) and (3). The pool operator shall not install, allow the installation of, or operate a pool with a drain, drain cover, or drain grate in a position or an application that conflicts with any of the following mandatory markings on the drain cover or grate under the standard required in R392-302-18(1)(a):

(a) whether the drain is for single or multiple drain use;

(b) the maximum flow through the drain cover; and

(c) whether the drain may be installed on a wall or a floor.

(3) The pool operator shall not install, allow the installation of, or operate a pool with a drain cover or drain grate unless it is over or in front of:

(a) the sump that is recommended by the drain cover or grate manufacturer;

(b) a sump specifically designed for that drain by a Registered Design Professional as defined in ASME A112.19.8a-2008; or

(c) a sump that meets the ASME A112.19.8a-2008 standard.

[~~(4) Spa pool outlets shall meet all of the requirements of subsections R392-302-18(1) through R392-302-18(3); however, the following exceptions apply:~~

~~(a) The designing architect or engineer shall ensure multiple spa outlets are spaced at least three feet apart from each other or that a third drain is provided and that the separation distance between individual outlets is at the maximum possible spacing.~~

~~(b) The department may exempt an acrylic or fiberglass spa from the requirement to locate outlets at the deepest point in the pool, if the outlets are located on side walls within three inches of the pool floor, and a wet-vacuum is available on site to remove any water left in the pool after draining.~~

~~(5) A wading pool shall have drainage to waste through a quick opening valve to facilitate emptying the wading pool should accidental bowel discharge or other contamination occur.~~

] ([~~6~~]4) Notwithstanding Section R392-302-3, all public pools must comply with this s[~~S~~]ubsection[~~s~~] R392-302-18([~~6~~]4) [~~through R392-302-18(6)(c) supersede section R392-302-3~~]. The pool owner or certified pool operator shall retrofit by December 19, 2009 each[~~swimming~~] pool circulation system on existing pools that do not meet the requirements of subsections R392-302-18(1) through R392-302-18[~~(5)~~](1)(h) and R392-302-18(2) through (3)(c). The owner or operator shall meet the retrofit requirements of this subsection by any of the following means:

(a) [~~A vacuum switch that meets both the American Society for Testing and Materials Standard Provisional Specification for Manufactured Safety Vacuum Release Systems (SVRS) for Swimming Pools, Spas, and Hot Tubs, PS 10-03, and the requirements of American Society of Mechanical Engineers Manufactured Safety Vacuum Release Systems for Residential and Commercial Pools, ASME A112.19.17 - 2002, which are incorporated by reference, installed on the suction side of the pump to prevent outlet entrapment.~~]Meet the requirements of R392-302-18(1)(a) and R392-302-18(2) through (3)(c) and install a safety vacuum release system which ceases operation of the pump, reverses the circulation flow, or otherwise provides a vacuum release at a suction outlet when it detects a blockage; that has been tested by an independent third party; and that conforms to ASME standard A112.19.17-2002 or ASTM standard F2387;

(i) To ensure proper operation, the certified pool operator shall inspect and test the vacuum [~~switch~~]release system at least once a week but no less often than established by the manufacturer. The certified pool operator shall test the [~~switch~~]vacuum release system in a manner specified by the manufacturer. The certified pool operator shall log all inspections, tests and maintenance and retain the records for a minimum of two years for review by the Department and local health department upon request.

(ii) The vacuum release system shall include a notification system that alerts patrons and the pool operator when the system has inactivated the circulation system. The pool operator shall submit to the local health department for approval the design of the notification systems prior to installation. The system shall activate a continuous clearly audible alarm that can be heard in all areas of the pool or a continuous visible alarm that can be seen in all areas of the pool. An easily readable sign shall be posted next to the sound or visible alarm source. The sign shall state, "DO NOT USE THE POOL IF THIS ALARM IS ACTIVATED." and provide the phone number of the pool operator.

(b) Install a[A]n outlet system that includes no fewer than two suction outlets separated by no less than [~~4~~]3 feet, [~~1.22~~]0.914 meters, on the horizontal plane as measured from the centers of the drain covers or grates or located on two different planes and connected to pipes of equal diameter. The outlet system shall meet the requirements of R392-302-18(1)(a) through R392-302-18(1)(h) and 18(2) through (3)(c).[~~The suction outlets shall be plumbed so water is drawn simultaneously without valves through the outlets to a common line to the pump system~~];[~~ or~~]

(c) Meet the requirements of R392-302-18(1)(a) and R392-302-18(2) through (3)(c) and installing (or having an existing) gravity drain system where, rather than drawing directly from the drain, the pump draws from a surge or collector tank wherein the contained water surface is maintained at atmospheric pressure;

(d) Install a drain of a size and shape that a human body cannot sufficiently block to create a suction entrapment hazard that meets the requirements of R392-302-18(1)(a) and R392-302-18(2) through (3)(c); or

([e]e) Any other system [~~that the operator demonstrates to the Department to prevent outlet entrapment.~~]determined by the federal Consumer Products Safety Commission to be equally effective as, or better than, the systems described in 15 USC 8003 (c)(1)(A)(ii)(I), (III), or (IV) at preventing or eliminating the risk of injury or death associated with pool drainage systems.

R392-302-19. Overflow Gutters and Skimming Devices.

(1) A pool having a surface area of over 3,500 square feet, 325.15 square meters, must have overflow gutters. A pool having a surface area equal to or less than 3,500 square feet, 325.15 square meters, must have either overflow gutters or skimmers provided.

(2) Overflow gutters must extend completely around the pool, except at steps, ramps, or recessed ladders. The gutter system must be capable of continuously removing pool water at 100 percent of the maximum flow rate. This system must be connected to the circulation system by means of a surge tank.

(3) Overflow gutters must be designed and constructed in compliance with the following requirements:

(a) The opening into the gutter beneath the coping or grating must be at least 3 inches, 7.62 centimeters, in height with a depth of at least 3 inches, 7.62 centimeters.

(b) Gutters must be designed to prevent entrapment of any part of a bather's body.

(c) The edge must be rounded so it can be used as a handhold and must be no thicker than 2.5 inches, 6.35 centimeters, for the top 2 inches, 5.08 centimeters.

(d) Gutter outlet pipes must be at least 2 inches, 5.08 centimeters, in diameter. The outlet grates must have clear openings and be equal to at least one and one-half times the cross sectional area of the outlet pipe.

(4) Skimmers complying with National Sanitation Foundation NSF/ANSI 50-[~~2004~~]2007 standards or equivalent are permitted on any pool with a surface area equal to or less than 3,500 square feet, 325.15 square meters[~~not more than 3,500 square feet, 325.15 square meters, of surface area~~]. At least one skimming device must be provided for each 500 square feet, 46.45 square meters, of water surface area or fraction thereof. Where two or more skimmers are required, they must be spaced to provide an effective skimming action over the entire surface of the pool.

(5) Skimming devices must be built into the pool wall and must meet the following general specifications:

(a) The piping and other components of a skimmer system must be designed for a total capacity of at least 80 percent of the maximum flow rate of the circulation system.

(b) Skimmers must be designed with a minimum flow rate of 25 gallons, 94.64 liters, per minute and a maximum flow rate of 55 gallons, 208.12 liters, per minute. The local health department may allow a higher maximum flow through a skimmer up to the skimmer's NSF rating if the piping system is designed to accommodate the higher flow rates. Alternatively, skimmers may also be designed with a minimum of 3.125 gallons, 11.83 liters, to 6.875 gallons, 26.02 liters, per lineal inch, 2.54 centimeters, of weir.

(6) Each skimmer weir must be automatically adjustable and must operate freely with continuous action to variations in water level over a range of at least 4 inches, 10.16 centimeters. The weir must operate at all flow variations. Skimmers shall be installed with the normal operating level of the pool water at the midpoint of the skimmer opening or in accordance with the manufacturer's instructions.

(7) An easily removable and cleanable basket or screen through which all overflow water passes, must be provided to trap large solids.

(8) The skimmer must be provided with a [~~device~~]system to prevent air-lock in the suction line. The[~~se devices~~]anti-air-lock may [~~include~~]be accomplished through the use of an equalizer pipe[~~,~~]or a surge tank[~~,~~] or through any other arrangement approved by the Department that will assure a sufficient amount of water for pump suction in the event the pool water drops below the weir level.[

~~(a)~~] If an equalizer pipe is used, the following requirements must be met:

([~~i~~]a) An equalizer pipe must be sized to meet the capacity requirements for the filter and pump[~~.~~];

([~~ii~~]b) An equalizer pipe may not be less than 2 inches, 5.08 centimeters, in diameter and must be designed to control velocity through the pipe in accordance with section R392-302-16(3)[~~.~~];

([~~iii~~]c) This pipe must be located at least 1 foot, 30.48 centimeters, below a valve or equivalent device that will remain tightly closed under normal operating conditions. In a shallow pool, such as a wading pool, where an equalizer outlet can not be submerged at least one foot below the skimmer valve, the equalizer pipe shall be connected to a separate dedicated outlet with an anti-entrapment outlet cover in the floor of the pool that meets the requirements of ASME A112.19.8A-2008 [~~.~~]; and

([~~iv~~]d) The equalizer pipe must be protected with a cover or grate that meets the requirements of ASME A112.19.8A-2008 and is sized to accommodate the design flow requirement of R392-302-19(5)[~~have an anti-vortex cover~~].

(9) The operator shall maintain proper operation of all skimmer weirs, float valves, check valves, and baskets. [~~must be maintained~~] Skimmer baskets shall be maintained in a clean and sanitary condition.[

~~(10) A spa pool must have a minimum number of surface skimmers based on one skimmer for each 100 square feet, 9.29 square meters of surface area.~~]

(10) Where skimmers are used, a continuous handhold is required around the entire perimeter of the pool except in areas of the pool that are zero depth and shall be installed not more than 9 inches, 2.86 centimeters, above the normal operating level of the pool. The decking, coping, or other material may be used as the handhold so long as it has rounded edges, is slip-resistant, and does not exceed 3.5 inches, 8.89 centimeters, in thickness. The overhang of the coping, decking, or other material must not exceed 2 inches, 5.08 centimeters, nor be less than 1 inch, 2.54 centimeters beyond the pool wall. An overhang may be up to a maximum of 3 inches to accommodate an automatic pool cover track system.

KEY: pools, spas, water slides
Date of Enactment or Last Substantive Amendment: [~~May 22, 2008~~]2009
Notice of Continuation: March 22, 2007
Authorizing, and Implemented or Interpreted Law: 26-15-2

Health, Health Care Financing, Coverage and Reimbursement Policy
R414-1-5
Incorporations by Reference

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 32840
FILED: 7/27/09 7:57 AM

RULE ANALYSIS
PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Subsection 26-18-3(2)(a) requires the Medicaid program to implement policy through administrative rules. The Department, in order to draw down federal funds, must have an approved State Plan with the Centers for Medicare and Medicaid Services. This change, therefore, incorporates the most current Medicaid State Plan by reference. It also implements by rule ongoing Medicaid policy for services

described in the Utah Medicaid Provider Manual, Medical Supplies Manual and List, and policy described in the hospital services provider manual. It further incorporates these manuals by reference.

SUMMARY OF THE RULE OR CHANGE: Subsection R414-1-5(2) is changed to update the incorporation of the State Plan by reference effective 10/01/2009. It also incorporates State Plan Amendments that become effective no later than 10/01/2009. The change further incorporates by reference the Medical Supplies Manual and List and the hospital services provider manual, effective 10/01/2009.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 26-1-5 and Section 26-18-3

TITLE OF MATERIALS INCORPORATED BY REFERENCES:

Official Title of Materials Incorporated: Hospital Services Provider Manual
Date Issued: 10/01/2009
Add, update, remove: Update

Official Title of Materials Incorporated: Utah Medicaid State Plan
Publisher: Division of Health Care Financing
Date Issued: 10/01/2009
Add, update, remove: Update

Official Title of Materials Incorporated: Medical Supplies Manual and List
Publisher: Utah Medicaid Provider Manual
Date Issued: 10/01/2009
Issue, or version: Section 2
Add, update, remove: Update

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: There is no budget impact because this change only fulfills the requirement to incorporate the State Plan by reference. Implementation of the State Plan is within legislative budget allotments. Further, the rule's incorporation of ongoing Medicaid policy described in the Medical Supplies Manual and List and in the hospital services provider manual does not create costs or savings to the Department or other state agencies.
♦ LOCAL GOVERNMENTS: There is no budget impact because this change only fulfills the requirement to incorporate the State Plan by reference. Implementation of the State Plan is within legislative budget allotments. Further, the rule's incorporation of ongoing Medicaid policy described in the Medical Supplies Manual and List and in the hospital services provider manual does not create costs or savings to local governments.
♦ SMALL BUSINESSES: There is no budget impact because this change only fulfills the requirement to incorporate the State Plan by reference. Implementation of the State Plan is within legislative budget allotments. Further, the rule's incorporation of ongoing Medicaid policy described in the Medical Supplies Manual and List and in the hospital services provider manual does not create costs or savings to small businesses.
♦ PERSONS OTHER THAN BUSINESS: There is no budget impact because this change only fulfills the requirement to incorporate the State Plan by reference. Implementation of the State Plan is within legislative budget allotments. Further, the rule's incorporation of ongoing Medicaid policy described in the Medical Supplies Manual and List and in the hospital services provider manual does not create costs or savings to persons other than small businesses, businesses, or local government entities.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs because this change only fulfills the requirement to incorporate the State Plan by reference. Implementation of the State Plan is within legislative budget allotments. Further, the rule's incorporation of ongoing Medicaid policy described in the Medical Supplies Manual and List and in the hospital services provider manual does not create costs or savings to a single Medicaid client or provider.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule should not have a direct fiscal impact on business. Incorporation of the State Plan by this rule assures that the Medicaid program is implemented through administrative rule.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HEALTH
HEALTH CARE FINANCING,
COVERAGE AND REIMBURSEMENT POLICY
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY, UT 84116-3231
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Craig Devashrayee by phone at 801-538-6641, by FAX at 801-538-6099, or by Internet E-mail at cdevashrayee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 5:00 PM ON 09/14/2009

THIS RULE MAY BECOME EFFECTIVE ON: 10/01/2009

AUTHORIZED BY: David Sundwall, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-1. Utah Medicaid Program.
R414-1-5. Incorporations by Reference.

(1) The Department [~~adopts~~]incorporates by reference the Utah State Plan Under Title XIX of the Social Security Act Medical Assistance Program effective [~~July~~]October 1, 2009. It also incorporates by reference State Plan Amendments that become effective no later than [~~July~~]October 1, 2009.

(2) The Department [~~adopts~~]incorporates by reference the Medical Supplies Manual and List described in the Utah Medicaid Provider Manual, Section 2, Medical Supplies, with its referenced attachment, Medical Supplies List, [~~July~~]October 1, 2009, as applied in Rule R414-70.

(3) The Department [~~adopts~~]incorporates by reference the Hospital Services Provider Manual, effective [~~July~~]October 1, 2009.

KEY: Medicaid
Date of Enactment or Last Substantive Amendment: [~~July 1~~], 2009
Notice of Continuation: April 16, 2007
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-1

Health, Health Care Financing, Coverage and Reimbursement Policy
R414-33B-5
Service Coverage

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 32860
FILED: 7/30/09 11:51 AM

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This change is necessary to implement provisions of the Deficit Reduction Act (DRA) that reform case management and targeted case management (TCM) activities. This change also implements Medicaid policy into rule in accordance with Subsection 26-18-3(2)(a).

SUMMARY OF THE RULE OR CHANGE: This change implements covered case management under the DRA and clarifies the limits of direct delivery of foster care services. It also specifies other noncovered services and activities, and clarifies the allowance for targeted case management during an inpatient stay.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Deficit Reduction Act of 2005 Pub. L. No. 109-171 Section 6052 and Section 26-1-5 and Section 26-18-3

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: There is no budget impact because this amendment only implements ongoing Medicaid policy into rule and clarifies service coverage under the DRA.
♦ LOCAL GOVERNMENTS: There is no budget impact because local governments do not fund targeted case management services.
♦ SMALL BUSINESSES: There is no impact to other persons and small businesses because this amendment only implements ongoing Medicaid policy into rule and clarifies service coverage under the DRA. This amendment does not affect client eligibility and current TCM services. The change, therefore, does not increase costs to Medicaid recipients and does not impact providers that render TCM services.
♦ PERSONS OTHER THAN BUSINESS: There is no impact to other persons and small businesses because this amendment only implements ongoing Medicaid policy into rule and clarifies service coverage under the DRA. This amendment does not affect client eligibility and current TCM services. The change, therefore, does not increase costs to Medicaid recipients and does not impact providers that render TCM services.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs because this amendment only implements ongoing Medicaid policy into rule and clarifies service coverage under the DRA. This amendment does not affect client eligibility or current TCM services. The change, therefore, does not increase costs to a Medicaid recipient and does not impact a provider that renders TCM services.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Current Medicaid policy is not changed by this rule adoption of those policies.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HEALTH
HEALTH CARE FINANCING,
COVERAGE AND REIMBURSEMENT POLICY
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY, UT 84116-3231
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Craig Devashrayee by phone at 801-538-6641, by FAX at 801-538-6099, or by Internet E-mail at cdevashrayee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 5:00 PM ON 09/14/2009

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2009

AUTHORIZED BY: David Sundwall, Executive Director

R414. Health, Health Care Financing,Coverage and Reimbursement Policy.
R414-33B. Substance Abuse Targeted Case Management.
R414-33B-5. Service Coverage.

(1) Medicaid [~~C~~]cover[~~ed~~]s[~~ services are~~]:

(a) [~~assessing and documenting the client's need for community resources and services~~]client assessment to determine service needs, including activities that focus on needs identification to determine the need for any medical, educational, social, or other services. Assessment activities include taking client history, identifying the needs of the client and completing related documentation, gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the client;

(b) develop[~~ing~~]ment of a written, individualized, coordinated case management service plan based on information collected through an assessment that specifies the goals and actions to address [~~to assure the client's adequate access to needed~~]the client's medical, social, educational and other [~~related~~]service[~~s~~] needs.[~~with~~] This includes input [~~as appropriate~~]from the client, the client's authorized health care decision maker, family, and other agencies knowledgeable about the client[~~'s needs;~~], to develop goals and identify a course of action to respond to the client's assessed needs;

(c) [~~linking the client with community resources and needed services, including assisting the client to establish and maintain eligibility for entitlements other than Medicaid~~]referral and related activities to help the client obtain needed services, including activities that help link the client with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the client;

(d) coordinating the delivery of services to the client, including CHEC screening and follow-up[~~, including consultation with other agencies to ensure the most appropriate interventions and services are provided by all agencies and providers involved in the client's care~~];

(e) [~~monitoring and coordinating as needed prescribed medications with prescribing professionals to ensure that all medications prescribed are appropriate, providing information on the client's medication regimen to other prescribers and other agencies and providers involved in the client's care~~]client assistance to establish and maintain eligibility for entitlements other than Medicaid;

(f) [~~periodically assessing and monitoring the client's status and functioning and modifying the targeted case management service plan, or the client's clinical treatment plan, as needed~~]monitoring and follow-up activities, including activities and contacts that are necessary to ensure the targeted case management service plan is effectively implemented and adequately addressing the needs of the client, which activities may be with the client, family members, providers or other entities, and conducted as frequently as necessary to help determine whether services are furnished in accordance with the client's case management service plan, whether the services in the case management service plan are adequate, whether there are changes in the needs or status of the client, and if so, making necessary adjustments in the case management service plan and service arrangements with providers;

(g) [~~periodic monitoring of the client to ensure needed services have been identified and that they are being obtained in a timely manner~~]contacting non-eligible or non-targeted individuals when the purpose of the contact is directly related to the management of the eligible individual's care. For example, family members may be able to help identify needs and supports, assist the client to obtain services, and provide case managers with useful feedback to alert them to changes in the client's status or needs;

(h) instructing the client or caretaker, as appropriate, in independently accessing needed services; and

(i) [~~monitoring the quality and appropriateness of the client's services; and~~

~~(j)~~]monitoring the client's progress and continued need for targeted case management and other services[~~;~~].

(2) The agency may bill Medicaid for the above activities only if:

(a) the activities are identified in the case management service plan and the time spent in the activity involves a face-to-face encounter, telephone or written communication with the client, family, caretaker, service provider, or other individual with a direct involvement in providing or assuring the client obtains the necessary services documented in the service plan[~~.~~]; and

(b) there are no other third parties liable to pay for services, including reimbursement under a medical, social, educational, or other program.

(3) Covered [~~C~~]case management service provided to a hospital or nursing facility patient is limited to a maximum of five hours per admission.

(4) Medicaid does not cover:

(a) documenting targeted case management services with the exception of time spent developing the written case management needs assessment, service plans, and 180-day service plan reviews;

(b) teaching, tutoring, training, instructing, or educating the client or others, except when the activity is specifically designed to assist the client, parent, or caretaker to independently obtain client services. For example, Medicaid does not cover client assistance in completing a homework assignment or instructing a client or family member on nutrition, budgeting, cooking, parenting skills, or other skills development;

(c) directly assisting with personal care or daily living activities that include bathing, hair or skin care, eating, shopping, laundry, home repairs, apartment hunting, moving residences, or acting as a protective payee;

(d) routine courier services. For example, running errands or picking up and delivering food stamps or entitlement checks;

(e) direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred. For example, providing medical and psychosocial evaluations, treatment, therapy and counseling, otherwise billable to Medicaid under other categories of service;

(f) direct delivery of foster care services that include research gathering and completion of documentation, assessing adoption placements, recruiting or interviewing potential foster care placements, serving legal papers, home investigations, providing

transportation, administering foster care subsidies, or making foster care placement arrangements;

(g) traveling to the client's home or other location where a covered case management activity occurs, nor time spent transporting a client or a client's family member;

(h) services for or on behalf of a non-Medicaid eligible or a non-targeted individual if services relate directly to the identification and management of the non-eligible or non-targeted individual's needs and care. For example, Medicaid does not cover counseling the client's sibling or helping the client's parent obtain a mental health service;

(i) activities for the proper and efficient administration of the Medicaid State Plan that include client assistance to establish and maintain Medicaid eligibility. For example, locating, completing and delivering documents to a Medicaid eligibility worker;

(j) recruitment activities in which the mental health center or case manager attempts to contact potential service recipients;

(k) time spent assisting the client to gather evidence for a Medicaid hearing or participating in a hearing as a witness; and

(l) time spent coordinating between case management team members for a client.

KEY: Medicaid
Date of Enactment or Last Substantive Amendment: [~~October 15, 2004~~]2009
Authorizing, and Implemented or Interpreted Law: 26-18-3

Health, Health Care Financing, Coverage and Reimbursement Policy
R414-33C-5
Service Coverage

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 32861
FILED: 7/30/09 12:23 PM

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This change is necessary to implement provisions of the Deficit Reduction Act (DRA) that reform case management and targeted case management (TCM) activities. This change also implements Medicaid policy into rule in accordance with Subsection 26-18-3(2)(a).

SUMMARY OF THE RULE OR CHANGE: This change implements covered case management under the DRA and clarifies the limits of direct delivery of foster care services. It also specifies other noncovered services and activities, and clarifies the allowance for targeted case management during an inpatient stay.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Deficit Reduction Act of 2005 Pub. L. No. 109-171 Section 6052 and Section 26-1-5 and Section 26-18-3

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: There is no budget impact because this amendment only implements ongoing Medicaid policy into rule and clarifies service coverage under the DRA.
♦ LOCAL GOVERNMENTS: There is no budget impact because local governments do not fund targeted case management services.
♦ SMALL BUSINESSES: There is no impact to other persons and small businesses because this amendment only implements ongoing Medicaid policy into rule and clarifies service coverage under the DRA. This amendment does not affect client eligibility and current TCM services. The change, therefore, does not increase costs to Medicaid recipients and does not impact providers that render TCM services.
♦ PERSONS OTHER THAN BUSINESS: There is no impact to other persons and small businesses because this amendment only implements ongoing Medicaid policy into rule and clarifies service coverage under the DRA. This amendment does not affect client eligibility and current TCM services. The change, therefore, does not increase costs to Medicaid recipients and does not impact providers that render TCM services.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs because this amendment only implements ongoing Medicaid policy into rule and clarifies service coverage under the DRA. This amendment does not affect client eligibility or current TCM services. The change, therefore, does not increase costs to a Medicaid recipient and does not impact a provider that renders TCM services.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Current Medicaid policy is not changed by this rule adoption of those policies. No fiscal impact expected.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HEALTH
HEALTH CARE FINANCING,
COVERAGE AND REIMBURSEMENT POLICY
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY, UT 84116-3231
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Craig Devashrayee by phone at 801-538-6641, by FAX at 801-538-6099, or by Internet E-mail at cdevashrayee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 5:00 PM ON 09/14/2009

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2009

AUTHORIZED BY: David Sundwall, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-33C. Targeted Case Management for the Homeless.
R414-33C-5. Service Coverage.

(1) [~~Targeted case management services include:~~]Medicaid covers:

(a) [~~assessing and documenting the client's potential strengths, resources and needs~~]client assessment to determine service needs, including activities that focus on needs identification to determine the need for any medical, educational, social, or other services. Assessment activities include taking client history, identifying the needs of the client and completing related documentation, gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the client;

(b) develop[~~ing~~]ment of a written, individualized, [~~and~~] coordinated case management service plan[~~:~~] based on information collected through an assessment that specifies the goals and actions to address the client's medical, social, educational and other service needs. This includes input from the client, the client's authorized health care decision maker, family, and other agencies knowledgeable about the client, to develop goals and identify a course of action to respond to the client's assessed needs;

[~~(i) that assures adequate access to medical, social, educational, and other related services; and~~

~~(ii) that is developed with input from the client, family, and other agencies knowledgeable about the client's needs;~~

~~]~~(c) [~~linking the client with community resources and needed services, including assisting the client to establish and maintain eligibility for entitlements other than Medicaid~~]referral and related activities to help the client obtain needed services, including activities that help link the client with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the client;

(d) coordinating the delivery of services to the client, including CHEC screening[~~s,~~] and follow-up[~~, and consultation with other agencies to ensure that the most appropriate interventions and services are provided by all agencies and providers involved in the client's care~~];

(e) [~~monitoring and coordinating prescribed medications with professionals to ensure that all medications are appropriate, as well as providing information on the client's medication regimen to other prescribers, agencies, and providers involved in the client's care~~]client assistance to establish and maintain eligibility for entitlements other than Medicaid;

(f) [~~periodically assessing and monitoring the client's status and functioning and modifying the targeted case management service plan as needed~~]monitoring and follow-up activities, including activities and contacts that are necessary to ensure the targeted case management service plan is effectively implemented and adequately addressing the needs of the client, which activities may be with the client, family members, providers or other entities, and conducted as frequently as necessary to help determine whether services are furnished in accordance with the client's case management service plan, whether the services in the case management service plan are adequate, whether there are changes in the needs or status of the client, and if so, making necessary adjustments in the case management service plan and service arrangements with providers;

(g) [~~monitoring to assure that appropriate and quality service is delivered in a timely manner~~]contacting non-eligible or non-targeted individuals when the purpose of the contact is directly related to the management of the eligible individual's care. For example, family members may be able to help identify needs and supports, assist the client to obtain services, and provide case managers with useful feedback to alert them to changes in the client's status or needs;

(h) instructing the client or caretaker, as appropriate, [~~to~~]in independently access[ing] needed services; and

(i) monitoring the client's progress and continued need for targeted case management and other services.

(2) The agency may bill Medicaid for the above activities only if:

(a) the activities are identified in the case management service plan and the time spent in the activity involves a face-to-face encounter[~~ and~~], telephone or written communication with the client, family, caretaker, service provider, or other individual with a direct involvement in providing or assuring [~~that~~]the client obtains the necessary services documented in the service plan[~~.~~]; and

(b) there are no other third parties liable to pay for services, including reimbursement under a medical, social, educational, or other program.

(3) [~~Targeted case management services~~]Covered case management service provided to a hospital or nursing facility patient [~~are~~]is limited to a maximum of five hours per admission.

(4) Medicaid does not cover:

(a) documenting targeted case management services with the exception of time spent developing the written case management needs assessment, service plans, and 180-day service plan reviews;

(b) teaching, tutoring, training, instructing, or educating the client or others, except when the activity is specifically designed to assist the client, parent, or caretaker to independently obtain client services. For example, Medicaid does not cover client assistance in completing a homework assignment or instructing a client or family member on nutrition, budgeting, cooking, parenting skills, or other skills development;

(c) directly assisting with personal care or daily living activities that include bathing, hair or skin care, eating, shopping, laundry, home repairs, apartment hunting, moving residences, or acting as a protective payee;

(d) routine courier services. For example, running errands or picking up and delivering food stamps or entitlement checks;

(e) direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred. For example, providing medical and psychosocial

evaluations, treatment, therapy and counseling, otherwise billable to Medicaid under other categories of service;

(f) direct delivery of foster care services that include research gathering and completion of documentation, assessing adoption placements, recruiting or interviewing potential foster care placements, serving legal papers, home investigations, providing transportation, administering foster care subsidies, or making foster care placement arrangements;

(g) traveling to the client's home or other location where a covered case management activity occurs, nor time spent transporting a client or a client's family member;

(h) services for or on behalf of a non-Medicaid eligible or a non-targeted individual if services relate directly to the identification and management of the non-eligible or non-targeted individual's needs and care. For example, Medicaid does not cover counseling the client's sibling or helping the client's parent obtain a mental health service;

(i) activities for the proper and efficient administration of the Medicaid State Plan that include client assistance to establish and maintain Medicaid eligibility. For example, locating, completing and delivering documents to a Medicaid eligibility worker;

(j) recruitment activities in which the mental health center or case manager attempts to contact potential service recipients;

(k) time spent assisting the client to gather evidence for a Medicaid hearing or participating in a hearing as a witness; and

(l) time spent coordinating between case management team members for a client.

KEY: Medicaid
Date of Enactment or Last Substantive Amendment: [~~April 7, 2005~~]2009
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3

Health, Health Care Financing, Coverage and Reimbursement Policy
R414-33D-5
Service Coverage

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 32862
FILED: 7/30/09 12:34 PM

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This change is necessary to implement provisions of the Deficit Reduction Act (DRA) that reform case management and targeted case management (TCM) activities. This change also implements Medicaid policy into rule in accordance with Subsection 26-18-3(2)(a).

SUMMARY OF THE RULE OR CHANGE: This change implements covered case management under the DRA and clarifies the limits of direct delivery of foster care services. It also specifies other noncovered services and activities, and clarifies the allowance for targeted case management during an inpatient stay.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Deficit Reduction Act of 2005 Pub. L. No. 109-171 Section 6052 and Section 26-1-5 and Section 26-18-3

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: There is no budget impact because this amendment only implements ongoing Medicaid policy into rule and clarifies service coverage under the DRA.
♦ LOCAL GOVERNMENTS: There is no budget impact because local governments do not fund targeted case management services.
♦ SMALL BUSINESSES: There is no impact to other persons and small businesses because this amendment only implements ongoing Medicaid policy into rule and clarifies service coverage under the DRA. This amendment does not affect client eligibility and current TCM services. The change, therefore, does not increase costs to Medicaid recipients and does not impact providers that render TCM services.
♦ PERSONS OTHER THAN BUSINESS: There is no impact to other persons and small businesses because this amendment only implements ongoing Medicaid policy into rule and clarifies service coverage under the DRA. This amendment does not affect client eligibility and current TCM services. The change, therefore, does not increase costs to Medicaid recipients and does not impact providers that render TCM services.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs because this amendment only implements ongoing Medicaid policy into rule and clarifies service coverage under the DRA. This amendment does not affect client eligibility or current TCM services. The change, therefore, does not increase costs to a Medicaid recipient and does not impact a provider that renders TCM services.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Current Medicaid policy is not changed by this rule adoption of those policies. No fiscal impact expected.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HEALTH
HEALTH CARE FINANCING,
COVERAGE AND REIMBURSEMENT POLICY
CANNON HEALTH BLDG
288 N 1460 W

SALT LAKE CITY, UT 84116-3231
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO: ♦ Craig Devashrayee by phone at 801-538-6641, by FAX at 801-538-6099, or by Internet E-mail at cdevashrayee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 5:00 PM ON 09/14/2009

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2009

AUTHORIZED BY: David Sundwall, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-33D. Targeted Case Management by Community Mental Health Centers for Individuals with Serious Mental Illness.
R414-33D-5. Service Coverage.

(1) [~~Covered services include~~]Medicaid covers:

(a) [~~assessing and documenting the client's potential strengths, resources and needs~~]client assessment to determine service needs, including activities that focus on needs identification to determine the need for any medical, educational, social, or other services. Assessment activities include taking client history, identifying the needs of the client and completing related documentation, gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the client;

(b) develop[~~ing~~]ment of a written, individualized, and coordinated case management service plan based on information collected through an assessment that specifies the goals and actions to address the client's medical, social, educational and other service needs. This includes input from the client, the client's authorized health care decision maker, family, and other agencies knowledgeable about the client, to develop goals and identify a course of action to respond to the client's assessed needs[~~to assure the client's adequate access to needed medical, social, educational, and other related services with input from the client, the client's family, and other agencies knowledgeable about the client's needs~~];

(c) [~~linking the client with community resources and needed services, including assisting the client to establish and maintain eligibility for entitlements other than Medicaid~~]referral and related activities to help the client obtain needed services, including activities that help link the client with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the client;

(d) coordinating the delivery of services to the client, including CHEC screening and follow-up[~~monitoring the client's symptomatology, functioning, medications, and medication regimen~~];

(e) [~~coordinating the client's medications and medication regimen with other providers~~]client assistance to establish and maintain eligibility for entitlements other than Medicaid;[~~,~~]

(f) [~~coordinating the delivery of needed services, including CHEC screenings and follow-up and coordinating with hospital or nursing facility discharge planners in the 30-day period prior to the patient's discharge into the community~~]monitoring and follow-up activities, including activities and contacts that are necessary to ensure the targeted case management service plan is effectively implemented and adequately addressing the needs of the client, which activities may be with the client, family members, providers or other entities, and conducted as frequently as necessary to help determine whether services are furnished in accordance with the client's case management service plan, whether the services in the case management service plan are adequate, whether there are changes in the needs or status of the client, and if so, making necessary adjustments in the case management service plan and service arrangements with providers;

(g) [~~monitoring to assure the appropriateness and quality of services delivered and that they are being obtained in a timely manner~~]contacting non-eligible or non-targeted individuals when the purpose of the contact is directly related to the management of the eligible individual's care. For example, family members may be able to help identify needs and supports, assist the client to obtain services, and provide case managers with useful feedback to alert them to changes in the client's status or needs;

(h) instructing the client or caretaker, as appropriate, in independently accessing needed services; and

(i) monitoring the client's progress and continued need for targeted case management and other services.

(2) The agency may bill Medicaid for the above activities only if:

(a) the activities are identified in the case management service plan and the time spent in the activity involves a face-to-face encounter, telephone or written communication with the client, family, caretaker, service provider, or other individual with a direct involvement in providing or assuring the client obtains the necessary services documented in the service plan[~~-~~]; and

(b) there are no other third parties liable to pay for services, including reimbursement under a medical, social, educational, or other program.

(3) Covered [~~C~~]case management service[~~s~~] provided to a hospital or nursing facility patient [~~are~~]is limited to a maximum of five hours per admission.

(4) Medicaid does not cover:

(a) documenting targeted case management services with the exception of time spent developing the written case management needs assessment, service plans, and 180-day service plan reviews;

(b) teaching, tutoring, training, instructing, or educating the client or others, except when the activity is specifically designed to assist the client, parent, or caretaker to independently obtain client services. For example, Medicaid does not cover client assistance in completing a homework assignment or instructing a client or family member on nutrition, budgeting, cooking, parenting skills, or other skills development;

(c) directly assisting with personal care or daily living activities that include bathing, hair or skin care, eating, shopping, laundry, home repairs, apartment hunting, moving residences, or acting as a protective payee;

(d) routine courier services. For example, running errands or picking up and delivering food stamps or entitlement checks;

(e) direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred. For example, providing medical and psychosocial evaluations, treatment, therapy and counseling, otherwise billable to Medicaid under other categories of service;

(f) direct delivery of foster care services that include research gathering and completion of documentation, assessing adoption placements, recruiting or interviewing potential foster care placements, serving legal papers, home investigations, providing transportation, administering foster care subsidies, or making foster care placement arrangements;

(g) traveling to the client's home or other location where a covered case management activity occurs, nor time spent transporting a client or a client's family member;

(h) services for or on behalf of a non-Medicaid eligible or a non-targeted individual if services relate directly to the identification and management of the non-eligible or non-targeted individual's needs and care. For example, Medicaid does not cover counseling the client's sibling or helping the client's parent obtain a mental health service;

(i) activities for the proper and efficient administration of the Medicaid State Plan that include client assistance to establish and maintain Medicaid eligibility. For example, locating, completing and delivering documents to a Medicaid eligibility worker;

(j) recruitment activities in which the mental health center or case manager attempts to contact potential service recipients;

(k) time spent assisting the client to gather evidence for a Medicaid hearing or participating in a hearing as a witness; and

(l) time spent coordinating between case management team members for a client.

KEY: Medicaid
Date of Enactment or Last Substantive Amendment: [~~July 20, 2005~~]2009
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3

Health, Health Care Financing, Coverage and Reimbursement Policy
R414-54-3
Services

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 32841
FILED: 7/27/09 7:59 AM

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this change is to incorporate by reference the Speech-Language Pathology Services Provider Manual, effective 10/01/2009.

SUMMARY OF THE RULE OR CHANGE: This change incorporates by reference the Speech-Language Pathology Services Provider Manual, effective 10/01/2009.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 26-18-3

TITLE OF MATERIALS INCORPORATED BY REFERENCES:

Official Title of Materials Incorporated: Speech-Language Pathology Services Provider Manual
Publisher: Division of Health Care Financing
Date Issued: 10/01/2009
Add, update, remove: Update

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: There is no budget impact because the incorporation of ongoing Medicaid policy described in the Speech-Language Pathology Services Provider Manual does not create costs or savings to the Department or other state agencies.
♦ LOCAL GOVERNMENTS: This change does not impact local governments because they do not fund or provide speech-language pathology services to Medicaid clients.
♦ SMALL BUSINESSES: There is no budget impact because the incorporation of ongoing Medicaid policy described in the Speech-Language Pathology Services Provider Manual does not create costs or savings to small businesses.
♦ PERSONS OTHER THAN BUSINESS: There is no budget impact because the incorporation of ongoing Medicaid policy described in the Speech-Language Pathology Services Provider Manual does not create costs or savings to other persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs because the incorporation of ongoing Medicaid policy described in the Speech-Language Pathology Services Provider Manual does not create additional costs to a Medicaid client or a loss of revenue to a Medicaid provider.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule should not have a direct fiscal impact on business. Incorporation of this section of the Provider Manual by this rule assures that the Medicaid program is implemented through administrative rule.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HEALTH
HEALTH CARE FINANCING,

COVERAGE AND REIMBURSEMENT POLICY
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY, UT 84116-3231
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Craig Devashrayee by phone at 801-538-6641, by FAX at 801-538-6099, or by Internet E-mail at cdevashrayee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 5:00 PM ON 09/14/2009

THIS RULE MAY BECOME EFFECTIVE ON: 10/01/2009

AUTHORIZED BY: David Sundwall, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-54. Speech-Language Pathology Services.
R414-54-3. Services.

(1) Speech-language pathology services are optional.

(2) Speech-language pathology services are limited to services described in the Speech-Language Pathology Services Provider Manual, effective [~~July~~]October 1, 2009, which is incorporated by reference.

(3) The Speech-Language Pathology Services Provider Manual specifies the reasonable and appropriate amount, duration, and scope of the service sufficient to reasonably achieve its purpose.

(4) Speech-language pathology services may be provided by licensed speech-language pathologists, or speech-language pathology aides under the supervision of speech-language pathologists.

KEY: Medicaid, speech-language pathology services
Date of Enactment or Last Substantive Amendment: [~~July 1~~], 2009
Notice of Continuation: March 9, 2009
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3

Health, Health Care Financing, Coverage and Reimbursement Policy
R414-59-4
Client Eligibility Requirements

NOTICE OF PROPOSED RULE
(Amendment)

DAR FILE NO.: 32842
FILED: 7/27/09 8:02 AM

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this change is to incorporate by reference the Audiology Provider Manual, effective 10/01/2009.

SUMMARY OF THE RULE OR CHANGE: This change incorporates by reference the Audiology Provider Manual, effective 10/01/2009.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 26-18-3

TITLE OF MATERIALS INCORPORATED BY REFERENCES:

Official Title of Materials Incorporated: Audiology Provider Manual
Publisher: Division of Health Care Financing
Date Issued: 10/01/2009
Add, update, remove: Update

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: There is no budget impact because the incorporation of ongoing Medicaid policy described in the Audiology Provider Manual does not create costs or savings to the Department or other state agencies.
♦ LOCAL GOVERNMENTS: This change does not impact local governments because they do not fund or provide audiology services to Medicaid clients.
♦ SMALL BUSINESSES: There is no budget impact because the incorporation of ongoing Medicaid policy described in the Audiology Provider Manual does not create costs or savings to small businesses.
♦ PERSONS OTHER THAN BUSINESS: There is no budget impact because the incorporation of ongoing Medicaid policy described in the Audiology Provider Manual does not create costs or savings to other persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs because the incorporation of ongoing Medicaid policy described in the Audiology Provider Manual does not create additional costs to a Medicaid client or a loss of revenue to a Medicaid provider.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule should not have a direct fiscal impact on business. Incorporation of this section of the Provider Manual by this rule assures that the Medicaid program is implemented through administrative rule.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HEALTH
HEALTH CARE FINANCING,

COVERAGE AND REIMBURSEMENT POLICY
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY, UT 84116-3231
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO: ♦ Craig Devashrayee by phone at 801-538-6641, by FAX at 801-538-6099, or by Internet E-mail at cdevashrayee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 5:00 PM ON 09/14/2009

THIS RULE MAY BECOME EFFECTIVE ON: 10/01/2009

AUTHORIZED BY: David Sundwall, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-59. Audiology-Hearing Services.
R414-59-4. Client Eligibility Requirements.

(1) Audiology-hearing services are available only to clients who are pregnant women or who are individuals eligible under the Early and Periodic Screening, Diagnosis and Treatment Program.

(2) An individual receiving audiology-hearing services may receive audiology services as described in the Audiology Provider Manual, effective [~~July~~]October 1, 2009, which is incorporated by reference.

(3) An individual receiving audiology-hearing services must meet the criteria established in the Audiology Provider Manual and obtain prior approval if required.

KEY: Medicaid, audiology
Date of Enactment or Last Substantive Amendment: [~~July 1~~], 2009
Notice of Continuation: November 22, 2005
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3

Health, Health Care Financing, Coverage and Reimbursement Policy
R414-306
Program Benefits

NOTICE OF PROPOSED RULE
(Amendment)

DAR FILE NO.: 32859
FILED: 7/30/09 11:27 AM

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this change is to clarify eligibility criteria for retroactive Medicaid coverage and to comply with federal requirements.

SUMMARY OF THE RULE OR CHANGE: This amendment changes the effective date of Medicaid eligibility to the first day of the month for each month. This change complies with federal requirements to determine the effective date for Medicaid eligibility for the retroactive period.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 26-18-3

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: Failure to make this change will cause the state to lose federal financial participation funds. While there may be some minimal costs associated with this change, the Department cannot quantify the cost because it does not have information regarding individual medical expenses for the days before the current effective date of Medicaid eligibility. Nevertheless, the Department does not anticipate large costs because current operations assist individuals to apply in a timelier fashion that allows them to receive coverage for the time period in which they had medical expenses.
♦ LOCAL GOVERNMENTS: This change does not impact local governments because they do not determine eligibility nor receive monies collected as spenddowns from Medicaid recipients.
♦ SMALL BUSINESSES: This change does not impact small businesses because they do not determine Medicaid eligibility. Medicaid applicants may see some savings if they delay applying for Medicaid and cannot get coverage for some days in the retroactive period. The Department cannot quantify the savings, however, because it does not have information regarding individual medical expenses for days before the current effective date of Medicaid eligibility.
♦ PERSONS OTHER THAN BUSINESS: This change does not impact small businesses because they do not determine Medicaid eligibility. Medicaid applicants may see some savings if they delay applying for Medicaid and cannot get coverage for some days in the retroactive period. The Department cannot quantify the savings, however, because it does not have information regarding individual medical expenses for days before the current effective date of Medicaid eligibility.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs because this change does not require a Medicaid recipient to pay more for Medicaid coverage, and it does not reduce eligibility for Medicaid services.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This change is required by federal law and will not have a negative fiscal impact on business.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HEALTH
HEALTH CARE FINANCING, COVERAGE AND REIMBURSEMENT POLICY
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY, UT 84116-3231
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Craig Devashrayee by phone at 801-538-6641, by FAX at 801-538-6099, or by Internet E-mail at cdevashrayee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 5:00 PM ON 09/14/2009

THIS RULE MAY BECOME EFFECTIVE ON: 10/01/2009

AUTHORIZED BY: David Sundwall, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-306. Program Benefits.
R414-306-3. [~~QMB and SLMB~~]Qualified Medicare Beneficiary Date of Entitlement.

(1) [~~The Department adopts~~]Eligibility for the Qualified Medicare Beneficiary (QMB) program begins the first day of the month after the month the Medicaid eligibility agency determines that the individual is eligible, in accordance with the requirements of 42 U.S.C. 1396a(e)(8)[~~Subsection 1902(e)(8) of the Compilation of the Social Security Laws, 2001 ed., U.S. Government Printing Office, Washington, D.C., which is incorporated by reference~~].

(2) There is no provision for retroactive QMB assistance.

R414-306-4. Effective Date of Eligibility.

[~~(1) The Department adopts 42 CFR 435.914, 2001 ed., which is incorporated by reference.~~

~~(2) Eligibility for any Medicaid program, or the SLMB or QI-1 program, shall begin no earlier than the date that is three months before the date of application for benefits. Coverage shall not be effective on the first day of a month if that date is more than three months before the application date. Coverage in the months before the application month cannot begin before the date the applicant met the eligibility criteria.~~

~~(a) Institutional Medicaid shall begin on the date that the Department receives verification of nursing home admission from the nursing home, but no earlier than the date that is three months before the date of application for nursing home services.~~

~~(b) Eligibility under a Home and Community Based (HCB) Services waiver shall begin on the date the client is determined to meet the level-of-care criteria and home and community based services are scheduled to begin within the month, but no earlier than the date that is three months before the date of application for HCB services.~~

~~(c) Eligibility for benefits as a Qualifying Individual-Group 1 can begin no earlier than the date that is three months before the date of application and in no case before January 1, 1998. An individual selected to receive QI-1 benefits in a month of the year is entitled to receive such assistance for the remainder of the calendar year if the individual continues to be a qualifying individual and the program still exists. Receipt of QI-1 benefits in one calendar year does not entitle the individual to continued assistance in any succeeding year.~~

~~(3) Eligibility in the application month and on-going months shall begin on the first day of such month, except for~~

~~(a) an individual who just moved to Utah, in which case the effective date of eligibility of such individual cannot be earlier than the date that the individual meets the state residency requirement defined in R414-302-2; and~~

~~(b) an individual who is a qualified alien subject to the five-year bar on receiving regular Medicaid services, in which case eligibility cannot begin earlier than the date that is five years after the date the person became a qualified alien, or the date the five-year bar ends due to other events defined in statute.~~

~~(c) an individual who is a qualified alien not subject to the five-year bar on receiving regular Medicaid services, in which case eligibility cannot begin earlier than the date the individual's qualified alien status began.~~

~~(4) There is no provision for retroactive QMB assistance.~~

~~(5) After being approved for Medicaid, a client may request retroactive coverage based on the date of the approved application, but only if the client had not previously requested the retroactive coverage, and had either been denied for such time period or had failed to meet a spenddown for such time period. The recipient must provide verifications needed to establish eligibility for the retroactive period being requested.~~](1) Subject to the exceptions in Subsection R414-306-4(3), eligibility for any Medicaid program, and for the Specified Low-income Medicare Beneficiary (SLMB) or Qualified Individual (QI) programs begins the first day of the application month if the individual is determined to meet the eligibility criteria for that month.

(2) An applicant for Medicaid, SLMB or QI benefits may request medical coverage for the retroactive period. The retroactive period is the three months immediately preceding the month of application.

(a) An applicant may request coverage for one or more months of the retroactive period.

(b) Subject to the exceptions in Subsection R414-306-4(3), eligibility for retroactive medical coverage begins no earlier than the first day of the month that is three months before the application month.

(c) The applicant must receive medical services during the retroactive period and be determined eligible for the month he receives services.

(3) To determine the date eligibility for medical assistance may begin for any month, the following requirements apply:

(a) Eligibility of an individual cannot begin any earlier than the date the individual meets the state residency requirement defined in Section R414-302-2;

(b) Eligibility of a qualified alien subject to the five-year bar on receiving regular Medicaid services cannot begin earlier than the date that is five years after the date the person became a qualified alien, or the date the five-year bar ends due to other events defined in statute;

(c) Eligibility of a qualified alien not subject to the five-year bar on receiving regular Medicaid services can begin no earlier than the date the individual meets qualified alien status.

(4) If an applicant is not eligible for the application month, but requests retroactive coverage, the agency will determine eligibility for the retroactive period based on the date of that application.

(5) The agency may use the same application to determine eligibility for the month following the month of application if the applicant is determined ineligible for both the retroactive period and the application month. In this case, the application date changes to the date eligibility begins. The retroactive period associated with the application changes to the three months preceding the new application date.

(6) Medicaid eligibility for certain services begins when the individual meets the following criteria:

(a) Eligibility for coverage of institutional services cannot begin before the date that the individual has been admitted to a medical institution and meets the level of care criteria for admission. The medical institution must provide the required admission verification to the Department within the time limits set by the Department in Rule R414-501. Medicaid eligibility for institutional services does not begin earlier than the first day of the month that is three months before the month of application for Medicaid coverage of institutional services.

(b) Eligibility for coverage of home and community-based services under a Medicaid waiver cannot begin before the first day of the month the client is determined by the case management agency to meet the level of care criteria and home and community-based services are scheduled to begin within the month. The case management agency must verify that the individual meets the level of care criteria for waiver services. Medicaid eligibility for waiver services does not begin earlier than the first day of the month that is three months before the month of application for Medicaid coverage of waiver services.

(7) An individual determined eligible for QI benefits in a calendar year is eligible to receive those benefits throughout the remainder of the calendar year, if the individual continues to meet the eligibility criteria and the program still exists. Receipt of QI benefits in one calendar year does not entitle the individual to QI benefits in any succeeding year.

(8) After being approved for Medicaid, a client may later request coverage for the retroactive period associated with the approved application if the following criteria are met:

(a) The client did not request retroactive coverage at the time of application; and

(b) The agency did not make a decision about eligibility for medical assistance for that retroactive period; and

(c) The client states that he received medical services and provides verification of his eligibility for the retroactive period.

(9) A client cannot request coverage for the retroactive period associated with a denied application. The client, however, may reapply and a new retroactive coverage period is considered based on the new application date.

KEY: effective date, program benefits, medical transportation
Date of Enactment or Last Substantive Amendment: [~~July 19, 2004~~]2009
Notice of Continuation: January 25, 2008
Authorizing, and Implemented or Interpreted Law: 26-18

Health, Center for Health Data, Health Care Statistics
R428-15
Health Data Authority Health Insurance Claims Reporting

NOTICE OF PROPOSED RULE

(New Rule)
DAR FILE NO.: 32858
FILED: 7/29/09 4:30 PM

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule establishes the process for the submission of claims and enrollment data from Utah health insurance plans. Claims data are needed to develop and maintain a statewide all-claims database to report on episodes of care and to promote health care transparency.

SUMMARY OF THE RULE OR CHANGE: The Cost and Quality Data Project (H.B. 9), passed by the Utah Legislature in the 2007 General Session, directed the Utah Health Data Committee (HDC) to create an advisory panel to study issues related to the development of an All Payer Database (APD) that would assist in the analysis of a variety of health care data in Utah. Over a nine-month period (August 2007 - May 2008), a diverse panel of stakeholders developed a draft health data plan for this project. The plan, as outlined by H.B. 9, addressed the necessity of an APD, how it would be compiled, and how and by whom it would be used. On 07/08/2008, the HDC unanimously approved the plan at its quarterly meeting. In order to finance the project, the 2008 Legislature appropriated $615,000 of on-going monies via H.B. 133, Health Care Reform. This bill passed with overwhelming support from both parties and now has become a major focus of health care reform in Utah. The Utah Department of Health Office of Health Care Statistics (OHCS) is currently responsible for building and managing the APD. Health care insurance claims data will be submitted to the OHCS from insurance companies (payers) operating in Utah

and then entered into the APD. (DAR NOTE: H.B. 9 (2007) is found at Chapter 29, Laws of Utah 2007, and was effective 04/30/2007. H.B. 133 (2008) is found at Chapter 383, Laws of Utah 2008, and was effective 05/05/2008.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Title 26, Chapter 25 and Title 26, Chapter 33a

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: In order to finance the project, the 2008 Legislature appropriated $615,000 of on-going monies via H.B. 133. This bill passed with overwhelming support from both parties.
♦ LOCAL GOVERNMENTS: This rule has no anticipated cost or savings to local government.
♦ SMALL BUSINESSES: A carrier that covers fewer than 200 individual Utah residents is exempt from all requirements of this rule. It is highly unlikely that there are any small businesses that are licensed to provide health insurance coverage - including third party administrators - with fewer than 50 employees.
♦ PERSONS OTHER THAN BUSINESS: A carrier that covers more than 200 individual Utah residents will be required to submit data as required in the rule. Costs to these businesses will vary depending upon the information technology systems and support they have in place. The submission format and guidelines were developed with this dialogue and payer input in mind. The OHCS has accommodated the payers wherever possible to minimize financial and procedural impact. This rule has no anticipated cost or savings to individuals, local governments, and persons that are not small businesses.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The OHCS opened dialogue with payers in August 2008 about the Utah APD. The submission format and guidelines were developed with this dialogue and payer input in mind. The OHCS has accommodated the payers wherever possible to minimize financial and procedural impact. The APD architecture and data submission pathways were significantly altered to help reduce impact on the payers (e.g., establishing FTS Secure pathway in addition to UHIN Web Services, utilizing UHIN for X12-837 submission, developing claims standards that center around the X12 837 format).

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The OHCS has taken extraordinary steps to minimize financial impact on the carriers required to submit data. Utah is a national leader on this initiative. Fiscal impact is expected to be acceptable to regulated entities. The benefits to the public of this data should be very significant and permit consumers to better understand the cost of health care and make informed choices.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HEALTH
CENTER FOR HEALTH DATA,
HEALTH CARE STATISTICS
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY, UT 84116-3231
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Keely Cofrin Allen by phone at 801-538-6551, by FAX at 801-538-9916, or by Internet E-mail at kcofrinallen@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 5:00 PM ON 09/14/2009

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2009

AUTHORIZED BY: David Sundwall, Executive Director

R428. Health, Center for Health Data, Health Care Statistics.
R428-15. Health Data Authority Health Insurance Claims Reporting.
R428-15-1. Purpose and Authority.

(1) This rule establishes requirements for certain entities that pay for health care to submit data to the Utah Department of Health.

(2) This rule is promulgated under authority granted in Utah Code Title 26, Chapter 33a and in accordance with the Utah Health Data Plan as adopted in R428-1.

R428-15-2. Definitions.

These definitions apply to rule R428-15, in addition:

(1) "Office" means the Office of Health Care Statistics within the Utah Department of Health, which serves as staff to the Utah Health Data Committee.

(2) "Carrier" means:

(a) a commercial insurance company engaged in the business of health care insurance in the state of Utah, as defined in 31A-1-301 (74), including a business under an administrative services organization or administrative services contract arrangement;

(b) a third party administrator, as defined in 31A-1-301 (159), licensed by the state of Utah that collects premiums or settles claims of residents of the state, for health care insurance policies or health benefit plans, as defined in 31A-1-301 (148)

(c) a governmental plan as defined in Section 414 (d), Internal Revenue Code;

(d) a non-electing church plan as described in Section 410 (d), Internal Revenue Code;

(e) a licensed professional employer organization acting as an administrator of a health care insurance policy or health benefit plan funded by a self-insurance arrangement; or

(f) a dental stand-alone company as defined in 31A-8-101 (6).

(3) "Claim" means a request or demand on a carrier for payment of a benefit.

(4) "Health care claims data" means information consisting of, or derived directly from, member enrollment, medical claims, and pharmacy claims that this rule requires a carrier to report.

(5) "Health Insurance" has the same meaning as found in Subsection 31A-1-301.

(6) "Technical specifications" means the technical specifications document published by the Health Data Committee describing the variables and formats of the data that are to be submitted as well as submission directions and guidelines.

R428-15-3. Reporting Requirements.

(1) Each carrier shall submit enrollment, medical claims, and pharmacy data described in R428-15-5 where Utah is the patient's primary residence and enrollment, medical claims, and pharmacy data for services provided out of state to Utah residents.

(2) Each carrier shall begin submitting the required data to the office no later than October 17, 2009. The initial data submission must be completed by November 15, 2009. The initial data submission shall be for claims incurred from January 1, 2007 through December 31, 2008 and which are paid through September 30, 2009. Thereafter, each carrier shall submit monthly health care claims data. Each monthly submission is due no later than the last day of the following month.

R428-15-4. Reporting Process.

(1) Submission procedures and guidelines are described in detail in the technical specifications published by the Health Data Committee. The health care claims data shall be either X12 format, or flat text files formatted according to the technical specifications.

(2) All medical claims shall be submitted to the Office through the Utah Health Information Network (UHIN) in X12 format.

(3) All enrollment and pharmacy data files shall be submitted to the Office in flat text files using either UHIN or FTP Secure.

R428-15-5. Required Data Elements.

(1) The enrollment, medical claims, and pharmacy data elements are described in detail in the technical specifications published by the Health Data Committee. Each carrier shall submit data for all fields contained in the submission specifications if the data are available to the carrier.

(a) Each carrier must submit enrollment files as a flat file.

(b) Each carrier must submit medical claims as X12 messages as modified by this rule. All X12 format messages must contain all the necessary segments for processing through UHIN. This includes ISA/IEA segments, GS and GE segments, Segment Qualifier codes, etc., as specified in the X12 implementation guides. If a segment or qualifier is required for X12 format, it is required for all submissions under this rule. If a segment or qualifier is not required for X12 format, but is required by this rule, it must be submitted as required by this rule. Submitted files must be in the ASC X12 4010A1 x098 for a Professional Claim and in the ASC X12 4010A1 x096 for an Institutional claim.

(c) Each carrier must submit pharmacy claims as a flat file.

(2) Enrollment Files. Each carrier must submit the following data elements for each enrollment file:

(a) Record Type
(b) Transaction Code
(c) File Create Date
(d) Member ID
(e) Social Security Number
(f) Member's Relationship to Subscriber
(g) Last Name
(h) First Name
(i) Middle Name
(j) Sex
(k) Street
(l) City
(m) State
(n) Zip Code
(o) Primary Phone
(p) Birth date
(q) Race
(r) Ethnicity
(s) Primary/Secondary
(t) Designated Primary Care Physician
(u) PCP ID
(v) Healthplan Code
(w) Benefit Option Code
(x) Option Effective Date
(y) HP Termination Date
(z) Employer Group Code
(aa) Patient ID
(bb) Health Plan Description
(cc) Orig. HP Effective Date
(dd) Member Status.

(3) Professional Medical Claims. Each carrier must submit the following data elements for each professional medical claim:

(a) Data Element - Data Element Description
(b) BHT06 - BHT Beginning of Hierarchical Trans
(c) GS08 - Functional Group Header
(d) GS07 - Functional Group Header
(e) Submitter Information
(i) 1000A NM103 - Submitter Name
(ii) 1000A NM109 - Submitter Identifier
(iii) 1000A PER01-05 - Submitter EDI Contact Information
(f) 1000B NM103 - Receiver Name
(g) 1000B NM109 - Receiver Identifier
(h) Billing Provider
(i) 2010AA NM103 - Billing Provider Name
(ii) 2010AA NM109 - Billing Provider ID
(iii) 2010AA REF02 - Billing Provider Secondary ID
(i) 2000B SBR02 - Individual Relationship Code
(j) 2000B SBR03 - Insured Group or Policy Number
(k) 2010BB NM103 - Payer Name
(l) Subscriber Information
(i) 2010BA NM103 - Subscriber Lname
(ii) 2010BA NM104 - Subscriber Fname
(iii) 2010BA NM105 - Subscriber Middle Name
(iv) 2010BA NM109 - Subscriber Primary Identifier
(v) 2010BA N301 - Subscriber Address1
(vi) 2010BA N302 - Subscriber Address2
(vii) 2010BA N401 - Subscriber City Name

(viii) 2010BA N402 - Subscriber State
(ix) 2010BA N403 - Subscriber Zip Code
(x) 2010BA DMG20 - Subscriber Date of Birth
(xi) 2010BA DMG03 - Subscriber Sex
(xii) 2010BA REF01 - Subscriber Secondary ID Qualifier
(xiii) 2010BA REF02 - Subscriber Secondary ID
(m) Patient Information
(i) 2000C PAT01 - Patients Relationship to Insured
(ii) 2010CA NM103 - Patient Lname
(iii) 2010CA NM104 - Patient Fname
(iv) 2010CA NM105 - Patient Middle Name
(v) 2010CA NM109 - Patient Primary Identifier
(vi) 2010BA/2010CA N301 - Patient Address1
(vii) 2010CA N302 - Patient Address2
(viii) 2010CA N401 - Patient City Name
(ix) 2010CA N402 - Patient State
(x) 2010CA N403 - Patient Zip Code
(xi) 2010CA DMG02 - Patient Date of Birth
(xii) 2010CA DMG03 - Patient Sex
(xiii) 2010CA REF01 - Patient Secondary ID Qualifier
(xiv) 2010CA REF02 - Patient Secondary ID
(n) 2300 CLM05-1 - Facility Type Code
(o) 2300 CLM05-3 - Claim Frequency Type Code
(p) 2300 REF02 When REF01 = F8 - Original Reference Number
(q) 2300 CLM01 - Patient Account Number
(r) 2300 REF02 When REF01 = EA - Medical Record Number
(s) 2300 CLM02 - Total Claim Charge Amount
(t) 2300 AMT02 When AMT01 = F5 - Patient Paid Amount
(u) 2320 AMT02 When AMT01 = D - COB Payer Paid Amount
(v) 2310D NM103 - Service Facility Name
(w) 2310D NM109 - Service Facility ID Code
(x) 2330B DTP03 When DTP01 = 573 - Claim Adjudication Date
(y) 2320 AMT02 When AMT01 = B6 - COB Allowed Amount
(z) Claim Adjustment Information
(i) 2320 CAS01 - Claim Adjustment Group Code
(ii) 2320 CAS02 - Claim Adjustment Reason Code
(iii) 2320 CAS03 - Claim Level Adjustment Amount
(aa) 2310D NM109 - Laboratory or Facility Primary Identifier
(bb) Diagnosis Information
(i) 2300 HI01 -2 - Principal Diagnosis
(ii) 2300 HI02 -2
(iii) 2300 HI03 -2
(iv) 2300 HI04 -2
(v) 2300 HI05
(vi) 2300 HI06 -2
(vii) 2300 HI07 -2
(viii) 2300 HI08 -2
(ix) 2300 HI09 -2
(x) 2300 HI10
(xi) 2300 HI11 -2
(xii) 2300 HI12 -2
(cc) 2310B PRV03 or 2000A - Rendering Provider Specialty
(dd) Rendering Provider Information
(i) 2310B NM103 - Rendering Provider LName
(ii) 2310B NM104 - Rendering Provider FName
(iii) 2310B NM105 - Rendering Provider Name Middle
(iv) 2310B NM107 - Rendering Provider Name Suffix
(v) 2310B NM109 - Rendering Provider Primary Identifier
(vi) 2310B REF02 - Rendering Provider Secondary ID
(ee) 2400 LX01 - Line Counter
(ff) 2400 DTP03 WHEN DTP01 = 472 - Date(s) of Service
(gg) Provider Modifiers
(i) 2400 SV101-2
(ii) 2400 SV101-3
(iii) 2400 SV101-4
(iv) 2400 SV101-5
(v) 2400 SV101-6
(hh) 2400 SV104 - Days or Units
(ii) 2400 SV102 - Line Item Charge Amount
(jj) 2400 AMT02 - Allowed Amount
(kk) 2410 LIN03 - Drug Identification
(ll) 2410 REF02 When REF01 = XZ - Prescription Number
(mm) Drug Information
(i) 2410 CTP05-1 - Drug Units Qualifier
(ii) 2410 CTP04 - Drug Number of Units
(iii) 2410 CTP03 - Drug Cost or Unit Price
(nn) Line Adjustment Codes
(i) 2430 CAS01 - Line Adjustment Group Code
(ii) 2430 CAS02 - Line Adjustment Reason Code
(iii) 2430 CAS03 - Line Level Adjustment Amount.
(4) Institutional Medical Claims. Each carrier must submit the following data elements for each institutional medical claim:
(a) BHT01 BHT06 - Hierarchical Structure Code
(b) GS08 - Functional Group Header
(c) GS01 - Functional Group Header
(d) Submitter Information
(i) 1000A NM103 - Submitter Name
(ii) 1000A NM109 - Submitter Identifier
(iii) 1000A PER01-05 - Submitter EDI Contact Information
(e) 1000B NM103 - Receiver Name
(f) 1000B NM109 - Receiver Identifier
(g) Billing Provider Information
(i) 2010AA NM103 - Billing Provider Name
(ii) 2010AA NM109 - Billing Provider ID
(iii) 2010AA REF02 - Billing Provider Secondary ID
(h) 2000B SBR02 - Individual Relationship Code
(i) 2000B SBR03 - Insured Group or Policy Number
(j) 2010BC NM103 - Payer Name
(k) Subscriber Information
(i) 2010BA NM103 - Subscriber Lname
(ii) 2010BA NM104 - Subscriber Fname
(iii) 2010BA NM105 - Subscriber Middle Name
(iv) 2010BA NM109 - Subscriber Primary Identifier
(v) 2010BA N301 - Subscriber Address1

(vi) 2010BA N302 - Subscriber Address2
(vii) 2010BA N401 - Subscriber City Name
(viii) 2010BA N402 - Subscriber State
(ix) 2010BA N403 - Subscriber Zip Code
(x) 2010BA DMG02 - Subscriber Date of Birth
(xi) 2010BA DMG03 - Subscriber Sex
(xii) 2010BA REF01 - Subscriber Secondary ID Qualifier
(xiii) 2010BA REF02 - Subscriber Secondary Identification
(l) Patient Information
(i) 2000C PAT01 - Patients Relationship to Insured
(ii) 2010CA NM103 - Patient Lname
(iii) 2010CA NM104 - Patient Fname
(iv) 2010CA NM105 - Patient Middle Name
(v) 2010CA NM109 - Patient Primary Identifier
(vi) 2010BA/2010CA N301 - Patient Address1
(vii) 2010CA N302 - Patient Address2
(viii) 2010CA N401 - Patient City Name
(ix) 2010CA N402 - Patient State
(x) 2010CA N403 - Patient Zip Code
(xi) 2010CA DMG02 - Patient Date of Birth
(xii) 2010CA DMG03 - Patient Sex
(xiii) 2010CA REF01 - Patient Secondary ID Qualifier
(xiv) 2010CA REF02 - Patient Secondary Identification
(m) 2300 CLM05-1 - Facility Type Code
(n) 2300 CLM05-3 - Claim Frequency Type Code
(o) 2300 REF02 When REF01 = F8 - Original Reference Number
(p) 2300 DTP03 When DTP01 = 435 - Admission Date/Hour
(q) Institutional Claim Code Information
(i) 2300 CL101 - Institutional Claim Code Admit Type
(ii) 2300 CL102 -Institutional Claim Code Admit Source
(iii) 2300 CL103 - Institutional Claim Code Pt Status
(r) 2300 HI01-2 When HI01-1 = DR - Diagnosis Related Group (DRG)
(s) 2300 DTP03 when DTP01 = 434 - Statement Date
(t) 2300 DTP03 WHEN DTP01 = 096 - Discharge Date
(u) 2300 DTP03 When DTP01 = 096 - Discharge Hour
(v) 2300 CLM01 - Patient Account Number
(w) 2300 REF02 When REF01 = EA - Medical Record Number
(x) 2300 CLM02 - Total Claim Charge Amount
(y) 2300 AMT02 When AMT01 = F5 - Patient Paid Amount
(z) 2320 AMT02 WHEN AMT01 = C4 - Payer Prior Payment
(aa) 2310E NM103 - Service Facility Name
(bb) 2310E NM109 - Service Facility ID Code
(cc) 2330B DTP03 WHEN DTP01 = 573 - Claim Adjudication Date
(dd) 2320 AMT02 When AMT01 = B6 - COB Total Allowed Amount
(ee) Claim Adjustment Information
(i) 2320 CAS01 - Claim Adjustment Group Code
(ii) 2320 CAS02 - Claim Adjustment Reason Code
(iii) 2320 CAS03 - Claim Level Adjustment Amount
(ff) 2310E NM109 - Laboratory or Facility Primary ID
(gg) Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information PAT
(i) 2300 HI02-2 When HI02-1-ZZ - Reason for Visit 1
(ii) 2300 HI02-2 When HI02-1-ZZ - Reason for Visit 2
(iii) 2300 HI02-2 When HI02-1-ZZ - Reason for Visit 3
(hh) 2300 K3 - Present on Admission Indicator
(ii) Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information Admitting DX
(i) 2300 HI02-2 When HI02-1 = BJ
(ii) 2300 HI01-2 When HI01-1 = BK
(jj) Other Diagnosis Information
(i) 2300 HI01-2 When HI01-1 = BF
(ii) 2300 HI02-2 When HI02-1 = BF
(iii) 2300 HI03-2 When HI03-1 = BF
(iv) 2300 HI04-2 When HI04-1 = BF
(v) 2300 HI05-2 When HI05-1 = BF
(vi) 2300 HI06-2 When HI06-1 = BF
(vii) 2300 HI07-2 When HI07-1 = BF
(viii) 2300 HI08-2 When HI08-1 = BF
(ix) 2300 HI09-2 When HI09-1 = BF
(x) 2300 HI10-2 When HI10-1 = BF
(xi) 2300 HI11-2 When HI11-1 = BF
(xii) 2300 HI12-2 When HI12-1 = BF
(kk) Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information
(i) 2300 HI03-2 When HI03-1 = BN E-Code 1
(ii) 2300 HI03-2 When HI03-1 = BN E-Code 2
(iii) 2300 HI03-2 When HI03-1 = BN E-Code 3
(ll) 2300 HI01-2 When HI01-1 = BR Principal Procedure Code Principal Procedure
(mm) 2300 HI01-4 When HI01-1 = BR Principal Procedure Date
(nn) Other Procedure Codes and Dates
(i) 2300 HI01-2 When HI01-1 = BQ Other Procedure Code
(ii) 2300 HI01-4 When HI01-1 = BQ Other Procedure Date
(iii) 2300 HI02-2 When HI02-1 = BQ Other Procedure Code
(iv) 2300 HI02-4 When HI02-1 = BQ Other Procedure Date
(v) 2300 HI03-2 When HI03-1 = BQ Other Procedure Code
(vi) 2300 HI03-4 When HI03-1 = BQ Other Procedure Date
(vii) 2300 HI04-2 When HI04-1 = BQ Other Procedure Code
(viii) 2300 HI04-4 When HI04-1 = BQ Other Procedure Date
(ix) 2300 HI05-2 When HI05-1 = BQ Other Procedure Code
(x) 2300 HI05-4 When HI05-1 = BQ Other Procedure Date
(oo) Attending Physician Information
(i) 2000A or 2310A PRV03 - Attending Physician Specialty Information
(ii) 2310A NM103 - Attending Physician LName
(iii) 2310A NM104 - Attending Physician FName
(iv) 2310A NM105 - Attending Physician Name Middle

(v) 2310A NM107 - Attending Physician Name Suffix
(vi) 2310A NM109 - Attending Physician Primary ID
(vii) 2310A REF02 - Attending Physician Secondary ID
(pp) 2400 LX01 - Line Counter
(qq) 2400 DTP03 When DTP01 = 472 Date(s) of Service
(rr) Institutional Service Line Codes
(i) 2400 SV202-2 - Institutional Service Line Product/Service ID
(ii) 2400 SV202-3 - Institutional Service Line Procedure Modifier - 1
(iii) 2400 SV202-4 - Institutional Service Line Procedure Modifier - 2
(iv) 2400 SV202-5 - Institutional Service Line Procedure Modifier - 3
(v) 2400 SV202-6 - Institutional Service Line Procedure Modifier - 4
(vi) 2400 SV201 - Institutional Service Line (Revenue Codes)
(ss) 2400 SV205 - Service Units
(tt) 2400 SV203 - Line Item Charge Amount
(uu) Drug Information
(i) 2410 LIN03 - Drug Identification
(ii) 2410 REF02 when REF01 = XZ - Prescription Number
(iii) 2410 CTP05-1 - Drug Units Qualifier
(iv) 2410 CTP04 - Drug Number of Units
(v) 2410 CTP03 - Drug Cost or Unit Price
(vv) Line Adjustment Codes
(i) 2430 CAS01 - Line Adjustment Group Code
(ii) 2430 CAS02 - Line Level Adjustment Reason Code
(iii) 2430 CAS03 - Line Level Adjustment Amount.
(5) Pharmacy claims. Each carrier must submit the following data elements for each pharmacy claim:
(a) Payer Name
(b) Insured Group or Policy Number
(c) Subscriber Information
(i) Subscriber Last Name
(ii) Subscriber First Name
(iii) Subscriber Middle Name
(iv) Subscriber Primary Identifier
(v) Subscriber Address
(vi) Subscriber Address 2
(vii) Subscriber City
(viii) Subscriber State
(ix) Subscriber Zipcode
(x) Subscriber Phone
(xi) Subscriber Date of Birth
(xii) Subscriber Sex
(xiii) Subscriber Secondary Identification Qualifier
(xiv) Subscriber Secondary Identification
(d) Patient Information
(i) Patients Relationship to Insured
(ii) Patient Last name
(iii) Patient First name
(iv) Patient Middle Name
(v) Patient Primary Identifier
(vi) Patient Address
(vii) Patient Address 2
(viii) Patient City
(ix) Patient State
(x) Patient ZipCode
(xi) Patient Phone
(xii) Patient Date of Birth
(xiii) Patient Sex
(xiv) Patient Secondary Identification Qualifier
(xv) Patient Secondary Identification
(e) RxClaimNo
(f) RxClaimNoCrossRef
(g) RxNo
(h) PBMMebID
(i) RXClaimTxnType
(j) RxType
(k) RxClaimXrefNo
(l) RxAdjType
(m) SubscriberSfx
(n) Prescriber Information
(i) RxPrescriberID
(ii) RxPrescriberNoType
(iii) RxPrescriberName
(o) RxPharmacyNo
(p) MembMcareSTatus
(q) RxWrittenDt
(r) RxFilledDt
(s) Reject Codes
(i) Reject Code 1
(ii) Reject Code 2
(iii) Reject Code 3
(iv) Reject Code 4
(v) Reject Code 5
(t) RxPaidDt
(u) RxTotalPdAmt
(v) PatientPaidAmount
(w) RxQualifier
(x) RxID
(y) RxNDC
(z) RxTradeNm
(aa) RxGenericNm
(bb) GCNNumber
(cc) GPINumber
(dd) UnitsOfMeasure
(ee) UnitDoseIndicator
(ff) DispensingStatus
(gg) QuantityIntended
(hh) RxMtrcFilQty
(ii) RxDaysSupplyNo
(jj) DrugStrength
(kk) DosageDescription
(ll) CompoundIndicator
(mm) RxNoRefills
(nn) RxRefillNo
(oo) RxDAWCode
(pp) Therapeutic ClassCode - AHFS
(qq) USC Code
(rr) DEA Class of Drug
(ss) Drug Class
(tt) Drug Category Code
(uu) RxBrandInd

(vv) RecordDateTimeStamp.

R428-15-6. Exemptions.

A carrier that covers fewer than 200 individual Utah residents is exempt from all requirements of this rule.

R428-15-7. Third-party Contractors.

The Office may contract with a third party to collect and process the health care claims data and will prohibit it from using the data in any way but those specifically designated in the scope of work.

R428-15-8. Carrier Registration.

Each carrier shall register with the Office by completing the registration on line at: http://health.utah.gov/hda/apd/ . Each carrier shall register by September 21, 2009 and annually thereafter by September 1 of each year.

R428-15-9. Testing of Files.

(1) Prior to October 5, 2009, each carrier required to report under this rule shall submit to the Office a dataset for determining compliance with the standards for data submission. This test dataset must be in the same format as required by the technical specifications document and shall contain data for any month within 2007 or 2008.

(2) Each carrier must meet with the Office prior to the carrier's initial data submission to review individual submission formatting. The carrier must contact the Office to arrange this meeting by September 30, 2009.

(3) Carriers that become subject to this rule after September 21, 2009 shall submit to the Office a dataset for determining compliance with the standards for data submission no later than 90 days after the first date of becoming subject to the rule.

R489-15-10. Rejection of Files.

The Office or its designee may reject and return any data submission that fails to conform to the submission requirements. Paramount among submission requirements are First Name, Last Name, Member ID, Relationship to Subscriber, Date of Birth, Address, City, State, Zip Code, Sex, which are key data fields that the carrier must submit for each enrolled member and claim. A carrier whose submission is rejected shall resubmit the data in the appropriate, corrected format to the Office, or its designee within 10 state business days of notice that the data does not meet the submission requirements.

R428-15-11. Replacement of Data Files.

A carrier may replace a complete dataset submission if no more than one year has passed since the end of the month in which the file was submitted. However, the Office may allow a later submission if the carrier can establish exceptional circumstances for the replacement.

R428-15-12. Limitation of Liability.

As provided in Utah Code Section 26-25-1, a carrier that submits data pursuant to this rule, including third-party administrators that submit employee data, is not liable for providing the information to the Department.

R428-15-13. Penalties.

Pursuant to Section 26-23-6, a carrier that violates any provision of this rule may be assessed an administrative civil money penalty for each day of non-compliance. Fines may be imposed as follows:

(1) Not to exceed the sum of $10,000 per violation

(2) Each day of violation is a separate violation.

KEY: APD, all payer database, health care quality, transparency
Date of Enactment or Last Substantive Amendment: 2009
Authorizing and Implemented or Interpreted Law: 26-33a; 26-25

Insurance, Administration
R590-102
Insurance Department Fee Payment Rule

NOTICE OF PROPOSED RULE

(Amendment)
DAR FILE NO.: 32850
FILED: 7/29/09 8:43 AM

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule is required to note changes in the department's schedule of fees, which are approved by the legislature and to establish fee deadlines. The changes noted in this rule were made by the 2009 Legislature in the appropriations bill, H.B. 3. (DAR NOTE: H.B. 3 (2009) is found at Chapter 1, Laws of Utah 2009, and was effective 02/09/2009.)

SUMMARY OF THE RULE OR CHANGE: The rule updates the $2 decrease in fee amounts for credit card charges; deletes fees that are no longer being charged, such as, individual and agency late renewal fee; combines two title fees into one, however the total fee amount did not increase; and also updates the electronic list fee to account for public access to the department's electronic rate and form database.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 31A-3-103

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: The changes to this rule will not require the Department to add or reduce personnel and the impact on the state's budget should be minimal.
♦ LOCAL GOVERNMENTS: The changes to this rule will have no fiscal impact on local governments since the rule

deals solely with the relationship between the Department and its licensees.
♦ SMALL BUSINESSES: This rule has no fiscal impact on small businesses because it merely publishes the schedule of fees approved by the legislature in the appropriations bill, H.B. 3.
♦ PERSONS OTHER THAN BUSINESS: This rule has no fiscal impact on other persons because it merely publishes the schedule of fees approved by the legislature in the appropriations bill, H.B. 3.

COMPLIANCE COSTS FOR AFFECTED PERSONS: This rule has no fiscal impact on persons because it merely publishes the schedule of fees approved by the legislature in the appropriations bill, H.B. 3.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule will have no fiscal impact on businesses in Utah since it just publishes the schedule of fees approved by the legislature this year.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
INSURANCE
ADMINISTRATION
ROOM 3110 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY, UT 84114-1201
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Jilene Whitby by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at jwhitby@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 5:00 PM ON 09/14/2009

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2009

AUTHORIZED BY: Jilene Whitby, Information Specialist

R590. Insurance, Administration.
R590-102. Insurance Department Fee Payment Rule.
R590-102-3. Definitions.

In addition to the definitions in Title 31A, the following definitions shall apply for the purposes of this rule:

(1) "Admitted insurers" include: fraternal, health, health maintenance organization, life, limited health plan, motor club, non-profit health service, property-casualty, title insurers, and a prescription drug plan.

(2) "Agency" means:

(a) a person, other than an individual, including a sole proprietorship by which a natural person does business under an assumed name; and

(b) an insurance organization required to be licensed under Subsections 31A-23a-301, 31A-25-207, and 31A-26-209.

(3) "Captive insurer" includes association captive, branch captive, industrial insured captive, pure captive, sponsored captive, and special purpose financial captive.

(4) "Deadline" means the final date or time:

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order, and

(b) by which

(i) a payment must be received by the department without incurring penalties for late payment or non-payment; or

(ii) required information must be received by the department without incurring penalties for late receipt or non-receipt.

(5) "Fee" means an amount set by the commissioner, by statute, or by rule and approved by the legislature for licenses, registrations, certificates, and other filings and services provided by the Insurance Department.

(6) "Full-line agency" includes producer, consultant, independent adjuster, managing general agent, public adjuster, reinsurance intermediary broker, and third party administrator.

(7) "Full-line individual" includes a producer, consultant, independent adjuster, managing general agent, public adjuster, reinsurance intermediary broker, and third party administrator.

(8) "Limited-line agency" includes bail bond and limited-line producer.

(9) "Limited-line individual" includes bail bond agent, limited-lines producer and customer service representative.

(10) "Other organizations" include: home warranty, joint underwriter, purchasing group, rate service organization, risk retention group, service contract provider, surplus line insurer, accredited reinsurer, trusteed reinsurer, employee welfare fund and health discount program.

(11) "Paper application" means an application that must be manually entered into the department's database because the application was submitted by paper, facsimile, or email when the department has provided an electronic application process and stated the electronic process is the preferred process for receiving an application.

(12) "Paper filing" means a filing that must be manually entered into the department's database because the filing was submitted by paper, facsimile, or email when the department has provided an electronic filing process and stated the electronic process is the preferred process for receiving a filing.

(13) "Received by the department" means:

(a) the date delivered to and stamped received by the department, if delivered in person;

(b) the postmark date, if delivered by mail;

(c) the delivery service's postmark date or pick-up date, if delivered by a delivery service; or

(d) the received date recorded on an item delivered[~~transmitted~~], if delivered by:

(i) facsimile[~~,~~];

(ii) email; or

(iii) another[~~some other~~] electronic method; or

(e) a date specified in:

(i) a statute;

(ii) a rule; or

(iii) an order.

R590-102-5. Admitted Insurer and Prescription Drug Plan Fees.

(1) Annual license fees:

(a) certificate of authority, initial license application - due with license application: [~~$1,002~~]$1,000;

(b) certificate of authority - renewal - due by the due date on the invoice: [~~$302~~]$300;

(c) certificate of authority - late renewal - due for any renewal paid after the date on the invoice: [~~$352~~]$350;

(d) certificate of authority - reinstatement - due with application for reinstatement: [~~$1,002~~]$1,000.

(2) Other license fees:

(a) certificate of authority - amendments - due with request for amendment: [~~$252~~]$250;

(b)(i) Form A - application for merger, acquisition, or change of control, due with filing: [~~$2,002~~]$2,000.

(ii) Expenses incurred for consultant(s) services necessary to evaluate a Form A will be charged to the applicant and due by the due date on the invoice;

(c) redomestication filing - due with filing: [~~$2,002~~]$2,000; and

(d) application for organizational permit for mutual insurer to solicit applications for qualifying insurance policies or subscriptions for mutual bonds or contribution notes - due with application: [~~$1,002~~]$1,000.

(3) The annual initial or annual renewal license fee includes the following licensing services for which no additional fee is required:

(a) filing annual statement and report of Utah business - due annually on March 1;

(b) filing holding company registration statement - Form B;

(c) filing application for material transactions between affiliated companies - Form D;

(d) application for: stock solicitation permit, public offering filing, but not an SEC filing; an SEC filing; private placement offering; and

(e) application for individual license to solicit in accordance with the stock solicitation permit.

(4) Annual service fee:

(a) Due annually by the due date on the invoice.

(b) A prescription drug plan is exempted from payment of a service fee.

(c) The fee is based on the Utah premium as shown in the latest annual statement on file with the National Association of Insurance Commissioners (NAIC) and the department. Fee calculation example: the 2004 annual service fee calculation will use the Utah premium shown in the December 31, 2003 annual statement.

[~~(c)~~](d) Fee schedule:

(i) $0 premium volume: no service fee;

(ii) more than $zero but less than $1 million in premium volume: $700;

(iii) $1 million but less than $3 million in premium volume: $1,100;

(iv) $3 million but less than $6 million in premium volume: $1,550;

(v) $6 million but less than $11 million in premium volume: $2,100;

(vi) $11 million but less than $15 million in premium volume: $2,750;

(vii) $15 million but less than $20 million in premium volume: $3,500; and

(viii) $20 million or more in premium volume: $4,350.

[~~(d)~~](e) The annual service fee includes the following services for which no additional fee is required:

(i) filing of amendments to articles of incorporation, charter, or bylaws;

(ii) filing of power of attorney;

(iii) filing of registered agent;

(iv) affixing commissioner's seal and certifying any paper;

(v) filing of authorization to appoint and remove agents;

(vi) filing of producer/agency appointment with an insurer - initial;

(vii) filing of producer/agency appointment with an insurer - termination;

(viii) report filing, all lines of insurance;

(ix) rate filing, all lines of insurance; and

(x) form filing, all lines of insurance.

[~~(e)~~](f) The annual service fee is for services that the department will provide for an admitted insurer during the year. The fee is paid in advance of providing the services.

[~~(d)~~](5) Other fees:

[~~(i)~~](a) E-commerce fee: (see R590-102-17).

[~~(ii)~~](b) Insurer examination costs reimbursements from examined insurers - due by due date on the invoice: actual costs plus overhead expense.

R590-102-6. Other Organization, Surplus Lines Insurer, Accredited Reinsurer, Trusteed Reinsurer, and Employee Welfare Fund Fees.

(1) Annual license fee:

(a) other organization:

(i) initial - due with application: [~~$252~~]$250;

(ii) renewal - due annually by the due date on the invoice: [~~$202~~]$200;

(iii) late renewal - due for any renewal paid after the date on the invoice: [~~$252~~]$250;

(iv) reinstatement - due with application for reinstatement: [~~$252~~]$250;

(v) The annual other organizations initial or renewal fee includes the risk retention group annual statement filing - due annually on May 1.

(b) surplus line insurer, accredited reinsurer,[~~and~~] trusteed reinsurer, and employee welfare fund:

(i) initial - due with application [~~$1,002~~]$1,000.

(ii) renewal - due annually by the due date on the invoice: [~~$302~~]$300;

(iii) late renewal - due for any renewal paid after the date on the invoice: [~~$352~~]$300;

(iv) reinstatement - due with application for reinstatement: [~~$1,002~~]$1,000;

(v) The annual initial or renewal surplus line license fee includes the surplus lines annual statement filing for:

(A) U.S. companies - due annually on May 1; and

(B) foreign companies - due within 60 days of the annual statement's filing with the insurance regulatory authority where the company is domiciled.

(vi) The annual initial or renewal accredited reinsurer and trusteed reinsurer license fee includes the annual statement filing - due annually on March 1.

(2) Annual service fee:

(a) Other organization - due annually by the due date on the invoice: $200.

(b) Surplus lines insurer, accredited reinsurer,[~~and~~] trusteed reinsurer, and employee welfare fund - due annually by the due date on the invoice: $200

(c) The annual service fee includes the following services for which no additional fee is required:

(i) filing of power of attorney;

(ii) filing of registered agent; and

(iii) rate, form, report or service contract filing.

(d) The annual service fee is for services that the department will provide during the year. The fee is paid in advance of providing the services.

[~~(c)~~](3) Other fees: E-commerce fee: see R590-102-17.

R590-102-7. Captive Insurer Fees.

(1) Initial license application - due with license application: [~~$202~~]$200.

(2) Initial license application review - due by the due date on the invoice: actual costs incurred by the department to review the application.

(3) Annual license fees:

(a) initial - due by the due date on the invoice: [~~$5,002~~]$5,000;

(b) renewal - due by the due date on the invoice: [~~$5,002~~]$5,000;

(c) late renewal - due for any renewal paid after the date on the invoice: [~~$5,052~~]$5,050;

(d) reinstatement - due with application for reinstatement: [~~$5,052~~]$5,050.

(4) Other fees:

(a) e-commerce fee: see R590-102-17.

(b) Examination costs reimbursements from examined captive insurers - due by due date on the invoice: actual costs plus overhead expense.

R590-102-8. [~~Viatical~~]Life Settlement Provider Fees.

(1) Annual license fees:

(a) initial - due with application: [~~$1,002~~]$1,000;

(b) renewal - due by the due date on the invoice: [~~$302~~]$300;

(c) late renewal - due for any renewal paid after the date on the invoice: [~~$352~~]$350;

(d) reinstatement - due with reinstatement application: [~~$1,002~~]$1,000.

(2) Annual service fee - due by the due date on the invoice: $600.

(a) The annual service fee includes the following service for which no additional fee is required: rate, form, report or service contract filing.

(b) The annual service fee is for services that the department will provide during the year. The fee is paid in advance of providing the services.

(3) Other fees:

(a) e-commerce fee: see R590-102-17.

(b) Examination costs reimbursements from examined viatical settlement providers - due by due date on the invoice: actual costs plus overhead expense.

R590-102-10. Individual Resident and Non-Resident License Fees.

(1) Biennial resident and non-resident full-line individual initial license or renewal fee:

(a) initial license fee - due with application: [~~$72~~]$70:

(b) renewal license fee if renewed prior to license expiration date[~~renewal deadline~~] - due with renewal application: [~~$72~~]$70;

(c) [~~renewal license fee if renewed 1 through 30 days after renewal deadline and prior to license lapse - due with renewal application: $122;~~

~~(d) lapsed license~~]reinstatement license fee if inactive license is reinstated [~~31 days through 365 days~~]within one year following the license expiration date[~~after renewal deadline~~]- due with application for reinstatement: [~~$122~~]$120.

(2) Biennial resident and non-resident limited-line individual initial or renewal license fee:

(a) initial license fee - due with application: [~~$47~~]$45;

(b) renewal license fee if renewed prior to license expiration date[~~renewal deadline~~] - due with renewal application: [~~$47~~]$45;

(c) [~~renewal license fee if renewed 1 through 30 days after renewal deadline and prior to license lapse - due with renewal application: $97;~~

~~(d) lapsed license~~]reinstatement license fee if inactive license is reinstated [~~31 days through 365 days~~]within one year following the license expiration date[~~after renewal deadline~~] - due with application for reinstatement: [~~$97~~]$95.

(3) Other license fees: addition of producer classification or line of authority to individual producer license - due with request for additional classification or line of authority: [~~$27~~]$25.

(4) The biennial initial and renewal full-line producer and limited-line producer fee includes the following services for which no additional fee is required:

(a) issuance of letter of certification;

(b) issuance of letter of clearance;

(c) issuance of duplicate license;

(d) individual continuing education services.

(5) The biennial initial and renewal individual license fee includes services the department will provide during the year. The fee is paid in advance of providing the services.

(6) Other fees:

(a) e-commerce fee: see R590-102-17.

(b) title insurance product or service approval for dual licensed title licensee form filing fee - due with filing: $25.

R590-102-11. Agency License Fees, Other than Bail Bond Agencies.

(1) Biennial resident and non-resident agency initial or renewal license for a full-line agency and for a limited-line agency:

(a) initial license fee - due with application: [~~$77~~]$75;

(b) renewal license fee if renewed prior to license expiration date[~~renewal deadline~~] - due with renewal application: [~~$77~~]$75;

(c) [~~renewal license fee if renewed 1 through 30 days after renewal deadline and prior to license lapse - due with renewal application: $127;~~

~~(d) lapsed license~~]reinstatement license fee if inactive license is reinstated [~~31 days through 365 days~~]within one year following the license expiration date[~~after renewal deadline~~] - due with application for reinstatement: [~~$127~~]$125;

(d) resident title license:

(i) initial license fee - due with application: $100;

(ii) renewal license fee, if renewed prior to license expiration date - due with renewal application: $100.

(2) Other license fees: addition of producer classification or line of authority to agency license - due with request for additional classification or line of authority: [~~$27~~]$25.

(3) The biennial initial and renewal agency license fee includes the following services for which no additional fee is required:

(a) issuance of letter of certification;

(b) issuance of letter of clearance;

(c) issuance of duplicate license;

(d) filing of producer designation to agency license - initial;

(e) filing of producer designation to agency license - termination;

(f) filing of amendment to agency license; and

(g) filing of power of attorney.

(4) Other fees:

[~~(a)~~] e-commerce fee: see R590-102-17[~~;~~

~~(b) title agency filing fee for rate, form, or report - due with filing: $25~~].

R590-102-12. Bail Bond Agency.

(1) Annual bail bond agency per annual license period:

(a) initial license fee - due with application: [~~$252~~]$250;

(b) renewal license fee if renewed prior to license expiration date[~~renewal deadline~~] - due with renewal application: [~~$252~~]$250;

(c) [~~renewal license fee if renewed 1 through 30 days after renewal deadline and prior to license lapse - due with renewal application: $302; and~~

~~(d) lapsed license~~]reinstatement license fee if inactive license is reinstated [~~31 days~~]within one year following the license expiration date[~~after renewal deadline~~] - due with application for reinstatement: [~~$302~~]$300.

(2) The annual initial and renewal agency license fee includes the following services for which no additional fee is required:

(a) issuance of letter of certification;

(b) issuance of letter of clearance;

(c) issuance of duplicate license;

(d) filing of producer designation to agency license - initial;

(e) filing of producer designation to agency license - termination;

(f) filing of amendment to agency license; and

(g) filing of power of attorney.

(3) Other fees: E-commerce fee: see R590-102-17.

R590-102-13. Health Insurance Purchasing Alliance.

(1) Annual [~~health insurance purchasing alliance annual~~] license fee:

(a) initial [~~license fee~~]- due with application: [~~$502~~]$500;

(b) renewal [~~license fee if renewed prior to renewal deadline~~]- due [~~with renewal application~~]by the due date on the invoice: [~~$502~~]$500;

(c) late renewal [~~license fee if renewed 1 through 30 days after renewal deadline and prior to license lapse~~]- due [~~with renewal application~~]for any renewal paid after the date of the invoice: [~~$552~~]$550; and

(d) [~~lapsed license~~]reinstatement [~~fee if reinstated 31 days after renewal deadline~~]- due with application for reinstatement: [~~$552~~]$500.

(2) E-commerce fee: see R590-102-17.

R590-102-14. Continuing Education Fees.

(1) Annual continuing education provider license fees per annual license period:

(a) initial license fee - due with application: [~~$252~~]$250;

(b) renewal license fee if renewed prior to license expiration date[~~renewal deadline~~] - due with renewal application: [~~$252~~]$250;

(c) [~~late renewal license fee if renewed 1 through 60 days after renewal deadline and prior to license lapse - due with renewal application: $302; and~~

~~(d) Lapsed license~~]reinstatement license fee if inactive license is reinstated [~~61 days~~]within one year following the license expiration date[~~after renewal deadline~~] - due with application for reinstatement: [~~$302~~]$300.

(2) Continuing education course post-approval fee - due with request for approval: $5 per credit hour, minimum fee [~~$27~~]$25.

R590-102-16. Dedicated Fees.

The following are fees dedicated to specific uses:

(1) annual fraud assessment fee as calculated under Section 31A-31-108 and stated in the invoice - due by the due date on the invoice;

(2) annual title insurance regulation assessment fee as calculated under Section 31A-23a-415 and Rule R592-10 and stated in the invoice - due by the due date on the invoice;

(3) annual title assessment for the Title Recovery, Education, and Research Fund fee:

(a) individual title licensee applicant for initial license or renewal license - due with the initial application or the renewal application: $15;

(b) agency title licensee applicant - due with the initial application: $1,000.

(c) annual agency title licensee assessment based on annual written title insurance premium - due by the due date on the invoice:

(i) Band A: $0 to $1 million: $125;

(ii) Band B: more than $1 million to $10 million: $250;

(iii) Band C: more than $10 million to $20 million: $375;

(iv) Band D: more than $20 million: $500.

[~~(3)~~](4) relative value study book fee - due when book purchased or by invoice due date: [~~$12~~]$10;

[~~(4)~~](5) mailing fee for books - due if book is to be mailed to purchaser: $3;

[~~(5)~~](6) fingerprint fee - due with application for individual license:

(a) Bureau of Criminal Investigation (BCI): $15.00; and

(b) Federal Bureau of Investigation (FBI): $19.25; and

[~~(6) annual assessment for the Title Recovery, Education, and Research Fund fee:~~

~~(a) individual title licensee applicant for initial license or renewal license - due with the initial application or the renewal application: $15.00;~~

~~(b) agency title licensee applicant - due with the initial application: $1,000.~~

~~(c) annual agency title licensee assessment based on annual written title insurance premium - due by the due date on the invoice:~~

~~(i) Band A: $0 to $1 million: $125.00;~~

~~(ii) Band B: more than $1 million to $10 million: $250.00;~~

~~(iii) Band C: more than $10 million to $20 million: $375.00;~~

~~(iv) Band D: more than $20 million: $500.00.~~

]

R590-102-17. Electronic Commerce Dedicated Fees.

(1) E-commerce and internet technology services fee:

(a) admitted insurer and surplus lines insurer - due with the [~~annual~~]initial, annual renewal, or reinstatement application: $75;

(b) captive insurer - due with the [~~annual~~]initial, annual renewal, or reinstatement application: $250;

(c) other organization, professional employer organization, and [~~viatical~~]life settlement provider - due with the[~~annual~~] initial, annual renewal, or reinstatement application: $50;

(d) continuing education provider - due with the [~~annual~~]initial, annual renewal, or reinstatement application: $20;

(e) agency - due with the [~~biennial~~]initial, biennial renewal, or reinstatement application: $10;

(f) health insurance purchasing alliance - due with the [~~annual~~]initial, annual renewal, or reinstatement application: $10; and

(g) individual - due with the [~~biennial~~]initial, biennial renewal, or reinstatement application: $5.

(2) Database access fees:

(a) information accessed through an electronic portal set up for that purpose - due when the department's database is accessed to input or acquire data: $3 per transaction;

(b) rate and form filing database access to an electronic public rate and form filing:

(i) a separate fee is assessed per line of insurance accessed (accident and health, life and annuity, or property-casualty);

(ii) each line of insurance accessed is charged the following fees:

(A) a base fee, which entitles the user up to 30 minutes of access, the assistance of staff during that time, and one DVD - $45[~~.00~~];

(B) each additional 30 minutes of access time or fraction thereof, including the assistance of staff during that time - $45;

(iii) additional DVD - $2[~~.00~~];

(iv) payment due at time of service or by the due date on the invoice.

R590-102-18. Other Fees.

(1) photocopy fee - per page: $.50.

(2) Complete annual statement copy fee - per statement: [~~$42~~]$40.

(3) Fee for accepting service of legal process: [~~$12~~]$10.

(4) Fees for production of information lists regarding licensees or other information that can be produced by list:

(a) printed list, if the information is already in list format and only needs to be printed or reprinted: $1 per page;

(b) electronic list compiled by accessing information stored in the Department's database:

(i) [~~1 to 500 records: $52; and~~]a separate fee is assessed for each list compiled;

(ii) [~~501 or more records: $.11 per record.~~]each list is assessed one or more of the following fees:

(A) a base fee, which entitles the requestor up to 30 minutes of staff time to draft the information query, compile the information, prepare a CD, and prepare a CD for mailing to the requestor - $50, due with request for information;

(B) each additional 30 minutes or fraction thereof to draft the information query, compile the information, prepare a CD, and prepare a CD for mailing to the requestor - $50, due by the due date on the invoice;

(iii) additional CD - $1.00, due by the due date on the invoice.

(5) Returned check fee: $20.

(6) Workers compensation loss cost multiplier schedule: $5.

(7) Address correction fee -- assessed when department has to research and enter new address for a licensee -- due by the due date on the invoice: $35.

R590-102-19. Severability.

If any provision of this rule or its application to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of this provision to other persons or circumstances shall not be affected.

KEY: insurance fees
Date of Enactment or Last Substantive Amendment: [~~September 11, 2008~~]2009
Notice of Continuation: January 26, 2007
Authorizing, and Implemented or Interpreted Law: 31A-3-103

Insurance, Administration
R590-171
Surplus Lines Procedures Rule

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 32865
FILED: 7/30/09 3:00 PM

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule is being changed to update code references, to change terminology, clarify language, to add two new sections as a part of the clarification and standardization process, and to change a filing requirement.

SUMMARY OF THE RULE OR CHANGE: The passage of H.B. 374 in 2003 resulted in the replacement of the terms "agent" and "broker" for "producer" in the Insurance code and rules. The bill also created a new Chapter 23a from part of Chapter 23 in Title 31A, which requires the updating of code references in the rule. The rest of the changes are nonsubstantive and for clarification only. (DAR NOTE: H.B. 374 (2003) is found at Chapter 298, Laws of Utah 2003, and was effective 05/05/2003.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 31A-15-103 and Section 31A-15-111 and Section 31A-2-201

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: These changes will have no effect on the work load or income of the department or state budget. No filings will be required of insurance companies. The changes are mainly to conform the rule to the code and clarify the wording in the rule.
♦ LOCAL GOVERNMENTS: The changes to the rule will have no impact on local governments since the rule deals solely with the relationship between the department and their licensees.
♦ SMALL BUSINESSES: Since changes to the rule have been made to update code references where only the numbering of the references have been changed, to make changes in terminology, and to make wording changes for clarification purposes, the changes will have no fiscal impact on small businesses.
♦ PERSONS OTHER THAN BUSINESS: Since changes to the rule have been made to update code references where only the numbering of the references have been changed, to make changes in terminology, and to make wording changes for clarification purposes, the changes will have no fiscal impact on businesses or individuals that could be affected by this rule.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Since changes to the rule have been made to update code references where only the numbering of the references have been changed, to make changes in terminology, and to make wording changes for clarification purposes, the changes will have no fiscal impact on affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule will have no fiscal impact on the public or businesses in Utah.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
INSURANCE
ADMINISTRATION
ROOM 3110 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY, UT 84114-1201
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Jilene Whitbyby phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at jwhitby@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 5:00 PM ON 09/14/2009

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2009

AUTHORIZED BY: Jilene Whitby,

R590. Insurance, Administration.
R590-171. Surplus Lines Procedures Rule.
R590-171-2. Purpose and Scope.

A. The purpose of this rule is:

(1) to recognize The Surplus Line Association of Utah as the advisory organization of surplus lines [~~brokers~~]producers;

(2) to authorize The Surplus Line Association to conduct the examination of surplus lines transactions;

(3) to authorize The Surplus Line Association to collect a stamping fee;

(4) to require that each person licensed as a surplus lines [~~broker~~]producer in Utah be a member of the advisory organization;

(5) to regulate access to the surplus lines market, with exceptions made for substantial insureds who are presumed to be sophisticated insurance buyers who the commissioner finds can adequately protect their own interests because of their financial resources, business experience and insurance knowledge; and

(6) to prescribe procedures for the placement of insurance with surplus lines insurers.

B. This rule applies, pursuant to Section 31A-15-103, to the placement of insurance with surplus lines insurers on risks located in Utah.

R590-171-3. Definitions.

For the purpose of this rule the commissioner adopts the definitions as set forth in Section 31A-1-301 and in addition the following:

A. "Export list" means a list published by the commissioner of coverages and classes of insurance for which the commissioner has determined no general market exists with admitted insurers.

B. "Producer" means an insurance agent, broker or surplus lines broker as defined in Section [~~31A-23-102~~]31A-1-301-88.

C. "Surplus lines [~~broker~~]producer" means a [~~person licensed under Subsection 31A-23-204(5)~~]licensee as defined in Section 31A-23a-106(2)(a)(ix) to place insurance with surplus lines insurers in accordance with Section 31A-15-103 and this rule.

D. "Surplus lines insurer" means a nonadmitted insurer [~~with which a surplus lines~~]that may place business, pursuant to Title 31A, Chapter 15, Part 1 and this rule, with a surplus lines [~~broker may place business pursuant to Title 31A, Chapter 15, Part 1 and this rule~~]producer.

E. "Surplus lines transaction" means the solicitation, negotiation, procurement or effectuation with a surplus lines insurer of an insurance contract or certificate of insurance. It also means any renewal, cancellation, endorsement, audit, or other adjustment to the insurance contract.

R590-171-4. Surplus Line Association of Utah.

A. Surplus Line Association of Utah is recognized as the advisory organization of surplus lines [~~brokers~~]producers authorized by Section 31A-15-111.

B. Each person licensed as a surplus lines [~~broker~~]producer in Utah must be a member of the Surplus Line Association of Utah.

C. The Surplus Line Association of Utah is authorized:

(1) to facilitate and encourage compliance by its members with the laws of Utah and the rules of the commissioner relative to surplus lines insurance and to act in other matters as specified by Section 31A-15-111;

(2) to conduct the examination of surplus lines transactions required under Subsection 31A-15-103(11);

(3) to make a determination that a surplus lines transaction is in compliance with Subsection 31A-15-103(11) and with Sections R590-171-6 and 7 of this rule; and

(4) to collect the stamping fee prescribed by Subsection 31A-15-103(11)(d).

R590-171-6. Conditions for Placing Insurance with Surplus Lines Insurers.

Placement of insurance with surplus lines insurers pursuant to Section 31A-15-103 may only be done in accordance with either Section A, B or C below.

A. Insurance coverages and classes included on the export list may be placed with surplus lines insurers.

B. Insurance coverages and classes not included on the export list may be placed with surplus lines insurers only under the following conditions:

(1) A good faith effort must be made to place the insurance with admitted insurers the producer has reason to believe will consider writing the type of coverage or class of insurance involved. If that effort shows that the insurance cannot be obtained because of underwriting reasons or the insured requires specific terms and conditions of coverage which are unavailable through admitted insurers, the insurance may be placed with surplus lines insurers. Placement with the surplus lines insurer solely to obtain a better price does not constitute good faith unless the producer demonstrates that the price quoted by the admitted market is excessive as defined in Subsection 31A-19a-201(2).

(2) The inability to place the insurance through an admitted insurer with whom the producer has an established relationship is not an exception to the obligation to place the insurance with an admitted insurer.

(3) The producer must document his efforts to place the insurance with admitted insurers. The documentation must include the record of the efforts to place the insurance and a written explanation confirming the effort as being in good faith. The good faith effort documentation shall be maintained in the surplus lines [~~broker's~~]producer's and the originating producer's[~~producing agent's~~] files for at least three years from the inception date of coverage or renewal.

C. Substantial insureds may purchase insurance from surplus lines insurers pursuant to Section 31A-15-103 if each of the following conditions is met:

(1) the insured procures the insurance for its risk exposures by use of an employee of the insured whose full time responsibilities and duties consist of purchasing insurance and risk management;

(2) the insurance procured for property and casualty coverages, excluding workers' compensation insurance, exceeds an annual aggregate premium of $500,000; and

(3) the insured's risk manager and an officer of the company sign an affidavit confirming items (1) and (2). This affidavit shall be retained by the surplus lines [~~broker~~]producer and one copy shall be attached to the submission documentation required under R590-171-8.

D. All information relating to the placement of insurance pursuant to Section 31A-15-103 shall be made available to the commissioner upon his request.

R590-171-7. Conditions for Marketing Insurance with Surplus Lines Insurers.

A. Producers may not solicit business on behalf of a surplus lines insurer. However:

(1) Producers may advertise the availability of insurance products for the insurance coverages and classes included on the export list to potential insureds and other producers.

(2) Surplus lines [~~brokers~~]producers may advertise their services and product lines to other producers.

(3) Such advertisements shall identify the fact that the insurance will be placed with a surplus lines insurer. The advertisements must not identify the insurer by name nor act as a solicitation on behalf of any surplus lines insurer. The advertisements shall not identify specific rates or specific policy provisions.

B. Once negotiations over the available terms and conditions for specific coverages begin, at least the following facts must be disclosed in writing to the potential insured:

(1) that the insurance will be placed through a surplus lines insurer and the name of the insurer;

(2) that the producer is not [~~an agent~~]a producer of the potential insurer because surplus lines insurers are not permitted to appoint [~~agents~~]producers;

(3) that the surplus lines market is a specialty market that has limited regulatory oversight by the commissioner, and specifically, there is no regulation of policy coverage forms or rates; and

(4) that no protection is afforded under any Utah guaranty fund mechanism.

C. Subject to the general provisions of Section [~~31A-23-404~~]31A-23a-501, a surplus lines [~~broker~~]producer may originate surplus lines insurance or accept applications for surplus lines insurance from any other producer duly licensed as to the kinds of insurance involved. The surplus lines [~~broker~~]producer may compensate the originating producer involved in the transaction[~~producer~~].

D. Only that portion of a risk that is unacceptable to the admitted market may be placed with a surplus lines insurer. If it is not possible to obtain the full amount of insurance required by segmenting the risk, or if the only portion that the admitted market will write is incidental to the principal elements of coverage, it is permissible to place the full amount with a surplus lines insurer. An explanation must be provided in the submission documentation outlined in R590-171-8.

R590-171-8. Reporting and Examination.

A. No later than 60 days after the effective date of a policy or a certificate of insurance that has been placed with a surplus lines insurer, the surplus lines [~~broker~~]producer must file a complete copy of the policy or certificate and justification for placement with a surplus lines insurer with the Surplus Line Association for examination pursuant to Subsection 31A-15-103(11)(a).

B. Justification for placement with a surplus lines insurer shall:

(1) for insurance exposures placed pursuant to R590-171-6.A, consist of identification of the specific coverage or class on the export list; or

(2) for insurance exposures placed pursuant to R590-171-6.B, consist of a copy of the record of the effort to place with admitted insurers required by R590-171-6.B(3); or

(3) for insurance placed pursuant to R590-171-6.C, consist of a copy of an affidavit signed by the insured; and

(4) if applicable, consist of the explanation required by R590-171-7.D; and

(5) consist of any other information or documentation pertinent to the surplus lines placement.

C. The Surplus Line Association shall provide submission forms to be used for complying with R590-171-8.B.

D. If the contract or certificate is not available within 60 days, a binder with sufficient detail to determine the subject of the insurance, coverages, insured, insurer, premium amount and the justification required by R590-171-8B must be filed with the Surplus Lines Association of Utah[~~pending receipt of the actual policy or certificate of insurance~~].

E. If the examination performed by the Surplus Line Association determines that the placement of a policy or certificate of insurance with a surplus lines insurer is not in compliance with Section 31A-15-103(11)(a) or this rule, the Surplus Line Association shall take such corrective action as the Association Board of Directors considers appropriate, subject to the review of the commissioner. The Association shall advise the commissioner of all cases of noncompliance.

R590-171-9. Rule Distribution.

The Surplus Line Association of Utah shall distribute a copy of this rule to every surplus lines [~~broker~~]producer and instruct all surplus lines [~~brokers~~]producers as to its scope and operation.

R590-171-10. Penalties.

A person found to be in violation of this rule shall be subject to penalties as provided under 31A-2-308.

R590-171-11. Enforcement Date.

The commissioner will begin enforcing the revised provisions of this rule upon the effective date of this rule.

R590-171-[~~10~~]12. Severability.

If a provision of this rule or its application to any person or situation[~~circumstance~~] is [~~for any reason~~]held to be invalid, that invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable[~~the remainder of the rule and the application of such provisions is not effected~~].

KEY: insurance
Date of Enactment or Last Substantive Amendment: [~~September 1, 1995~~]2009
Notice of Continuation: June 14, 2005
Autorizing, and Implemented or Interpreted Law: 31A-2-201; 31A-15-103; 31A-15-111

Natural Resources, Forestry, Fire and State Lands
R652-20
Mineral Resources

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 32853
FILED: 7/29/09 2:00 PM

RULE ANALYSIS
PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of the rule change is to establish provisions for phasing out the rental credits for mineral leases on certain leases and making technical changes in the rule that reflect the increase in rental rates on mineral leases.

SUMMARY OF THE RULE OR CHANGE: Recent audits have indicated the state is not receiving full value for the public trust resources leased to persons for profit because the companies are receiving a free use of the leased land (rental credit) as long as royalties are paid. The rule amendment phases out rental credits against royalties on mineral leases over four years. Also, the legislature has established rental rates for Division leases and the new rate conflicts with the existing rule. The rule amendment changes the rental rates to match the fee schedule.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 65A-6-2 and Subsection 65A-6-4(2)

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: It is anticipated that there will be an increase in revenues because of: a) rental rate increases; and b) reductions in rental credits on mineral leases on those leases that have rental credits in their leases.
♦ LOCAL GOVERNMENTS: Local governments do not pay rentals or royalties to the state on any extracted minerals from state lands, so there are no impacts to local governments.
♦ SMALL BUSINESSES: There are currently no producers paying state rentals that are considered small businesses that will be impacted by this rule change.
♦ PERSONS OTHER THAN BUSINESS: This rule amendment only affects a contractual business relationship between a business and the state. No other persons are affected.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The increase in rental rates will increase rentals by 10% beginning in fiscal year 2010. Generally, the rentals are a fraction of the royalties paid by companies on mineral leases. The phase-out of rental credits will be phased in over four years and the increase will depend on the amount of sovereign lands leased by the state.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule eliminates the rental credit provision that some mineral leases have, and updates the rule to reflect rental rates approved by the legislature in the Division fee schedule. There will be a four year phase-in period for the rental credits to the businesses that have enjoyed that benefit, and an increase in rental rates for new leases.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
NATURAL RESOURCES
FORESTRY, FIRE AND STATE LANDS
1594 W NORTH TEMPLE
SUITE 3520
SALT LAKE CITY, UT 84116-3154
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Jennifer Wiglama by phone at 801-538-5495, by FAX at 801-533-4111, or by Internet E-mail at jenniferwiglama@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 5:00 PM 09/14/2009

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2009

AUTHORIZED BY: Richard Buehler, Director

R652. Natural Resources; Forestry, Fire and State Lands.
R652-20. Mineral Resources.
R652-20-1000. Rentals and Royalties.

1. Rentals. The Division is obligated to receive full value for the resources leased to persons of profit. This obligation includes obtaining a fair rental for the lands being used for mineral extraction.

(a) Rental rates are established in the Division fee schedule[~~for the first lease year is at the rate of $1 per acre, or fractional part thereof, per annum, regardless of percentage of state ownership in any given acre of land. Subsequent rental paying~~]Rental due dates shall be on or before the annual anniversary date of the effective date of the lease, the effective date of the lease being the first day of the month following the date on which the lease is issued.

(b) Any overpayment of advance rental occurring from mineral lease applicant's incorrect listing of acreage of lands described in the application may be credited toward the applicant's rental account.

(c) Minimum annual rental on any mineral lease is $20.

(d) The division shall accept lease payments made by any party, but the acceptance of lease payments shall not be deemed to be a recognition of any interest of the payee in the lease.

(e) Effective January 1, 2010, rental credits will be phased out over a four year period. For the calendar year beginning January 1, 2010, 75% of rentals due can be credited against royalties for those leases that allow rental credits. For the calendar year beginning January 1, 2011, 50% of rentals due can be credited against royalties for those leases that allow rental credits. For the calendar year beginning January 1, 2012, 25% of rentals can be credited against royalties for those leases that allow rental credits. Effective January 1, 2013, rental credits will no longer be allowed on any mineral leases.

2. Royalty Provisions

The following production royalty rates shall apply to all classified mineral leases, as listed in R652-20-200, issued on or after the effective date of the applicable adjusted royalty rate. Mineral leases entered into prior to the effective date of adjusted royalty rates shall retain the royalty rate as specified in the lease agreement.

(a) Royalty rates on substances under oil, gas, and hydrocarbon leases.

TABLE

Oil	12-1/2%	-	Sulfur	12-1/2%	
Gas	12-1/2%	-	Other hydrocarbon substances	6-1/4%(1)	

(1) For leases that allow rental credits, the[~~The~~] rental paid for the lease year shall be credited against production royalties as they accrue for that lease year, but not against advance or minimum royalties unless allowed by the mineral lease.

(2) During the first ten years of production and increasing annually thereafter at the rate of 1% to a maximum of 16-2/3%.

(b) Royalty rates on mineral commodities, coal, and solid hydrocarbons.

TABLE

Coal	8%	Phosphate	5%
Oil Shale (1)	5%	Potash and Associated Minerals	5%
Asphaltic/Bituminous Sands (2)	7%	Gypsum	5%
Gilsonite	10%	Clay	5%
Met. Minerals:		Geothermal Resources	10%
Fissionable	8%	Building Stone/Limestone (except 2% for calcined lime)	5%
Non-Fissionable	4%		
Gemstone/Fossil(3)	10%	Volcanic Materials	5%
Magnesium	1-1/2%	Industrial sands	5%
Salt (Sodium chloride) (4)	$0.50/dry ton		

(1) 5% during the first five years of production and increasing annually thereafter at the rate of 1% to a maximum of 12-1/2%.

(2) May be escalated after the first five years of production at the rate of 1% per annum to maximum of 12-1/2%.

(3) Requires payment of annual minimum royalty of $5 per acre.

(4) Beginning January 1, 2001, the royalty rate per ton will be adjusted annually by the Producer Price Index for Industrial Commodities as provided under R652-20-1000(e) using 1997 as the base year.

(c) Notwithstanding the terms of oil, gas, and hydrocarbon lease agreements, gas and natural gas liquid reports, and their required royalty payments, are required to be received by the division on or before the last day of the second month succeeding the month of production. This extension of payment and reporting time for gas and NGL does not alter the payment and reporting time for oil and condensate royalty which must be received by the division on or before the last day of the calendar month succeeding the month of production, as currently provided in the lease form.

(d) Readjustment of salt royalties on royalty agreements negotiated before July 9, 1992.

i) The division is obligated to receive full value for the public trust resources leased to persons for profit. This obligation includes obtaining a fair royalty for salt produced from the waters of Great Salt Lake. The division shall readjust the royalty rate for sodium chloride on all royalty agreements negotiated prior to July 9, 1992. The royalty rate will be readjusted in accordance with analysis done by the Utah Bureau of Economic and Business Research, Office of Energy and Resource Planning and division staff and with a rule change approved by the Board of State Lands and Forestry on July 9, 1992 to increase the royalty on salt from $0.10 per ton to a rate per ton approximately equivalent to three percent of gross value of dry salt. The division has determined this rate to be $0.50 per dry ton. The royalty rate shall be phased in as provided in Subsections (ii) and (iii).

ii) Effective January 1, 1997, the royalty rate for sodium chloride shall be $0.20 per dry ton. Effective January 1, 1998 and on each January 1 thereafter, the royalty rate for sodium chloride shall be increased by the lesser of $0.10 per dry ton or $0.10 per dry ton times the percent of salt in brine by weight at the point of intake for each lessee divided by the percent of salt by weight derived from samples at sampling point LVG4 as measured by the Utah Geological Survey for the current year. The method for calculating the percent salt in brine from Utah Geological Survey and company data shall be determined by the division, but shall include a weighted average of samples taken at low and high water and of samples taken at different depths at the sampling point. The point of sampling for each producer shall be determined by the division after considering factors including the location of the intake canal, point of diversion for water rights, and placement of intake pumps.

iii) The annual adjustment under Subsection(ii) shall continue until the royalty rate for a lessee is $0.50 per dry ton or an amount per ton as determined under Subsection (e), whichever is greater, at which time subsequent annual adjustments shall be determined in accordance with Subsection (e).

(e) Effective January 1, 2001 or the date on which the royalty paid by a lessee reaches $0.50 per dry ton, whichever is later, the royalty rate for sodium chloride will be adjusted annually by the Producer Price Index for Industrial Commodities using the following formula: $.50 times the Producer price index for Industrial Commodities for the current year divided by the Producer Price Index for Industrial Commodities for 1997.

R652-20-1100. Limits to Rental Credit.

For leases that allow rental credits, the[~~The~~] rental paid for the lease year shall be credited only against the production royalties as they accrue for that lease year.

R652-20-3200. Mineral Salts Leases Within Great Salt Lake.

1. Mineral leases for mineral salts on land within Great Salt Lake, shall be issued pursuant to the provisions of this rule, and other applicable laws and rules governing the issuance of mineral leases on state owned lands or mineral resources.

2. Definitions: The term "state land within Great Salt Lake", as used in this section, shall include all state lands lying within the exterior boundary lines of the meander-line around the lake as surveyed by the United States. The term "salts", as used in this section, shall mean, chlorides, sulphates, carbonates, boratex, silicates, oxides, nitrates and associated minerals existing at the surface and to the extent of their continuous depth, but shall not include the salts and other minerals contained in solution or suspension in the waters of Great Salt Lake as defined in R652-20-3100.

3. All mineral lessees granted a mineral salts lease under this section must have a royalty agreement as provided under R640-20-3100. This royalty agreement shall be a minimum royalty of $10,000.

4. Leases issued pursuant to this rule shall grant the lessee the right to mine, extract, or remove salts from the surface of the lands covered thereby, together with the right to use so much of the surface as is necessary for all purposes incident to the extraction

of salts and other minerals from brines of Great Salt Lake or the surface of the lands covered by the lease.

5. [~~These leases~~]Leases shall provide for a rental using rates established in the Division fee schedule[~~of $1 per acre per annum~~] and shall be coterminous with R652-20-3100.[~~ Ten years after date of issuance, the rental thereunder shall increase from $1 per acre to $2 per acre per annum.~~]

6. Leases issued pursuant to this rule shall contain provisions necessary to affect the purpose of this rule, including, the following provisions: the rights of the lessee; the term of the lease; annual rental and royalties; rights reserved to the lessor; bonds; reporting of technical data; operation requirements; lessees consent to suit in any dispute arising under the terms of this lease or as a result of operations carried on under this lease; procedures for notification; transfers of interest by lessee; establishment of water rights and water usage; discovery of other minerals; terms and conditions of lease forfeiture; protection of the state from liability from all actions of the lessee; and all other provisions that the division deems necessary to protect the interest of the state and to fulfill the purpose of this rule.

KEY: royalties, salt, primary term, administrative procedures
Date of Enactment or Last Substantive Amendment: [~~May 26,~~]2009
Notice of Continuation: April 2, 2007
Authorizing, and Implemented or Interpreted Law: 65A-6-2; 65A-6-4(3)

Public Service Commission, Administration
R746-100-16
Use of information Claimed to Be Confidential in Commission Proceedings

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 32867
FILED: 7/30/09 4:36 PM

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this amendment is to provide by rule provisions the same treatment in Public Service Commission proceedings for information claimed to be confidential as is done through separate protective orders issued in individual proceedings. This will facilitate the exchange of information as is currently done in Commission proceedings without having to wait for a party to request a protective order, wait for responses to the request and then proceed to issue a protective order.

SUMMARY OF THE RULE OR CHANGE: The amendment adds a new section, R746-100-16, to the Commission's Rule R746-100. The proposed amended places in the rule the same or similar provisions as the Commission has included in individual protective orders issued in Commission proceedings.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 54-1-1 and Section 54-1-3 and Section 54-3-21 and Section 54-4-1.5 and Section 54-4-2

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: There are no additional costs anticipated for state agencies as the rule replicates the process currently followed in the normal course of Commission proceedings in issuing individual protective orders in a proceeding. There will be some savings, although minimal, as the Commission will not need to issue separate protective orders in individual proceedings, relying instead on the provisions of the proposed rule amendment to obtain the same result.
♦ LOCAL GOVERNMENTS: There are no costs or savings for local governments as the rule has no application to local government activities.
♦ SMALL BUSINESSES: There are no costs and minimal savings anticipated for small business. The savings potential arises from the ability for any small business that may participate in a Commission proceeding to rely upon the proposed rule amendment's provisions rather than having to request an individual protective order or follow a separate protective order in a Commission proceedings. Historically, few, if any small businesses participate in Commission proceedings. Special interest advocacy groups, with less than 50 employees, have occasionally participated, and these will have the same potential for minimal savings.
♦ PERSONS OTHER THAN BUSINESS: There are no costs and minimal savings anticipated for other participants. The savings potential arises from the ability of a participant that may participate in a Commission proceeding to rely upon the proposed rule amendment's provisions rather than having to request an individual protective order or follow a separate protective order in a Commission proceedings.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs for affected persons as the proposed amendment places in administrative rule the same or similar processes and procedures currently followed in Commission proceedings relating to the availability and use of information claimed to be confidential.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There are no anticipated fiscal impacts from the rule. The rule follows existing practice of the Commission dealing with information claimed to be confidential and places in one rule

what the Commission uniformly does in individual proceedings.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

PUBLIC SERVICE COMMISSION
ADMINISTRATION
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY, UT 84111-2316
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Sandy Mooy by phone at 801-530-6708, by FAX at 801-530-6796, or by Internet E-mail at smooy@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 5:00 PM ON 09/15/2009

THIS RULE MAY BECOME EFFECTIVE ON: 09/23/2009

AUTHORIZED BY: Sandy Mooy, Legal Counsel

R746. Public Service Commission, Administration.
R746-100. Practice and Procedures Governing Formal Hearings.
R746-100-16. Use of information Claimed to Be Confidential in Commission Proceedings.

A. Information, documents and material submitted or requested in or relating to any Commission proceeding which is claimed to be confidential will be treated in as follows.

1.a. Nature of Confidential Information. A person (Providing Party) required or requested to provide documents, data, information, studies, and other materials of a sensitive, proprietary or confidential nature (Confidential Information) to the Commission or to any party in connection with a Commission proceeding may request protection of such information in accordance with the terms of this rule. Confidential treatment shall be requested only to the extent a good faith reasonable basis exists for claiming that specific information constitutes a trade secret or is otherwise of such a highly-sensitive or proprietary nature that public disclosure would be inappropriate. Confidential treatment shall be requested narrowly as to only that specific information for which protection is reasonably required.

b. Identification of Confidential Information. All documents, data, information, studies and other materials filed in conjunction with a Commission proceeding, made available to proceeding participants, furnished, or whether made available pursuant to any interrogatories, or requests for information, subpoenas, depositions, or other modes of discovery or otherwise, that are claimed to be Confidential Information, shall be furnished pursuant to the terms of this rule or any superseding Protective Order, and shall be treated by all persons accorded access thereto pursuant to this rule or Protective Order, and shall neither be used nor disclosed by any recipient thereof except for the purpose of the proceeding in which it was obtained and solely in accordance with this rule or superseding Protective Order. All material claimed to be Confidential Information shall be so marked by the person producing it by stamping or noting the same with the a designation substantially as follows "CONFIDENTIAL - - SUBJECT TO UTAH PUBLIC SERVICE COMMISSION RULE 746-100-16", or "CONFIDENTIAL - SUBJECT TO PROTECTIVE ORDER" or "CONFIDENTIAL - - SUBJECT TO PROTECTIVE ORDER IN DOCKET NO. XX-XXX-XX (reflecting the appropriate docket number" All copies of documents so marked will be made on yellow paper. Parties shall ensure that line numbering in any redacted version of a document shall conform to and retain the general formatting and line numbering used in the unredacted version of the document. Individuals providing electronic documents to the Commission should file both a confidential and non-confidential version each clearly marked as such. For purposes hereof, notes made pertaining to or as the result of a review of Confidential Information shall be considered Confidential Information and subject to the terms of this rule.

c. Use of Confidential Information and Persons Entitled to Review. The Commission, Division of Public Utilities, and Office of Consumer Services shall be provided with Confidential Information and may use the Confidential Information as these agencies deem necessary to perform their statutory functions, provided they shall protect the confidentiality of the information as required by Utah law. Other than these state agencies, all Confidential Information made available pursuant to this rule shall be given solely to counsel for the participants (which may include counsels' paralegals, administrative assistants and clerical staff to the extent reasonably necessary for performance of work on the matter), and shall not be used nor disclosed except for the purpose of the proceeding in which they are provided and in accordance with this rule; provided, however, that access to any specific Confidential Information may be authorized by counsel, solely for the purpose of the proceeding, to those persons indicated by the participants as being their experts in the matter (including such experts' administrative assistants and clerical staff, and persons employed by the participants, to the extent reasonably necessary for performance of work on the matter). Persons designated as experts shall not include persons employed by the participants who could use the information in their normal job functions to the competitive disadvantage of the person providing the Confidential Information. The Commission, the Division of Public Utilities, and the Office of Consumer Services, and their respective counsel and staff, under and pursuant to the applicable provisions of Title 54, Utah Code Ann., the Rules of Civil Procedure and the Rules of the Commission, may have access to any Confidential Information made available pursuant to this rule or Protective Order and shall be bound by the terms of this rule, except as otherwise stated herein and except for the requirement of signing a nondisclosure agreement. Further, nothing herein shall prevent disclosure as required by law pursuant to interrogatories, administrative requests for information or documents, subpoena, civil investigative demand or similar process, provided, however, that the person being required to disclose Confidential Information shall promptly give prior notice by telephone and written notice of such requirement of disclosure by electronic mail facsimile and overnight mail to the person that provided such Confidential Information, addressed to the providing person and attorneys of record for such person, so that the person that provided the Confidential Information may seek appropriate restrictions on disclosure or an appropriate protective

order. The disclosing person will not oppose action by, and will cooperate with the person that provided the Confidential Information to obtain an appropriate protective order or other reliable assurance that confidential treatment will be accorded the Confidential Information.

d. Nondisclosure Agreement. Prior to giving obtaining access to Confidential Information, as contemplated in 1.b. above, counsel or any experts shall agree in writing to comply with and be bound by this rule and any Protective Order. Confidential Information shall not be disclosed to any person who has not signed a Nondisclosure Agreement in the form which is provided below or referenced in the Protective Order. The Nondisclosure Agreement shall require the person to whom disclosure is to be made to read a copy of this rule and any applicable Protective Order and to certify in writing that he or she has reviewed the same and has consented to be bound by the terms. The agreement shall contain the signatory's full name, permanent address and employer, and the name of the person with whom the signatory is associated. Such agreement shall be delivered to the providing person and counsel for the providing person prior to the expert gaining access to the Confidential Information.

The Nondisclosure Agreement may be in the following form:

"Nondisclosure Agreement. I have reviewed Public Service Commission of Utah Rule 746-100-16 and/or the Protective Order entered by the Public Service Commission of Utah in Docket No. XX-XXX-XX with respect to the review and use of confidential information and agree to comply with the terms and conditions of the rule and/or Protective Order." Thereafter there shall be lines upon which shall be placed the individual's signature, the typed or printed name of the individual, identification or name of the individual's employer or firm employing the individual (if any), the business address for the individual, identification or name of the party in the proceeding with which the individual is associated, and the date the nondisclosure agreement is executed by the individual.

e. Additional protective measures. To the extent a Providing Party reasonably claims that additional protective measures, beyond those required under this rule, are warranted for certain highly proprietary, highly sensitive or highly confidential material (Highly Sensitive Information), the Providing Party shall promptly inform the requester (Requesting Party) of the claimed highly sensitive nature of identified material and the additional protective measures requested by the Requested Party. If the Providing Party and Requesting Party are unable to promptly reach agreement on the treatment of Highly Sensitive Information, the Providing Party shall petition the Commission for an order granting additional protective measures. The Providing Party shall set forth the particular basis for: the claim, the need for the specific, additional protective measures, and the reasonableness of the requested, additional protection. A Requesting Party and any other party may respond to the petition and oppose or propose alternative protective measures to those requested by the Providing Party. Disputes between the parties shall be resolved by the Commission.

2.a. Challenge to Confidentiality or Proposed Additional Protective Measures. This rule establishes a procedure for the expeditious handling of Confidential Information; it shall not be construed as an agreement, or ruling on the confidentiality of any document.

b. In the event that persons are unable to agree that certain documents, data, information, studies, or other matters constitute Confidential Information, are highly sensitive documents and information referred to in A.1.e. above, or agree on the appropriate treatment of Highly Sensitive Information, the person objecting to the classification as Confidential Information or the person claiming highly sensitive documents and information and the need for additional protective measures shall forthwith submit the disputes to the Commission for resolution.

c. Any person at any time upon at least ten (10) days prior notice, when practicable, may seek by appropriate pleading, to have documents that have been designated as Confidential Information, or which were accepted into the sealed record in accordance with this rule or a Protective Order, removed from the protective requirements of this rule or the Protective Order, or from the sealed record and placed in the public record. If the confidential, or proprietary nature of this information is challenged, resolution of the issue shall be made by the Commission after proceedings in camera which shall be conducted under circumstances such that only those persons duly authorized to have access to such confidential matter shall be present. The record of such in camera hearings shall be marked substantially as follows "CONFIDENTIAL--SUBJECT TO RULE 746-100-16 OR PROTECTIVE ORDER IN CASE NO. XX-XXX-XX (reflecting the appropriate docket number)." unless the Commission determines, and so provides by order, that such marking need not occur. It shall be transcribed only upon agreement by the parties, or order of the Commission, and in that event shall be separately bound, segregated, sealed, and withheld from inspection by any person not bound by the terms of this rule or Protective Order, unless and until released from the restrictions of this rule or Protective Order, either through agreement of the parties, or after notice to the parties and hearing, pursuant to an order of the Commission. In the event the Commission should rule in response to such a pleading that any information should be removed from the protective requirements of this rule or Protective Order, or from the protection of the sealed record, such order of the Commission shall not be effective for a period of ten (10) days after entry of the order.

3.a. Receipt into Evidence. At least ten (10) days prior to the use of or substantive reference to any Confidential Information as evidence, if practicable, the person intending to use such Confidential Information shall make that intention known to the providing person. The requesting person and the providing person shall make a good faith effort to reach an agreement so that the Confidential Information can be used in a manner which will not reveal its trade secret, confidential or proprietary nature. If such efforts fail, the providing person shall separately identify, within five (5) business days, which portions, if any, of the documents to be offered or referenced on the record containing Confidential Information shall be placed in the sealed record. Only one (1) copy of documents designated by the providing person to be placed in a sealed record shall be made and only for that purpose. Otherwise, persons shall make only general references to Confidential Information in any proceedings.

b. Seal. While in the custody of the Commission, Confidential Information provided pursuant to this rule or a Protective Order shall be marked substantially as follows: "CONFIDENTIAL--SUBJECT TO PUBLIC SERVICE COMMISSION OF UTAH RULE 746-100-16 OR PROTECTIVE

ORDER IN CASE NO. XX-XXX-XX (reflecting the appropriate docket)".

c. In Camera Hearing. Any Confidential Information that must be orally disclosed to be placed in a sealed record of a proceeding shall be offered in an in camera hearing, attended only by persons authorized to have access to the Confidential Information under this rule or Protective Order. Similarly, cross-examination on or substantive reference to Confidential Information, as well as that portion of the record containing references thereto, shall be similarly marked and treated.

d. Appeal. Sealed portions of the record in any proceeding may be forwarded to any court of competent jurisdiction on appeal in accordance with applicable rules and regulations, but under seal as designated herein, for the information and use of the court.

e. Return. Unless otherwise ordered, Confidential Information, including transcripts of any depositions to which a claim of confidentiality is made, shall remain under seal, shall continue to be subject to the protective requirements of this rule or Protective Order, and shall be returned to the providing person or counsel for the providing person within 30 days after final settlement, or conclusion of the matters in which they were used, including administrative or judicial review thereof. Alternatively, a person receiving Confidential Information pursuant to the terms of this rule or Protective Order may certify, within 30 days after final settlement, or conclusion of the matter including administrative or judicial review thereof, that the Confidential Information has been destroyed. Counsel who are provided access to Confidential Information pursuant to the terms of this rule or Protective Order may retain the Confidential Information, their notes, work papers or other documents as their attorneys' work product created with respect to their use and access to Confidential Information in the matter. An expert witness, accorded access to Confidential Information pursuant to this rule or Protective Order, shall provide to counsel for the person on whose behalf the expert was retained or employed, the expert's notes, work papers or other documents pertaining or relating to any Confidential Information. Counsel shall retain these experts' documents with counsel's documents. In order to facilitate their ongoing responsibility, this provision shall not apply to the Commission, the Division of Public Utilities or the Office of Consumer Services, which may retain Confidential Information obtained under this rule or Protective Order subject to the other terms of this rule or Protective Order. Any party that intends to use or disclose Confidential Information obtained pursuant to this rule or a Protective Order in any subsequent Commission dockets or proceedings, shall do so in accordance with the terms of this rule or any applicable protective orders issued in such other subsequent Commission dockets or proceedings and only after providing notice of such intent to the providing person along with an identification of the original source of the Confidential Information.

4. Use in Proceedings. Where reference to Confidential Information is required in pleadings, cross-examinations, briefs, arguments, or motions, it shall be by citation of title, or exhibit number, or by some other nonconfidential description. Any further use of, or substantive references to Confidential Information shall be placed in a separate section of the pleading, brief, or document and submitted under seal. This sealed section shall be served only on counsel of record (one copy each), who have signed a Nondisclosure Agreement and counsel for the Division of Public Utilities and Office of Consumer Services. All the protections afforded in this rule apply to materials prepared and distributed under this paragraph.

5. Use in Decisions and Orders. The Commission will attempt to refer to Confidential Information in only a general, or conclusionary form and will avoid reproduction in any decision of Confidential Information to the greatest possible extent. If it is necessary for a determination in a proceeding to discuss Confidential Information other than in a general, or conclusionary form, it shall be placed in a separate section of an Order, or Decision, under seal. This sealed section shall be served only on counsel of record (one copy each) who have signed a Nondisclosure Agreement and counsel for the Division of Public Utilities and Office of Consumer Services. Counsel for other parties shall receive the cover sheet to the sealed portion and may review the sealed portion on file with the Commission once they have signed a Nondisclosure Agreement.

6. Segregation of Files. Those parts of any writing, depositions reduced to writing, written examination, interrogatories and answers thereto, or other written references to Confidential Information in the course of discovery, if filed with the Commission, will be sealed by the Commission, segregated in the files of the Commission, and withheld from inspection by any person not bound by the terms of this rule or Protective Order, unless such Confidential Information is released from the restrictions of this rule or Protective Order, either through agreement of the parties, or after notice to the parties and hearing, pursuant to an order of the Commission and/or final order of a court having jurisdiction.

7. Preservation of Confidentiality. All persons who may be entitled to receive, or who are afforded access to any Confidential Information by reason of this rule or Protective Order shall neither use, nor disclose the Confidential Information for purposes of business or competition, or any other purpose other than the purposes of preparation for and conduct of Commission proceedings, and then solely as contemplated herein, and shall take reasonable precautions to keep the Confidential Information secure in accordance with the purposes and intent of this rule or a Protective Order.

8. Reservation of Rights. Persons affected by the terms of this rule or a Protective Order retain the right to question, challenge, and object to the admissibility of any and all data, information, studies and other matters furnished under the terms of this rule or a Protective Order in response to interrogatories, requests for information, other modes of discovery, or cross-examination on the grounds of relevancy or materiality. This rule or a Protective Order shall in no way constitute any waiver of the rights of any person to contest any assertion by another person or finding by the Commission that any information is a trade secret, confidential, or privileged, and to appeal any assertion or finding.

KEY: government hearings, public utilities, rules and procedures, confidential information
Date of Enactment or Last Substantive Amendment: [~~April 1, 2004~~|2009
Notice of Continuation: December 3, 2007
Authorizing, and Implemented or Interpreted Law: 54-1-1; 54-1-3; 54-1-6; 54-3-21; 54-4-1; 54-4-1.5; 54-4-2; 54-7-17; 63G-4

Public Service Commission, Administration
R746-360-4
Application of Fund Surcharges to Customer Billings

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 32851
FILED: 7/29/09 11:28 AM

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The proposed amendment will reduce the Universal Public Telecommunications Service Support Fund surcharge from 0.5 percent to 0.25 percent. This will more closely match future anticipated funds and fund balance to future anticipated expenditures.

SUMMARY OF THE RULE OR CHANGE: The intrastate retail surcharge will be reduced from 0.5 percent to 0.25 percent.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 54-8b-15

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: There will be a reduction in costs. The surcharge is assessed on all retail intrastate telecommunications services. A reduction in the surcharge will result in a decrease in the amount paid by state government for retail intrastate telecommunications services. While the Commission has information concerning the periodic surcharge amounts collected by telecommunications carriers, it does not have the ability to disaggregate those amounts to determine the amounts paid by specific customers of the telecommunications carriers. The overall reduction in the fund balance over a 2-year period is expected to be $4,000,000, while still retaining a $4,000,000 balance in the fund.
♦ LOCAL GOVERNMENTS: There will be a reduction in costs. The surcharge is assessed on all retail intrastate telecommunications services. A reduction in the surcharge will result in a decrease in the amount paid by local governments for retail intrastate telecommunications services. While the Commission has information concerning the periodic surcharge amounts collected by telecommunications carriers, it does not have the ability to disaggregate those amounts to determine the amounts paid by specific customers of the telecommunications carriers.
♦ SMALL BUSINESSES: There will be a reduction in costs. The surcharge is assessed on all retail intrastate telecommunications services. A reduction in the surcharge will result in a decrease in the amount paid by all businesses for retail intrastate telecommunications services. While the Commission has information concerning the periodic surcharge amounts collected by telecommunications carriers, it does not have the ability to disaggregate those amounts to determine the amounts paid by specific customers of the telecommunications carriers.
♦ PERSONS OTHER THAN BUSINESS: There will be a reduction in costs. The surcharge is assessed on all retail intrastate telecommunications services. A reduction in the surcharge will result in a decrease in the amount paid by all customers for retail intrastate telecommunications services. While the Commission has information concerning the periodic surcharge amounts collected by telecommunications carriers, it does not have the ability to disaggregate those amounts to determine the amounts paid by specific customers of the telecommunications carriers.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The Commission will make the rule effective at a future date which will allow telecommunications carriers collecting the surcharge adequate time to become aware of the reduction and change their billing systems to accommodate the change. This date is anticipated to be 11/01/2009. Costs for telecommunications carriers to collect the reduced surcharge are expected to remain the same as before the proposed amendment. However, there could be a reduction in telecommunications costs. The surcharge is assessed on all retail intrastate telecommunications services. A reduction in the surcharge will result in a decrease in the amount paid by for retail intrastate telecommunications services purchased from telecommunications carriers which are not self-provided by a carrier. While the Commission has information concerning the periodic surcharge amounts collected by telecommunications carriers, it does not have the ability to disaggregate those amounts to determine the amounts paid by specific customers of the telecommunications carriers.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Although there will be a reduction in the amount of the surcharge, the exact impact upon businesses is difficult to project beyond the absolute percentage reduction, from 0.5 to 0.25 percent, a reduction of one half the surcharge amount previously applied to intrastate retail telecommunications services. The dollar amount of the reduction for any individual entity will depend upon the amount of retail intrastate telecommunications services used by the customer.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
PUBLIC SERVICE COMMISSION
ADMINISTRATION
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY, UT 84111-2316
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Sandy Mooy by phone at 801-530-6708, by FAX at 801-530-6796, or by Internet E-mail at smooy@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 5:00 PM 09/14/2009

THIS RULE MAY BECOME EFFECTIVE ON: 09/23/2009

AUTHORIZED BY: Sandy Mooy, Legal Counsel

R746. Public Service Commission, Administration.
R746-360. Universal Public Telecommunications Service Support Fund.
R746-360-4. Application of Fund Surcharges to Customer Billings.

A. Commencement of Surcharge Assessments -- Commencing June 1, 1998, end-user surcharges shall be the source of revenues to support the fund. Surcharges will be applied to intrastate retail rates, and shall not apply to wholesale services.

B. Surcharge Based on a Uniform Percentage of Retail Rates -- The retail surcharge shall be a uniform percentage rate, determined and reviewed annually by the Commission and billed and collected by all retail providers.

C. Surcharge -- The surcharge to be assessed shall equal [~~0.45~~]0.25 percent of billed intrastate retail rates.

KEY: public utilities, telecommunications, universal service
Date of Enactment or Last Substantive Amendment: [~~October 1, 2008~~]2009
Notice of Continuation: November 25, 2008
Authorizing, and Implemented or Interpreted Law: 54-3-1; 54-4-1; 54-7-25; 54-7-26; 54-8b-12; 54-8b-15

Public Service Commission, Administration
R746-700
Complete Filings for General Rate Case and Major Plant Addition Applications

NOTICE OF PROPOSED RULE
(New Rule)
DAR FILE NO.: 32866
FILED: 7/30/09 4:34 PM

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of the rule is to describe the information to be filed in and with a general rate case application or alternative cost recovery for a major plant addition application for the filing to comply with the requirements of Subsections 54-7-12(2) and 54-7-13.4(2).

SUMMARY OF THE RULE OR CHANGE: The rule provisions describe the various informational requirements that need to be met for a general rate case application to be considered a complete filing for Subsection 54-7-12(2) and for an alternative cost recovery for a major plant addition application to be considered a complete filing for Subsection 54-7-13.4(2).

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 54-7-12(1)(b)(ii) and Subsection 54-7-13.4(1)(a)(ii)

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: No additional costs or savings are anticipated for the Commission or state agencies participating in Commission proceedings. The information, materials, data, etc. outlined in the proposed rule are the same that are developed, exchanged, and analyzed by participants in these types of proceedings conducted by the Commission.
♦ LOCAL GOVERNMENTS: None--The proposed rule does not affect local government activities.
♦ SMALL BUSINESSES: No additional costs or savings are anticipated for small business or other businesses participating in Commission proceedings. The information, materials, data, etc. outlined in the proposed rule are the same that are developed, exchanged, and analyzed by participants in these types of proceedings conducted by the Commission.
♦ PERSONS OTHER THAN BUSINESS: No additional costs or savings are anticipated for participants participating in Commission proceedings. The information, materials, data, etc. outlined in the proposed rule are the same that are developed, exchanged, and analyzed by participants in these types of proceedings conducted by the Commission.

COMPLIANCE COSTS FOR AFFECTED PERSONS: No additional costs or savings are anticipated for any participant participating in Commission proceedings. The information, materials, data, etc. outlined in the proposed rule are the same that are developed and analyzed by public utilities in their preparations to file applications with the Commission. They are the same materials that are exchanged among participants and analyzed by participants in these types of proceedings conducted before the Commission.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The proposed rule will have no fiscal impact upon affected

business other than any that may have been anticipated by the Legislature in amending and enacting Sections 54-7-12 and 54-7-13.4, which direct the Commission to promulgate rules outlining the informational requirements for these type of applications to be considered complete. The Commission developed the rule in consultation with participants from prior Commission proceedings to follow and incorporate the participants' practices relating to the information developed and exchanged among themselves and with the Commission in these types of proceedings.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

PUBLIC SERVICE COMMISSION
ADMINISTRATION
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY, UT 84111-2316
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO: ♦ Sandy Mooy by phone at 801-530-6708, by FAX at 801-530-6796, or by Internet E-mail at smooy@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 5:00 PM ON 09/15/2009

THIS RULE MAY BECOME EFFECTIVE ON: 09/23/2009

AUTHORIZED BY: Sandy Mooy , Legal Counsel

R746. Public Service Commission, Administration.
R746-700. Complete Filings for General Rate Case and Major Plant Addition Applications.
R746-700-1. General Provisions Applicable to All 7XX Series Rules.

This rule provides provisions for complete filings for general rate case and alternative cost recovery for major plant addition applications and other 7XX series rules, meaning R746-700-1 through and including R746-700-51.

A. Purpose. The 7XX series rules apply to an application for a general rate case filed by a public utility for an increase or decrease in base rates pursuant to 54-7-12 and an application for alternative cost recovery for a major plant addition filed by an electrical corporation or gas corporation public utility for cost recovery of a major plant addition pursuant to 54-7-13.4.

B. A public utility anticipating to file a general rate case or major plant addition application shall file with the Commission a non-binding notification of its intent to file such application at least 30 days prior to the anticipated filing date of the application. The notification shall be served on all parties that participated in the public utility's last prior general rate case or major plant addition proceeding respectively. The Commission may grant an exception or modification to this notification requirement based on a showing of good cause by the public utility.

C. Minimum filing requirements for a complete filing. Sections 700-10, 700-20, 700-21, 700-22, 700-23, 700-30, 700-40, 700-41, 700-50, and 700-51 set forth the information which must be contained in an application, testimony, exhibits, evidence, data, and any other informational documents filed with an application for the application to be considered a complete filing pursuant to 54-7-12(2) or 54-7-13.4(2).

D. Paper and Electronic media documents.

1. All documents filed with the Commission are to be in paper and electronic media versions as directed by R746-100. When a particular exhibit, data or informational document or its accompanying documentation required by a rule is voluminous, a proceeding participant shall file only three complete paper versions and the electronic media version with the Commission. The proceeding participant shall file any additional paper versions as subsequently directed by the Commission.

2. A proceeding participant is encouraged to provide voluminous material to other participants in a proceeding in an electronic media version. Unless a participant in a Commission proceeding notifies the Commission and other proceeding participants that it is unable or unwilling to receive documents in electronic media, provision of documents to a participant need only be in electronic media.

3. An applicant shall provide electronic media versions of its application and additional information and documents to be provided pursuant to any series 7XX rule to the Division of Public Utilities and the Office of Consumer Services, other parties granted intervention in the utility's last prior application proceeding, and any other person that has petitioned for intervention in the proceeding. An applicant need not provided these documents to a person whose intervention it opposes unless and until the person is granted intervention by the Commission. Notwithstanding the foregoing, the applicant shall provide a reasonable number of paper copies of the documents to the Division of Public Utilities and the Office of Consumer Services upon request.

E. Format, detail, etc. of documents, information, data, etc., indication of non-existence of information or unavailability of information of the type, detail or format described in a rule provision in the public utility's normal course of business and accounting, and confidential and privileged documents or information.

1. The format, detail, etc. of documents, data, information, etc. provided pursuant to any 7XX series rule shall be in the same format, detail, etc. as provided in the public utility's last prior proceeding or as otherwise directed by the Commission in or subsequent to the last prior proceeding. If a document, spreadsheet, schedule, etc. has internal formulas or other types of inter-cell relationships, the electronic media version shall be provided with such formulas or cell relationships intact.

2. If any series 7XX rule requires particular documents, data, information, etc. to be produced and the documents, data, information, etc. do not exist, the proceeding participant shall specifically so indicate. If any 7XX series rule requires information to be produced of a certain type or in a certain detail, format, etc. which is not so maintained in the normal course of business and accounting, the participant will so indicate and identify and provide what information does exist as maintained by the participant.

3. Information claimed to be confidential that would fall within any 7XX series rule that is filed or provided by a proceeding participant in connection with an application shall be filed or provided under the terms of R746-100-16 or any applicable

protective order. If a proceeding participant believes a document, data, information, etc. would fall within any 7XX series rule but claims a privilege affects its production, in lieu of providing the document, data, information, etc., the participant shall provide a description of the document, data, information, etc. and explain the privilege's application to the document, data, information, etc.

R746-700-10. Test Period Information to Be Included With a General Rate Case Application.

A. Cases where the test period is first identified in the application.

1. The applicant will provide information which will demonstrate what adjustments are required to be made to the 12 months of actual, unadjusted results of operations data, including all regulated costs and revenues, contained in the most recent periodic reported results of operations submitted to the Commission, to arrive at the test period used by the applicant in its application, on both a Utah jurisdiction and total company basis. If the public utility does not submit periodic reported results of operations to the Commission, the applicant shall use the public utility's most recently audited 12-month period in lieu thereof as the base period upon which the test period used in the application is developed.

a. Adjustments to be demonstrated include, but are not limited to: normalization adjustments, annualization adjustments, accounting adjustments, adjustments to reflect prior Utah regulatory decisions and policies made by the Commission with respect to any item or matter (including those which are not supported or advocated by the applicant for use in the general rate case) contained in the application, and all further adjustments to arrive at the test period used by the applicant in the general rate case filing.

b. The applicant will provide information explaining why the test period used is the most appropriate for the case.

c. In addition to the information relating to each adjustment identified in compliance with R746-700-10.A1.a, the applicant will also provide a summary index which identifies each adjustment or portion of an adjustment made in the filing material which can be used to locate where each adjustment or portion thereof is addressed, treated, applied, etc. in the application, testimony, exhibits and other documentation submitted. The summary index may be presented in testimony, as a table embedded in testimony, as an exhibit to testimony, or in any other manner so long as it is clearly identified.

2. If the test period used in the application is a future test period, in addition to the demonstration of adjustments to be made for the test period used by the applicant in the general rate case application, the applicant will make the same demonstration for the 12-month period ending on the last day of June or December, whichever is closest, following the filing date of the application if this alternative period does not have an end date beyond the test period used in the general rate case application.

B. Cases where the test period is identified and approved prior to the filing of an application.

1. An applicant planning to file an application may first request Commission approval of a test period to be used prior to filing an application. The request to approve the proposed test period shall be accompanied by testimony and exhibits providing information supporting the proposed test period.

2. Subsequent to the Commission's approval of a test period, the applicant may then submit an application, using as the test period for the case the test period previously approved by the Commission and need not provide the alternative test period demonstration required by R746-700-10.A.2.

R746-700-20. Information For a General Rate Case Application for an Electrical Corporation or a Gas Corporation.

An applicant submitting a general rate case application shall provide the following information with the application, on a total company and Utah jurisdictional basis using the allocation methods used in the public utility's last general rate case proceeding or any allocation method subsequently approved by the Commission. An applicant will provide an index which identifies where in the application, testimony, exhibits, documents, information, data, etc. filed with the application the applicant has responded to and complied with these R746-700-20 rule requirements. The index may be presented in testimony, as a table embedded in testimony, as an exhibit to testimony, or in any other manner so long as it is clearly identified.

A. Historical results of operations information:

1. actual, unadjusted results of operations, including all regulated costs and revenues, for an historical 12-month period as contained in its last periodic reported results of operations filing submitted to the Commission.

2. adjusted results of operations for the same period.

3. a description of any significant changes in accounting policies for the 24-month period prior to the historical period and any subsequent accounting changes through the date of the general rate case application and, if a forecasted test period is used, any future significant changes included in a future test period, along with their impact on the filing. Significant changes for this purpose are anything referenced or that would be referenced in footnotes of financial statements or auditor's reports.

B. If a non-forecasted test period is used in the application, the applicant shall provide information identifying and supporting each and every modification to the historical results of operations to arrive at the non-forecasted test period used in the general rate case application.

C. If a fully or partially forecasted test period is used in the application, which forecasted test period was not previously approved by the Commission for the general rate case application, the following forecasted test period information shall be provided (the format of the forecasted test period data shall be comparable to the historical results of operation information):

1. Revenues, with details supporting the test period revenues including (as applicable):

a. Usage, per customer by customer class

b. Demand and energy usage

c. Assumptions used in the development of the revenue forecasts

d. Billing determinants, by customer class, used to calculate the forecast test period revenues.

e. Charges, fees, and rates used in the forecast development

f. Contract changes or other specific changes anticipated in the forecast.

2. Operating Costs, using the same cost categories as used in the base period used for compliance with R746-700-10.A, with details supporting the test period operating cost information, including:

a. Forecasted costs relying on escalators or drivers will include the details of the base costs and the key drivers that impact the forecasted amount. If forecasted costs are not based on historical levels that have been inflated or escalated, the applicant shall provide supporting documents in the most detailed level available.

b. The information will identify the index or rate of inflation applied to accounts, budget items or specific cost components that result in adjusted costs in the forecasted test period. Source documents supporting the index or rate of inflation applied will be identified and will be provided or made available.

3. Labor Costs shall be identified separately. The applicant will provide:

a. The actual most recent number of full-time equivalent employees and, separately, the forecasted number of full-time equivalent employees for the forecasted period. The most recent number of actual contract labor employees and the forecasted number of contract labor employees for the test period will also be provided as available and separately identified. The most recent number of actual union labor employees and the forecasted number of union labor employees for the test period will also be provided as available and separately identified.

b. The associated costs related to the full time equivalent labor and contract labor levels. Direct employees, contract employees, union and nonunion employees will each be provided separately.

c. Overtime costs, premiums, incentives, or other labor costs included in the forecast, with each provided separately. Union and nonunion costs shall be provided separately.

d. Any assumed salary and wage increases included in the projected labor costs will be identified. Any of the increases supported by a union contract will be so identified.

e. Pensions and benefits, overheads or other employee benefit costs that are included in the forecast period. Each of the separate employee benefit components will be separately identified (i.e., medical, dental, pensions, etc.) Any assumptions regarding projected increases in such costs caused by factors other than changes in full time employee levels will be identified and described, with supporting assumptions identified.

f. If projected increases in pension expense cause a material cost impact, at a minimum, the following information should be provided for one year prior to the historical period through the test period: service cost, interest cost, expected return on assets, net amortization and deferral, amortization of prior service cost, and total net periodic pension cost. The information shall also include for each of the 12-month periods the expected long-term rate of return on assets, discount rate, salary increase rate, amortization of transition asset or obligation, percent of pension cost capitalized, minimum required contribution per IRS, maximum allowable contribution per IRS, and actual (or projected) contribution made to the trust fund. Also included shall be the projected year-end balance at the end of each of the 12-month periods for accumulated benefit obligation, projected benefit obligation, fair value of plan assets, and market related value of assets.

4. Capital Expenditures or additions. The applicant will provide capital expenditures detail, and changes affecting rate base, including:

a. The detail for the changes, beginning with the start of the historic period results of operation through the test period. The detail will include dollar amounts and in-service dates.

b. The detailed calculation of depreciation expense and accumulated depreciation impacts as a result of the capital expenditures affecting rate base. For depreciation expense, the information will include the balances by plant account or function, depending on how the projection is done, to which the depreciation rates are being applied and the respective depreciation rates being used, by account or function, depending on how the projection is done.

c. Interdependencies of capital expenditures to operation and maintenance items will be identified.

d. A list will be provided of all major capital additions to rate base individually exceeding $1,000,000 or 0.01% of total company net plant in service, whichever is greater for each year, beginning with the year prior to the historic periodic reported year through the test period. Projects under $1,000,000 shall be grouped in aggregate utilizing the utility's usual plant categorizations. A brief description will be provided for each major capital addition in the list.

i. exceeding 0.1% of total company net plant in service or $5,000,000, whichever is greater, for an electrical corporation, or

ii. exceeding 0.1% of total company net plant in service or $1,000,000, whichever is greater, for a gas corporation.

e. Detailed calculation of plant retirements.

5. Regulatory Adjustments. The applicant will provide details of all the regulatory adjustments required in the filing:

a. Information for recurring regulatory adjustments, such as amortizations, indicating compliance with past Commission orders for any item included in the filing.

b. Separately, a reversing adjustment and the reasons for non-inclusion or departure from a Commission ordered practice or adjustments if the applicant does not wish to have them apply to the application.

c. Unless already included in unadjusted results, regulatory adjustment information will include disallowances from prior orders, implementation of accounting orders approved by the Commission, or other adjustments necessary to make the forecasted test period data acceptable for ratemaking in Utah. Each of the regulatory adjustments will be supported by prefiled testimony or a detailed description contained within the schedules.

6. Other Rate Base. Details of other rate base accounts shall be provided by the applicant. For other items of rate base, such as deferred debits, accumulated deferred income taxes, materials and supplies, miscellaneous rate base, customer advances, deferred credits, etc., the applicant shall provide information showing the 12-month period of the historical results of operations, and any changes, both debits and credits, to those amounts through the test period resulting in the projected amount included in the filing. The information shall provide descriptions of any adjustments and modifications made to the historical period amounts and assumptions included in the projections. For any accounts in which no change from the historical level is proposed, a description of why the amount is not forecasted to change shall be included.

7. Taxes. Forecasting methods, calculations and key assumptions used to adjust historical tax information to projected costs and results will be provided on a tax item basis (i.e., income, FICA, property taxes, etc).

R746-700-21. Cost of Service and Rate Design Information for a General Rate Case Application for an Electrical Corporation or a Gas Corporation.

An applicant shall file the following Cost of Service and Rate Design information with any general rate case application. An applicant will provide an index which identifies where in the application, testimony, exhibits, documents, information, data, etc. filed with the application the applicant has responded to and complied with these R746-700-21 rule requirements. The index may be presented in testimony, as a table embedded in testimony, as an exhibit to testimony, or in any other manner so long as it is clearly identified.

A. A Utah Class Cost of Service Study.

1. A Utah Class Cost of Service Study based on the test period with supporting documentation including the development of allocation factors.

2. If a new customer class is proposed, the applicant shall either:

a. include class cost of service studies; one which uses only existing customer classes and another with the newly proposed class included, or

b. explain why no cost of service study including the new customer class is included and how the new customer class is to be treated in setting rates in the case.

B. Its proposal for spreading any Utah revenue requirement change among the rate schedules. This will include the dollar and percentage revenue requirement change for each rate schedule.

C. Its proposed rates for each rate component of each rate schedule and the billing determinants for the test period for all rate components used to calculate revenues necessary to recover the proposed revenue requirement. An exhibit will be provided showing the test period blocking based on adjusted actual and forecasted billing units in the development of the revenues for each rate schedule.

D. Its proposed tariff sheets for all tariff provisions for which it proposes changes.

1. An applicant need not include proposed tariff sheets for changes to tariff pages showing rates, charges, or fees if these proposed price changes are provided in a readily identifiable form elsewhere in the application.

R746-700-22. Additional Information for a General Rate Case Application Using a Forecasted Test Period Filed by an Electrical Corporation or a Gas Corporation.

If not already included with the application, pursuant to R746-700-20 or R746-700-21, an applicant shall also file with the Commission the following information or documents when filing a general rate case application which uses a forecasted test period. An applicant will provide an index which identifies where in the application, testimony, exhibits, documents, information, data, etc. filed with the application the applicant has responded to and complied with these R746-700-22 rule requirements. The index may be presented in testimony, as a table embedded in testimony, as an exhibit to testimony, or in any other manner so long as it is clearly identified. Contemporaneously with the filing of an application, an electrical corporation or gas corporations shall provide the following information and documents to the parties specified in R746-700-1.E.3, unless the information or document is already included in or with the application.

A. Definitions. As used herein, the following terms shall have the indicated meanings:

1. Time Periods. Definitions of time periods for which information is to be provided in compliance with this rule are as follows:

a. Year: A 12-month period designated as "12 months ending Month Date, Year".

b. Base Year (BY): The 12-month historical period ending on the ending date for the most recent periodic reported results of operations filing submitted for the public utility, or if it does not file periodic results of operations, the base period upon which the test period used in the application is developed.

c. Test Period (TP): The 12-month period used as the test period for the general rate case application.

d. Historical Year(s) (HY): Year(s) immediately preceding the Base Year.

e. To Date: Up to the most recent date for which information is reasonably available to the public utility in preparing its general rate case application.

f. Workpapers: The documents and source material used to develop the inputs to the general rate case filing. The type, nature, level of detail, format, etc. of the information compilation, schedule, document, etc. shall be reasonably comparable to that provided to parties in the public utility's prior general rate cases.

2. Provide, Describe, etc. The terms "provide" or "describe," or terms with similar meaning, shall mean to deliver available electronic copies and/or paper copies of designated data and documents to interested persons; provided that, when necessary and appropriate, prompt arrangements may be made for review of designated data and documents at a utility location in Utah or at another mutually agreeable place. Spreadsheets and workpapers are to be provided in "live" electronic format (not PDF), i.e. models and spreadsheets are to be provided with formulas intact and input data available.

3. Materiality. Materiality is defined as a change in requested Utah jurisdictional revenue requirement equal to or greater than 0.1 % of total state revenue requirement or $500,000, whichever is less.

4. Model(s). The term Model(s) shall mean the major analytical software tools and spreadsheets used by the utility to develop its general rate case application. Smaller analytical tools, such as special purpose electronic spreadsheets, are not included in the definition of the term Model(s) for purposes of this rule.

B. Revenue Requirement Information.

1. Forecasted test period data. A comparison of the Test Period data Results of Operations (RO) to the Base Year actual, unadjusted RO and adjusted RO on both a jurisdictional and total company basis. This is to be made available in a side-by-side comparison on a consistent basis by FERC Account.

2. Operating and Capital Budgets. A comparison of the utility's operating budget and capital budget to the actual results for the Base Year, the prior Historical Year, and To Date on a total company basis. This comparison is to be at the most detailed level available and provide available explanation for material variances.

3. Labor Costs. A comparison of budgeted labor costs and number of full-time equivalents to the actual labor costs and full-time equivalents by year for the Base Year and the prior Historical Year on a total company basis. These shall show

separately, to the degree available, the direct labor costs, premiums, incentives, benefits and overhead costs. These shall show contract labor costs separately from direct labor costs, and union labor costs separate from nonunion costs. The information shall provide available explanations for material variances.

4. Workpapers. The information shall provide the forecast workpapers (including assumptions, spreadsheets and tests).

5. Forecasted Data - Revenue Requirement.

a. Support and explanations for forecasted values, including Base Year starting values, adjustments made to the Base Year values and key drivers that impact the forecasts, together with supporting documents.

b. Indices, inflation rates and escalation factors used in preparing forecasts, including supporting source documents.

c. A revenue requirement workbook that tracks all input data beginning with the Base Year through the Test Period. This will provide summarized revenue requirement sections of the jurisdictional allocation model for the Base Year, the Test Period and any intervening year. The workbook and summaries are to include, inter alia, billing determinants, rate base and capital structure, including dollar capitalization, for the specified Years.

d. Complete net power cost calculations for any intervening year between the Base Year and Test Period.

6. Models. Workable versions of Models utilized in determining or projecting rate case values, with formulae intact and source data included, along with available instructions and write-ups regarding use of the Model and written descriptions of the Model and its inputs.

C. Cost of Service Information

1. Forecasted Data - Class Cost of Service. Class cost of service data on a Utah allocated basis under all approved jurisdictional allocation methods for the Base Year and Test Period.

2. Forecasted Data - Rate Design. Test Period rate design data on a Utah allocated basis under all approved jurisdictional allocation methods used for reporting purposes.

D. Miscellaneous Information

1. Accounting - Changes. A detailed description of Material changes in accounting policies or procedures adopted by the utility since the prior general rate case or as anticipated through the end of the Test Period. This will include a detailed description of the impact of change in accounting policy or procedure on the Test Period and identify the basis of the change.

2. Accounting - Write-offs. A detailed description of Material write-offs of assets and/or liabilities from the start of the Base Year - To Date that affect Utah revenue requirement. For each material write-off, the following will be provided:

a. Copy of journal entry recording the write-off;

b. Detailed description of the purpose of the write-off;

c. Copies of studies, reports or analyses done in determining whether or not to write off the asset;

d. Amount of the write-off and identification of the accounts charged on a total Company and a Utah jurisdictional basis; and

e. Amount included in the projected Test Period for write-offs, if any, on a total Company and a Utah jurisdictional basis, by account.

3. Affiliates - Organizational Charts. For the Base Year and Test Period and continuing To Date, the affiliates organization chart for the utility including a clear indication of affiliates, parent companies, divisions and subsidiaries indicating their regulatory status.

4. Affiliates. A detailed description of corporate restructurings and changes in affiliate relationships since the filing of the prior general rate case and also describe changes in the corporate and affiliate relationships between the Base Year and the end of the Test Period reflected in the filing.

5. Affiliates. A copy of Material new or Materially modified contracts or agreements entered into since the filing of the prior general rate case, including attachments thereto, if relevant to the costs the utility seeks to recover from Utah ratepayers through Utah regulatory operations or costs allocated or directly charged to Utah regulated operations included in the general rate case application, between the utility and/or its parent company and affiliated companies for services and/or goods rendered between or among them. This is to include a list of active contracts unless already provided in the most recent Affiliate Interest Report.

6. Affiliates. A copy of cost allocation manuals and/or policies and procedures that set forth the detailed cost allocation methodology and/or pricing methodology used to charge costs between affiliates that have changed since the filing of the prior general rate case.

7. Audit - Financial. A copy of each adjusting journal entry made in response to the utility's independent auditors' final recommendations in their most recent audit of the utility. Supporting documentation will be included. The information will also identify and provide adjusting journal entries included in the independent auditors' final recommendations that were not accepted by or made by the utility, along with a description of why the adjustment was not accepted or made.

8. Audit - Financial. A copy of management letters received from the utility's independent auditors or responses to those management letters for the Base Year, the prior Historical Year and the period To Date.

9. Audit - Financial Audit Workpapers. If access to audit workpapers is allowed by the utility's independent auditor, the utility will coordinate review of the financial audit workpapers for the most recent completed financial audit conducted by the utility's independent auditors at a mutually agreed upon location. If access to workpapers is not allowed by the independent auditor, the utility will coordinate the review of the most recent quarterly review conducted by the utility's independent external auditors prepared for the utility's board of directors.

10. Audits - Internal. A listing of internal audits conducted by or for the utility or its parent company for the Base Year, the prior Historical Year and To Date if relevant to the costs the utility seeks to recover from Utah ratepayers through Utah regulatory operations or the costs allocated or directly charged to Utah regulated operations included in the general rate case application. Notice of Internal Audit reports completed during the pendency of the case will be provided upon completion to all parties participating in the case.

11. Board of Directors - Meeting Minutes. The Board of Directors' meeting minutes for the Base Year, the prior Historical Year and To Date for the utility and the parent company if relevant to the costs the utility seeks to recover from Utah ratepayers

through Utah regulatory operations or the costs allocated or directly charged to Utah regulated operations included in general rate case filings for the same period.

12. Budget. Complete copies of detailed annual operating and capital budgets for the Base Year through the end of the Test Period.

13. Budget. Copies of operating and capital budget instructions and directives provided to employees, including assumptions, directives, manuals, policies and procedures, timelines, and descriptions of budget procedures for the budget or forecast for the Test Period and To Date.

14. Budgets - Operating Plans. If available, copies of written operating plans that describe the utility's goals and objectives for the Base Year through the end of the Test Period.

15. Budget - Variance. A complete copy of quantitative and narrative monthly, quarterly and annual comparisons of operating and capital budgets to actual expenditures for the Base Year, the prior Historical Year, and for the period from the Base Year To Date.

16. Cost of Capital - Debt Expense. The currently forecasted financings for the next three years.

17. Cost of Capital - Debt Expense. The monthly balance of short-term debt and monthly short-term debt cost rates, for the Base Year, the prior two Historical Years and To Date.

18. Cost of Capital. Copies of the most recent bond rating agencies reports on the Company.

19. Employee Costs. A breakdown of the total amount of gross payroll and employee benefit costs (by benefit type) for the Base Year, the prior Historical Year and through the end of the Test Period between amounts expensed and amounts capitalized and provide the percentage of payroll and employee benefits (by benefit type) charged to expense for each Year.

20. For the Base Year, the prior Historical Year, To Date and for the Test Period, the amount of overtime, the amount of premium pay, the amount of other salary/labor costs and the amount of incentive compensation in total and expensed for each.

21. Employee Costs. A list of compensation and benefit studies the utility has for the Base Year, the prior Historical Year and To Date and indicate which of the studies were used (if any) in projecting the compensation and employee benefit costs for the Test Period.

22. Employee Costs - Employee Levels. Describe, in detail, Material employee reductions, employee severance plans, or early retirement programs conducted or anticipated by the utility during the Base Year, the prior Historical Year, and To Date and as projected through the end of the Test Period that are and are not reflected in the application. If anticipated, but not reflected in the application, explain why they are not included. This should provide information on major plans or programs beyond cost management efforts undertaken in the normal course of business. This should include, but not be limited to, a detailed description of the plan, number of employees offered or projected to be offered early retirement or severance, number of employees accepting or projected to accept early retirement or severance, projected cost savings and costs associated with the program. For costs incurred, identify the amounts, by FERC account, and the dates the entries were booked.

23. Employee Costs - Employee Level. Separate lists of the budgeted and the actual number of employees (where available), by month, for the Base Year, the prior Historical Year, the Test Period and To Date. If the labor force levels are other than full-time equivalent positions, provide a separate listing stated in terms of full-time equivalent positions.

24. Employee Costs - Wages and Salaries Levels. The actual percentage of increases in salaries and wages for exempt, non-exempt and union employees for the Base Year, the prior Historical Year, Test Period and To Date.

25. Employee Costs - Incentive Plans. Complete copies of bonus programs or incentive award programs in effect for the utility for the Base Year, the prior Historical Year, the Test Period and To Date. Identify incentive and bonus program expenses incurred in the Base Year, the prior Historical Year, the Test Period and To Date and identify the amounts included in the Test Period. Identify the accounts charged. Identify incentive and bonus program expenses charged or allocated to the utility from affiliates or the parent company in the Base Year, the prior Historical Year, the Test Period and To Date.

26. Employee Costs - Benefits. A listing of health and other benefits received by employees during the Base Year. Provide a detailed description of changes to employee benefits occurring subsequent to the Base Year To Date and anticipated future changes through the end of the Test Period that are reflected in the filing.

27. Employee Costs - Pensions. The two most recent pension actuarial reports prepared for the utilty.

28. Employee Costs - Post Retirement Benefits Other Than Pensions (PBOP). The two most recent PBOP actuarial reports prepared for the utility.

29. Employee Costs - Pensions and Post Retirement Benefits Other Than Pensions (PBOP). The list of assumptions used by the utility and its actuaries regarding the pension and PBOP costs for the Test Period that are included in the filing.

30. Operation, Maintenance, Administrative and General (OMAG) Expenses - Other - Contributions. For the Base Year and the Test Period, a list of contributions for charitable and political purposes, if any, included in accounts other than below the line. Indicate the amount of the expenditure, the recipient of the contribution, and the specific account in which the expense is included in the filing. Also identify for the Base Year and the Test Period the amounts of contributions for charitable and political purposes charged to the utility from affiliates in accounts other than below the line accounts.

31. OMAG Expenses - Advertising. For the Base Year, the prior Historical Year and the Test Period the amount of advertising expense, by account, by type of advertising (i.e., informational, instructional, promotional).

32. OMAG Expenses - Dues, Industry Associations. The Material amounts included in the Base Year, the prior Historical Year and the Test Period for above-the-line payments to industry associations. Identify the organization/association name and amounts, along with the account in which the costs are included in the filing. If any of the dues or other amounts paid to the organizations/associations go toward lobbying and public relations efforts and are recorded in above-the-line accounts, provide the associated amounts included in the above-the-line accounts whether Material in magnitude or not.

33. OMAG Expenses - Outside Services Expense. An itemization of Material outside services expenses included in FERC

account 923 for the Base Year, the prior Historical Year and the Test Period.

34. OMAG Expense - Injuries and Damages. The amount of injuries and damages expense for the Base Year, the prior Historical Year, the Test Period and To Date.

35. OMAG Expense - Insurance. The amount of insurance expense, by insurance type (i.e., property insurance, liability insurance, workers compensation, directors and officers liability insurance, etc.) for the Base Year, the prior Historical Year and the Test Period and identify the accounts the associated costs are included in.

36. OMAG Expense - Insurance. For insurance coverage for which the utility is self-insured, a description of that self insurance, a description of how it is accounted for in the utility's books and records and a description of activity for the Base Year, the prior Historical Year and the Test Period.

37. OMAG Expense - Legal Settlements. A list of Material amounts included in the Base Year and the Test Period (on a direct charge basis, affiliate billing, or allocation) that are the result of the settlement of lawsuits or other legal action.

38. OMAG - Uncollectibles - Bad Debt Reserve. For the Base Year, the prior Historical Year and the Test Period the beginning bad debt reserve balance, the amount written off, the recoveries, the reserve adjustment, other charges or credits, and the ending reserve balance. For the same periods, provide the total amount of retail revenue from retail sales and total retail bad debt expense.

39. OMAG - Uncollectibles. A detailed description of changes in the utility's collection policies or write-off policies since the filing of the prior general rate case.

40. OMAG - Cost-saving Programs. A list and detailed description of cost-saving or cost increasing programs and initiatives implemented during the Base Year, To Date, and included in the Test Period. This should provide information on major plans or programs beyond efforts undertaken in the normal course of business and having a Material impact.

41. Financial - Strategic Plans. Copies of completed strategic plans and the most recent plan approved by the Board of Directors for the utility and the plan that was utilized at the time of and in the preparation of its application, if different.

42. Penalties and Fines. A list of penalties and fines in the Base Year and the Test Period and indicate in which accounts the associated amounts are included.

43. Rate Base - Working Capital. A complete copy of the lead/lag study, with supporting workpapers, used to compute cash working capital for the utility's application.

44. Reserve Accounts. Information on whether or not the utility maintains reserve accounts (e.g., an injuries and damages reserve account). If so, provide the monthly balances in reserve accounts for the Base Year, the prior Historical Year, the Test Period and To Date. This listing should include the monthly debits and credits to the reserve accounts. Also, provide the amount included in the Base Year and the projected Test Period expenses, by account, for building-up the reserve balances.

45. Revenues: Regulated Retail Sales. Provide by customer class, by month, the number of customers, actual usage, and normalized usage for the Base Year, the prior Historical Year, the Test Period and To Date.

46. Revenues - Other. Provide on a total company and a Utah jurisdictional basis, for the Base Year, the prior Historical Year, the Test Period and To Date the amount of other nonregulated-retail-sales revenues by revenue type.

47. Sales of Property. For the Base Year, the prior Historical Year, the Test Period and To Date, information showing whether the utility sold property, in which the proceeds for a property, which alone, or for multiple properties, which in the aggregate, would be Material. If so, for each such sale identify the property sold; whether, when, and in what manner it was included in rate base; show details of how the gain or loss was calculated; indicate when the sale occurred; and explain how and whether the utility is treating such gain or loss in its application. For sales in which the proceeds would be Material, individually or in the aggregate, provide a list of any properties currently offered for sale and those projected to be offered for sale through the end of the Test Period. The property sales information may be limited to sales of property that had been or are included in Utah rates while in service.

48. Taxes: Income. A list of and provide copies or make available for review, subject to R746-100-16, an appropriate protective order, confidentiality agreement, or other confidentiality protective arrangement, depending on specific content, revenue ruling requests, IRS responses, and correspondence between the utility and the IRS since the filing of the prior rate case.

49. Taxes: Income. Provide copies or make available for review, subject to R746-100-16, an appropriate protective order, confidentiality agreement, or other confidentiality protective arrangement, copies of the most recent State and Federal income tax returns in which the utility participated.

50. Taxes: Income. Provide a copy of the current tax sharing agreement in which the utility participates.

R746-700-23. Additional Power Costs Information for a Forecasted Test Period to Be Filed by an Electrical Corporation.

A. An electrical corporation that has included power costs in a forecasted test period shall also file with the Commission the following information or documents relating to its power cost projections with a general rate case application. An applicant will provide an index which identifies where in the application, testimony, exhibits, documents, information, data, etc. filed with the application the applicant has responded to and complied with these R746-700-23 rule requirements. The index may be presented in testimony, as a table embedded in testimony, as an exhibit to testimony, or in any other manner so long as it is clearly identified. Contemporaneously with the filing of an application, an electrical corporation shall provide the following information and documents to the parties specified in R746-700-1.E.3, unless the information or document is already included in or with the application.

B. All information should be provided or available electronically and, in the case of Excel spreadsheets, with all formulas intact including all hierarchy of linked spreadsheets. The term "PCM" herein refers to any power cost model used by the utility, or any subsequent enhancements to or replacements of the power cost model used in the utility's last prior general rate case. The term "workpapers" means the documents used to develop the inputs to the PCM. This may include such items such as contracts, emails, white papers, studies, utility computer programs, Excel spreadsheets, word process documents, pdf and text files, computer

programs, or any other data or documents relied upon to support the cost details in the application. If the inputs used in the PCM were developed from a document, such as a contract, provide the contract with the PCM inputs highlighted.

C. Power Cost Modeling Data:

1. Workpapers that show the source, calculations and details supporting the testimony, other exhibits and all PCM input data. The workpapers will include, at a minimum, copies of the net power cost report in Excel and the net power cost model database.

2. Identification of the time periods (Reference Period) used to determine input items (e.g., outage rates) in the PCM which are based upon an examination, average, etc. of a multi-year period.

3. Compilations of actual net power costs produced by the utility that were referenced in the testimony or exhibits, to the extent that actual power cost results are discussed or cited in the utility's testimony or exhibits.

4. A list and explanation of all modeling or logic changes or enhancements to the PCM that have been implemented since the last prior general rate case. This will include a statement of the direction and amount of change in net power costs resulting from each such change and documentation describing each Material change as well as PCM runs and workpapers quantifying the impacts of these changes.

5. Access to or a copy of the PCM model used by the utility to compute power costs in the Test Period.

6. The latest documentation for the PCM.

7. The current topology maps in the PCM along with an explanation for all the differences that have been made to the topology since the last prior general rate case and an explanation of why the changes were made. Include supporting documentation, such as contracts resulting in changes to the transfer capabilities used in the PCM.

8. All documents, workpapers, data or other information used by the utility in determining, setting, or calculating any PCM input, constraint, etc., including, but not limited to, where applicable:

a. market caps,

b. outage rates (planned and unplanned) including all backup data showing each outage (planned or unplanned, etc.) and duration (planned or unplanned) considered in the Reference Period, including NERC cause code, type of event, duration, energy lost, etc.,

c. the date and a copy of any forward price curve used, showing monthly heavy load hour and light load hour,

d. short-term firm transactions (including short-term firm indexed transactions and swaps), each transaction or contract will have a designation as to its purpose (i.e., trading, arbitrage or balancing.),

e. all contracts modeled in the PCM that were not included in or have been amended since the last prior general rate case, providing for each:

(i) A copy of the contract (in pdf or electronic format, if available), and

(ii) input assumptions related to the contract,

f. all fuel cost inputs,

g. heat rate curves for each resource, including the derivation of the heat rate curves,

h. identification of each instance in which the utility changed any maximum capacities, minimum up or down times or unit minimum capacities for thermal or hydro generators modeled in the PCM since the last prior general rate case,

i. each load adjustment,

j. inputs for Qualifying Facility or QF contracts,

k. screens applied to restrict uneconomic dispatch of resources,

l. start up fuel costs, start up O&M costs and any other form of start up costs modeled,

m. loss factor data used to develop the load forecast for the system and for each state for the most recent five calendar years and for the most recent five fiscal years; include a comparison of those loss factors to those that were used in developing loads for the PCM for the test period used in the case,

n. the system level loss factors assumed in any PCM used in the most recent (or current) rate cases for any other jurisdiction in which the utility operates,

o. the actual generation of each coal, gas, hydro and wind generating unit modeled in the PCM for each month for the Reference Period,

p. hourly generator logs for each wind, coal, gas and hydro unit modeled in the PCM for the Reference Period,

q. the schedule for each generation unit's planned and actual outages for the test period, the most recent calendar year and the next four calendar years,

r. hourly logs for all contracts modeled in the PCM, showing actual data (hourly sales or purchases) for the Reference Period,

s. the details of Short Term Firm and Non-Firm transmission used by the utlity during the Reference Period.

t. for each of the transmission contracts whose costs are included in the PCM, identify the purpose of the transaction, why it is used and useful in the test period, the amount of capacity or type of transmission service it provides, and where the capacity or service provided by this contract is modeled in the PCM,

u. data for the Reference Period or for the most recent four years available for all third party transmission imbalance transactions that have been included in Short Term Firm or secondary transactions during that period,

v. any links and other inputs for Short Term Firm (including any related to SP 15) and Non-Firm transmission modeling used in the PCM,

w. the hydro planned and unplanned outage rate,

x. to the extent that the utility uses any ramping adjustment in its case, information describing and detailing all ramping adjustments made (including all ramping energy assumed to be lost for each outage event modeled in the ramping analysis),

y. the costs of wind integration as modeled in the PCM, and

z. hedging contracts, already in place and those assumed for forecasting purposes.

R746-700-30. Information for an Alternative Cost Recovery for a Major Plant Addition Application Filed by an Electrical Corporation or a Gas Corporation.

An applicant submitting an alternative-cost-recovery-for-a-major-plant-addition application shall include the following information as part of the application, on a total company and Utah jurisdictional basis using Commission approved allocation methods where applicable. If the same information was previously provided

by the applicant in a prior proceeding in which the plant's construction or acquisition was approved by the Commission pursuant to 54-17-302, the applicant shall provide copies of such previously provided information with the application. If the plant's construction or acquisition was approved subject to conditions pursuant to 54-17-302, the information shall be provided as ordered by the Commission in the order approving the major plant addition subject to conditions. An applicant will provide an index which identifies where in the application, testimony, exhibits, documents, information, data, etc. filed with the application the applicant has responded to and complied with these R746-700-30 rule requirements. The index may be presented in testimony, as a table embedded in testimony, as an exhibit to testimony, or in any other manner so long as it is clearly identified.

A. General Information.

1. All documents and presentations that were provided to management, senior management and the Board of Directors of the utility and its affiliates related to the plant addition.

2. Copies of all Board of Directors' minutes of the utility and its affiliates where the plant was discussed, approved, reviewed, evaluated, or presented.

3. Details of the plant being acquired including its location, capacity, technologies used, project milestones or progress dates, projected in-service date and demonstrating that the plant addition is a major plant addition under 54-17-13.4.

4. Description of any changes, modifications, etc. to the existing utility plant/system that may be necessary to integrate the plant addition with the utility's system.

5. Information establishing the prudence of the plant addition, information addressing the provisions of 54-17-13.4, and the provisions of 54-17-302 and 54-17-303.

6. Information establishing the consistency of the plant addition to projected plant acquisitions in the utility's latest Integrated Resource Plan and its Action Plan. Show that the plant addition resource is as favorable or more favorable than the compared Integrated Resource Plan resource items in terms of least cost and least risk or explain why it need not.

7. Any and all documents and analyses that address the plant addition's projected costs, savings and benefits and demonstrate how and when the utility's ratepayers will see a net benefit from the plant addition and quantify the net benefit.

8. Where applicable, information on whether and how the plant addition has been or will be inspected as part of due diligence, including identification of who conducted or will conduct the inspection and copies of all reports or other documents prepared by the inspectors.

9. A list of all outside consultants or advisors used, or expected to be used by the utility in connection with the plant addition and all reports, including interim reports, prepared by outside consultants or advisors.

10. All internal reports that were prepared when analyzing the purchase or construction of the plant addition.

11. Where applicable, copies of contracts that are expected to be assumed following close of acquisition.

12. Where applicable, copies of all contracts between the utility and the seller or operator of the plant addition.

13. Where applicable, a history of the plant addition to be acquired including financial and performance characteristics for the past five years, or from the start of commercial operation, whichever is less.

14. Where applicable, information on the utility's understanding of the reasons why the seller is selling the facility.

15. Where applicable, information on the seller's book value of the plant.

16. An indication whether the seller will allow interested persons who have signed a confidentiality agreement with the utility access to the seller's books and records for audit, and what restrictions may apply to such access.

B. Financial and Revenue information.

1. Provide information of the revenues, costs and benefits arising from the plant addition, identifying any limits and conditions on forecast information/calculations.

2. Information on the net revenue impact of bringing the plant online and operating the plant within the utility's system compared to operations without the plant.

3. Justification for any acquisition premium the utility plans to include in rates and recover from ratepayers.

C. Capital cost, rate base and jurisdictional allocation information.

1. Information on how the utility plans to finance the construction or acquisition of the plant addition. This is to include the timing and amount of any equity, debt, or other security issuances and any documents to, or received from, any investment bankers or other entities regarding the issuance of any securities connected with the plant addition.

2. Information indicating whether the utility has discussed the plant addition with any rating agencies and provide any reports or rating agencies provided with respect to the plant addition. If not, indicate when it plans to discuss the plant addition with any rating agency.

3. Information on how much of the purchase price or construction costs the utility intends to place into rate base.

4. Information showing the amount and relating to any analysis of AFUDC associated with the plant addition.

5. Information on the utility's anticipated jurisdictional allocation for the plant addition and any change in allocation factors and other plant, revenue and expense/cost allocations arising from the plant addition.

D. Cost and Operating Expenses Information.

1. A complete analysis of all costs associated with constructing, acquiring and operating the plant for which the utility will seek recovery from Utah ratepayers and identify any costs for which no recovery will be sought from Utah ratepayers.

2. Information on all clearances, permits or other government regulatory authorizations necessary, to be modified and completed for the plant and their associated costs.

3. Information on any liquidated damages clause and early termination fees, penalties, or other expenses which may be incurred if the plant is not completed or acquired.

4. Information on whether that are any integration costs or fees (transmission, pipeline, etc.).

5. Information on any costs analysis analyzing bringing the plant online.

6. Information on how the plant addition will change and the amount of change on the utility's Operation and Maintenance costs.

7. All operating cost analyses that have been completed related to the plant addition.

8. The planned accounting treatment for the plant, including the proposed journal entries or other accounting entries for such planned accounting treatment.

9. A description of and the amounts for overhead, closing, contingent or any other costs for which the utility expects it will ask recovery as a result of the acquisition.

E. For an electrical corporation, the following Net Power Costs information.

1. The impacts of the plant addition on any utility power cost and production cost dispatch models. If any models are revised to accommodate the plant addition, the revised models will be available to the parties participating in the application proceeding.

2. A net power cost study (NPC) in the utility's production cost dispatch model that documents changes from previous net power cost estimates. All relevant workpapers and documentation to allow any other person to perform an independent analysis and verification of the NPC will be provided.

3. Show how the plant addition impacts planned outages, unplanned outages, and maintenance at the utility's generation resources.

R746-700-40. Information for a General Rate Case Application for a Telecommunications Corporation.

An applicant submitting a general rate case application shall provide the following information with the application, on a total company and Utah jurisdictional basis using Commission approved allocation methods. An applicant will provide an index which identifies where in the application, testimony, exhibits, documents, information, data, etc. filed with the application the applicant has responded to and complied with these R746-700-40 rule requirements. The index may be presented in testimony, as a table embedded in testimony, as an exhibit to testimony, or in any other manner so long as it is clearly identified.

A. General Information

1. Historical results of operations information consisting of actual, unadjusted results of operations, including all regulated costs and revenues, for an historical 12-month period used as a basis for the test period.

2. Adjusted results of operations for the same period. These adjustments shall include, but are not limited to, normalization adjustments, annualization adjustments, accounting adjustments, adjustments to reflect prior Utah regulatory decisions and policies made by the Commission with respect to any item or matter (including those which are not supported or advocated by the applicant for use in the general rate case) contained in the application.

3. Description and details for all additional adjustments necessary to arrive at the test period used in the general rate case application.

4. A description of any significant changes in accounting policies or procedures for the 12-month period prior to the historical period and any subsequent accounting changes through the date of the general rate case application and, if a future test period is used, any future changes included in a future test period, along with their impact on the filing. Significant changes for this purpose are anything referenced or that would be referenced in footnotes of financial statements or auditor's reports.

5. Information giving a fully referenced Part 64 and, where available, a Part 36 allocation. If no Part 36 allocation information is available, the utility shall provide an alternative permitting comparable cost of service allocations. Fully referenced means that sources of all total amounts are indicated and that source documents are included in the filed information. The names and sources of allocators to determine jurisdictional or non regulated portions shall be included in lines with the allocated amounts. The Part 64 allocation shall provide full allocation of all joint costs incurred by the utility for both non-regulated and regulated activities and affiliated companies.

6. A copy of each adjusting journal entry made with supporting documentation in response to the utility's independent auditors' final recommendations in their most recent audit of the utility. The utility will identify and provide adjusting journal entries included in the independent auditors' final recommendations that were not accepted by or made by the utility, along with a description of why the adjustment was not accepted or made.

7. A copy of management letters received from the utility's outside auditors or responses to those management letters for the time period of the beginning of the historical period to the date of filing of the application.

8. A listing of internal audits, and copies thereof, conducted by or for the Company or its parent for the time period beginning with the historical period to the date of the application, if relevant to the costs the utility seeks to recover from Utah ratepayers through Utah regulatory operations or the costs are allocated or directly charged to Utah regulated operations included in the general rate case application.

9. Beginning with the start of the historical period, provide the affiliates organization chart for the utility including a clear indication of affiliates, parent companies, divisions and subsidiaries indicating their regulatory status. Include a personnel organization chart with names that provides line of authority and reporting for board members, management and mid-management including joint responsibilities for non-regulated affiliate responsibilities.

10. A detailed description of corporate restructurings and changes in affiliate relationships since the prior general rate case and also describe changes in the corporate and affiliate relationships between the historical period and the end of the test period used in the application.

11. Beginning with the two years prior to the historical period through the date of the application, provide the beginning bad debt reserve balance, the amount written off, the recoveries, the reserve adjustment, other charges or credits, and the ending reserve balance. For the same period, provide the total amount of retail revenue from retail sales and total retail bad debt expense.

12. A detailed description of any changes in the utility's collection policies or write-off policies since the last general rate case.

13. A list of penalties and fines in the historical period and the test period and indicate in which accounts the associated amounts are included.

14. Description of all calculations and all supporting spreadsheets and explicit data source information for all numbers in the narrative portion of the application or any testimony and exhibits included with the application.

B. Tax adjustments

1. An exhibit explaining procedures used to calculate test period tax adjustments.

2. An adjustment summary for tax expenses for normalized results of operations.

3. Information explaining every adjustment that is done to test period tax expense and that is shown in the adjustment summary. Adjustments will be in "top sheet" form.

4. A list of, revenue ruling requests, IRS responses, and correspondence between the utility and the IRS since the last general rate case.

5. A copy of the current tax sharing agreement in which the company participates.

6. List all property held for future use included in rate base. Listed property shall not include any item included in plant in service in rate base and the pro forma balance. The description shall include:

a. Location of property;

b. Date of acquisition;

c. Original cost;

d. Accumulated depreciation;

e. net original cost;

f. Planned or expected in-service date; and

g. Planned or expected use of property.

7. Copies of supporting work papers on the account Property Held for Future Use which shall include an explanation of all additions and transfers, including:

a. Description of property;

b. Description of transaction; and

c. Amount.

C. An applicant need not file the following information or documents with a general rate case application, but shall have such information and documents available for delivery and shall include a certification with its application that this information and these documents have been prepared and are available at the time it files its general rate case application. Contemporaneously with the filing of an application, an applicant shall also deliver this information and these documents to the Division of Public Utilities.

1. The financial audit work papers for the most recent completed financial audit conducted by the utility's independent auditors. The utility will provide a letter authorizing the external audit firm to meet with requesting parties to discuss work papers with them and allow parties to make copies of selected work papers.

2. Any revenue ruling requests, IRS responses, and correspondence between the utility and the IRS since the last general rate case.

3. Copies of the most recent State and Federal income tax returns in which the utility participated.

R746-700-41. Cost of Service and Rate Design Information for a General Rate Case Application for a Telecommunications Corporation.

An applicant shall file the following Cost of Service and Rate Design information with any general rate case application.

A. A Utah Class Cost of Service Study or alternative comparable class cost of service information based on the test period with supporting documentation including the development of allocation factors.

B. Its proposal for spreading any Utah revenue requirement change among the rate schedules. This will include the dollar and percentage revenue requirement change for each rate schedule.

C. Its proposed rates for each rate component of each rate schedule and the billing determinants for the test period for all rate components used to calculate revenues necessary to recover the proposed revenue requirement.

D. Its proposed tariff sheets for all terms, rates, charges fees, etc. for which it proposes changes.

R746-700-50. Information for a General Rate Case Application for a Water Corporation.

An applicant shall be in compliance with the reporting requirements of R746-400 prior to submitting an application for a general rate case. If the applicant is not in compliance with that rule, the applicant shall first submit any missing reports prior to submitting an application for a general rate case. An applicant submitting a general rate case application shall provide the following information with the application:

A. General Information:

1. Most recent Division of Drinking Water certification/report.

2. Certificate of Public Convenience and Need Number granted by the Commission and its date.

3. Date the utility started operation.

4. The number of connections approved and current area served, which may be shown by service area map.

5. Ownership and officers.

6. Associated companies (if any).

7. A copy of its current tariff.

B. Engineering Information.

1. Source of water supply

2. Information for all Wells

3. Mains and meters information

4. Reservoirs information

5. Storage capacity

6. Service deficiencies and remedies

7. Service quality

8. Additions or improvements in the last five years

9. Any anticipated additions or improvements

10. Efforts to encourage conservation

C. Customer Connection Information

1. Each connection identified by unique lot number or address

2. The date first put into service

3. Whether metered or unmetered.

4. Whether classified as residential or commercial

5. The water usage per month or billing cycle, showing minimum and overage gallons used

6. The amount billed per month or billing cycle

7. The anticipated growth, showing minimum and overage gallons used

8. Water usage and billings projected for the next three years

9. Information on any secondary/irrigation water system (the same information as C. 1, 2, 5, 6, 7 and 8 above).

10. Identification whether secondary water is distributed through the culinary system.

D. Accounting and Financial Data, which shall include the prior two complete years and current up to the date of general rate case application, unless otherwise specified:

1. Identification (contact information) for any accountant used by the utility.

2. Copies of the General Ledger.

3. Copies of the Balance Sheet

4. Copies of the Income Statement

5. Pro Forma Income Statements, categorized by the National Association of Regulatory Utility Commissions, NARUC, System of Accounts, to include:

a. the prior two years of revenues and expenses, and

b. the projected revenues and expenses for the next three years, to include the Company's anticipated growth rate and requested rate increase.

6. A copy of or the utility's check register

7. Billing documentation/reports, tied back to the tariff rates

8. Information on the utility plant, including, but not limited to:

a. Acquisition date,

b. Acquisition price or cost,

c. Salvage value,

d. Expected useful life,

e. Annual depreciation amount per asset,

f. Accumulated depreciation per asset and reconciled to the total accumulated depreciation amount to the most recent Annual Report. (If these amounts do not match the most recent Annual Report provide detailed explanations for any needed adjustments),

g. If an asset was donated, the amount applied to Contribution in Aid of Construction per asset,

h. If donated, the accumulated amortization of the Contribution in Aid of Construction per asset and reconciled to the total accumulated amortization amount to the most recent Annual Report. (If these amounts do not match the most recent Annual Report provide detailed explanations for any needed adjustments), and

i. Projected future asset purchases for the next three years, providing the estimated acquisition date and price.

9. Copies of tax returns for the prior two complete years,

10. Information on all Notes Payable, Loans, and other Obligations, This will include all outstanding and those retired within the past two years, including:

a. Interest rate,

b. Beginning date,

c. Date of last scheduled payment (the Loan pay-off date), and

d. Amount of payment

E. Customer Notice Information

1. A copy of any notice sent to customers notifying them that the utility is seeking a rate increase.

R746-700-51. Cost of Service and Rate Design Information for a General Rate Case Application for a Water Corporation.

An applicant shall file the following Cost of Service and Rate Design information with any general rate case application.

A. A Class Cost of Service Study, if one has been prepared, based on the test period with supporting documentation including the development of allocation factors.

B. Its proposal for spreading any revenue requirement change among the rate schedules. This will include the dollar and percentage revenue requirement change for each rate schedule.

C. Its proposed rates for each rate component of each rate schedule and the billing determinants for the test period for all rate components used to calculate revenues necessary to recover the proposed revenue requirement.

D. Its proposed tariff sheets for all terms, rates, charges fees, etc. for which it proposes changes.

KEY: utilities, filings, applications, major plant additions
Date of Enactment or Last Substantive Amendment: 2009
Authorizing, and Implemented or Interpreted Law: 54-7-12(1)(b)(ii); 54-7-13.4(1)(a)(ii)

Tax Commission, Auditing
R865-4D-2
Refund Procedures for Special Fuel Used Off-Highway or to Operate a Power Take-Off Unit, and Sales Tax Liability Pursuant to Utah Code Ann. Sections 59-13-301 and 59-13-304

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 32852
FILED: 7/29/09 1:39 PM

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Section 59-13-301 provides that special fuel tax paid for fuel used off-highway shall be refunded and provides the commission rulemaking authority to govern the procedures for allowing refunds. The commission believes that it's current rule recordkeeping requirements may be more burdensome than necessary.

SUMMARY OF THE RULE OR CHANGE: The proposed amendment provides that if an off-highway location does not have an address, a description of that location will suffice; also the amount of time of the off-highway use is necessary only if the claimed use is idling of the vehicle, all other uses may be evidenced by the date of the off-highway use.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 59-13-301

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: None--The proposed amendments impact only the recordkeeping requirements of applicants for special fuel tax refund for off-highway use of special fuel.
♦ LOCAL GOVERNMENTS: None--The proposed amendments impact only the recordkeeping requirements of applicants for special fuel tax refund for off-highway use of special fuel.
♦ SMALL BUSINESSES: None--The proposed amendments impact only the recordkeeping requirements of applicants for special fuel tax refund for off-highway use of special fuel.
♦ PERSONS OTHER THAN BUSINESS: None--The proposed amendments impact only the recordkeeping requirements of applicants for special fuel tax refund for off-highway use of special fuel.

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--The proposed amendments ease recordkeeping requirements.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There are no anticipated fiscal impacts.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
TAX COMMISSION
AUDITING
210 N 1950 W
SALT LAKE CITY, UT 84134
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ D'Arcy Dixon by phone at 801-297-3906, by FAX at 801-297-3901, or by Internet E-mail at ddixon@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 5:00 PM 09/14/2009

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2009

AUTHORIZED BY: D'Arcy Dixon,

R865. Tax Commission, Auditing.
R865-4D. Special Fuel Tax.
R865-4D-2. Refund Procedures for Special Fuel Used Off-Highway or to Operate a Power Take-Off Unit, and Sales Tax Liability Pursuant to Utah Code Ann. [~~Sections~~]Section 59-13-301[~~and 59-13-304~~].

(1)(a) "Off-highway," for purposes of determining whether special fuel is used in a vehicle off-highway, means every way or place, of whatever nature, that is not generally open to the use of the public for the purpose of vehicular travel.

(b) "Off-highway" does not include:

(i) a parking lot that the public may use; or

(ii) the curbside of a highway.

(2) Fuel used in a vehicle off-highway is calculated by taking off-highway miles divided by the average number of miles per gallon. Any other method of calculating special fuel used off-highway must be supported by on-board computer information or other information that shows the number of gallons used off-highway with accuracy equal or comparable to on-board computers.

(3) Where a power take-off unit is driven by the main engine of the vehicle and used to operate auxiliary equipment, a quantity, as enumerated below, of the total special fuel delivered into the service tank of the vehicle shall be deemed to be used to operate the power take-off unit. The allowances for power take-off units are as follows:

(a) concrete mixer trucks - 20 percent;

(b) garbage trucks with trash compactor - 20 percent;

(c) vehicles with powered pumps, conveyors or other loading or unloading devices may be individually negotiated but shall not exceed:

(i) 3/4 gallon per 1000 gallons pumped; or

(ii) 3/4 gallon per 6000 pounds of commodities, such as coal, grain, and potatoes, loaded or unloaded.

(d) Any other method of calculating the amount of special fuel used to operate a power take-off unit must be supported by documentation and records, including on-board computer printouts or other logs showing daily power take-off activity, that establish the actual amount of power take-off activity and fuel consumption.

(4) Allowances provided for in Subsections (2) and (3) will be recognized only if adequate records are maintained to support the amount claimed.

(5) In the case of users filing form TC-922, Fuel Tax Return For International Fuel Tax Agreement (IFTA) And Special Fuel User Tax, or form TC-922C, Refund of Tax Paid on Exempt Fuel for Non-Utah Based Carriers, the allowance provided for in Subsection will be refunded to the extent total gallons allocated to Utah through IFTA exceed the actual taxable gallons used in Utah, except that in no case will refunds be allowed for power take-off use that does not occur in Utah.

(6) Special fuel used on-highway for the purpose of idling a vehicle does not qualify for a refund on special fuel tax paid since the fuel is used in the operation of a motor vehicle.

(7) The following documentation must accompany a refund request for special fuel tax paid on special fuel used in a vehicle off-highway:

(a) evidence that clearly indicates that the special fuel was used in a vehicle off-highway;

(b)(i) the specific address of the off-highway use with [~~a detailed description of the off-highway nature of the location~~]a description that is adequate to verify that the location is off-highway; or

(ii) if a specific address is not available, a description of the off-highway location that is adequate to verify that the location is off-highway;

(c) a description of how the vehicle was used off-highway;

[~~(c)~~](d)(i) the [~~amount of time in which the vehicle used the fuel~~]date of the off-highway use; and

(ii) if the claimed use is idling while off-highway, the amount of time the vehicle was idling at that location;

[~~(d)~~](e) the amount of fuel the vehicle used off-highway; and

[~~(c)~~](f) the make and model, weight, and miles per gallon of the vehicle used off-highway.

(8) Special fuel that is purchased exempt from the special fuel tax or for which the special fuel tax has been refunded is subject to sales and use tax, unless specifically exempted under the sales and use tax statutes.

KEY: taxation, fuel, special fuel
Date of Enactment or Last Substantive Amendment: [~~March 26~~], 2009
Notice of Continuation: February 26, 2007
Authorizing, and Implemented or Interpreted Law: 59-13-301

Transportation, Operations, Construction
R916-5
Health Reform -- Health Insurance Coverage in State Contracts -- Implementation

NOTICE OF PROPOSED RULE

(New Rule)
DAR FILE NO.: 32863
FILED: 7/30/09 2:57 PM

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of the Rule is to comply with H.B. 331 of the 2009 General Legislative Session which created Section 72-6-107.5. Said statute requires that contracts entered into on or after 07/01/2009, have provisions requiring health insurance as specified in this statute. The statute also requires administrative rules that define the process and enforcement. In order to facilitate the contract requirements required as of 07/01/2009, it is necessary to have the administrative rules in place at the same time. (DAR NOTE: H.B. 331 (2009) is found at Chapter 13, Laws of Utah 2009, and was effective 05/12/2009.)

SUMMARY OF THE RULE OR CHANGE: This is a new rule and required in H.B. 331. The rule introduces the procedure and requirements for implementation of the Health Reform -- Health Insurance Coverage in State Contracts as required by Section 72-6-107.5. H.B. 331 requires all contractors, subcontractors, and subconsultants at any tier, entering into any State Contract, to have and maintain for the duration of the contract an offer of qualified health insurance coverage for their employees and their employees dependents that live and/or work in the State of Utah. (DAR NOTE: A corresponding 120-day (emergency) rule was published in the July 15, 2009, Bulletin under DAR No. 32768 and was effective 07/01/2009.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 72-6-107.5(6)

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: Enactment of this rule may indirectly increase the cost of state construction projects depending upon the contractor. The extent of such increases is currently unknown.
♦ LOCAL GOVERNMENTS: No cost or savings are anticipated for local governments with this new rule. No new requirements were created with this new rule that impact local governments. (Note: while not affected by this rule, H.B. 331 does affect public transit districts.)
♦ SMALL BUSINESSES: Enactment of this rule may result in certain cost increases to private contractors, but may benefit individuals working for such contractors. Enactment of this rule likely will not result in direct, measurable costs and/or benefits for local governments.
♦ PERSONS OTHER THAN BUSINESS: Enactment of this rule may result in certain cost increases to private contractors, but may benefit individuals working for such contractors. Enactment of this rule likely will not result in direct, measurable costs and/or benefits for local governments.

COMPLIANCE COSTS FOR AFFECTED PERSONS: To the extent there are cost increases to contractors (including designers), it is highly likely that such cost increases will be passed on as part of the costs of the contract that the State pays. The statute already provides the requirements that may cause cost increases. The rule does not add to these cost increases.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: As stated, the statute itself created the fiscal impacts. The rule does not add additional burdens than are already provided by the statute. The rule will not impact the costs. The statute will increase the cost of the contracts as the price of the insurance passed along in the bids and subsequent contracts.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
TRANSPORTATION
OPERATIONS, CONSTRUCTION
CALVIN L RAMPTON COMPLEX
4501 S 2700 W
SALT LAKE CITY, UT 84119-5998
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Maureen Short by phone at 801-965-4026, by FAX at 801-965-4338, or by Internet E-mail at maureenshort@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 5:00 PM ON 09/14/2009

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2009

AUTHORIZED BY: John Njord, Executive Director

R916. Transportation, Operations, Construction.
R916-5. Health Reform -- Health Insurance Coverage in State Contracts -- Implementation.
R916-5-1. Purpose.

The purpose of this Rule is to comply with Utah Code Annotated Section 72-6-107.5 and establish the requirements and procedures a contractor, subcontractor, consultant and subconsultant must follow to demonstrate they will maintain an offer of health insurance as required by Section 72-6-107.5. The Rule also establishes penalties for anyone covered by this Rule if they intentionally violate the provisions of Section 72-6-107.5.

R916-5-2. Authority.

This Rule is authorized under Section 72-6-107.5 which requires the Utah Department of Transportation to make rules related to health insurance in certain design and construction contracts.

R916-5-3. Definitions.

(1) Except as otherwise stated in this rule, terms used in this rule are defined in Section 72-6-107.5

(2) In addition:

(a) "Executive Director" means the Executive Director of the Department of Transportation, including, unless otherwise stated, the Executive Director's duly authorized designee.

(b) "Department" means the Department of Transportation established pursuant to Section 72-1-201.

(c) "Employee(s)" is as defined in 72-6-107.5 and includes only those employees that live and/or work in the State of Utah along with their dependents. "Employee" for purposes of this rule, shall not be construed as to be broader than that the use of the term employee for purposes of State of Utah Workers' Compensation laws.

(d) "State" means the State of Utah. The definitions found in Section 72-6-107.5 shall apply to Rule 916-5.

R916-5-4. Applicability of Rule.

(1) Except as provided in Rule R916-5-4(2) below, this Rule R916-5 applies to all contracts entered into by the Department on or after July1, 2009, if:

(a) the contract is for design and/or construction; and

(b)(i) the prime contract is in the amount of $1,500,000 or greater; or

(ii) a subcontract, at any tier, is in the amount of $750,000 or greater.

(2) This Rule R916-5 does not apply if:

(a) the application of this Rule 916-5 jeopardizes the receipt of federal funds;

(b) the contract is a sole source contract; or

(c) the contract is an emergency procurement; or

(d) the Rule is in conflict with federal law.

(3) This Rule R 916-5 does not apply to a change order as defined in Section 63G-6-103, or a modification to a contract, when the contract does not meet the initial threshold required by Rule R 916-5-4(1).

(4) A person who intentionally uses change orders or contract modifications to circumvent the requirements of subsection (1) is guilty of an infraction.

R916-5-5. Contractors or Consultants to Comply with Section 72-6-107.5.

All contractors, subcontractors, consultants or subconsultants that are subject to the requirements of Section 72-6-107.5 shall comply with all the requirements, penalties and liabilities of Section 72-6-107.5.

R916-5-6. Not Basis for Protest, Suspension, Disruption, or Termination Design or Construction.

(1) The failure of contractors, subcontractors, consultants, or subconsultants to comply with Section 72-6-107.5:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor or consultant under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8, Legal and Contractual Remedies; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor or consultant as a basis for any action or suit that would suspend, disrupt or terminate the design or construction.

(2) A contractor who is unable to demonstrate compliance within 14 calendar days of bid opening or when proposals are due may be declared non-responsive and the Department may award the contract to the lowest responsive bidder.

(3) A consultant who is unable to demonstrate compliance within 14 calendar days of being ranked first during the consultant selection process, may be declared non-responsive and the Department may enter negotiations with the new first-ranked responsive consultant.

R916-5-7. Requirements and Procedures a Contractor or Consultant Must Follow.

A contractor, or consultant, subcontractors or subconsultants must comply with the following requirements and procedures in order to demonstrate compliance with Section 72-6-107.5.

(1) Demonstrating Compliance with Health Insurance Requirements. The following requirements must be met by a contractor, consultants, subcontractors, and subconsultants that are subject to the requirements of this Rule no later than the time of execution of the contract:

(a) demonstrate compliance by a written certification to the Executive Director that the contractor, consultants, subcontractors, and subconsultants has and will maintain for the duration of the contract an offer of qualified health insurance coverage for the employees, as such employees are defined in Section 34A-2-104 for employees' who live and/or work within the State, along with their dependents. Employee, for purposes of this Rule, shall be no broader than the use of the term employee for purposes of the State's Worker's Compensation requirements; and

(b) The contractor or consultant shall also provide such written certification prior to the execution of the contract, in regard to all subcontractors or subconsultants at any tier that are subject to the requirements of this Rule.

(2) Recertification. The Executive Director shall have the right to request a recertification by the contractor or consultant by submitting a written request to the contractor or consultant, and the contractor or consultant shall so comply with the written request within ten (10) working days of receipt of the written request; however, in no case may the contractor or consultant be required to demonstrate such compliance more than twice in any 12-month period.

(3) Demonstrating Compliance with Actuarially Equivalent Determination. The actuarially equivalent determination required by Subsection (1) of 72-6-107.5 is met by the contractor or consultant if the contractor or consultant provides the Executive Director with a written statement of actuarial equivalency from either the Utah Insurance Department or an actuary selected by the contractor or the contractor's insurer or an actuary selected by the consultant or the consultant's insurer

(a) for purposes of Rule R916-5, actuary equivalency, or greater is achieved by meeting or exceeding a federally qualified health care plan. The benchmark plan is the Children's Health Insurance Program. The insurance program may be found at: http://dfcm.utah.gov/downloads/Health%20Insurance%20Benchmark.pdf The plan may be used for evaluating the offered health plan to determine if it is actuarial equivalent or superior.

(4) Time Frame Availability for Health Insurance. The health insurance must be available upon the first of the month following the initial ninety (90) days from the beginning of employment.

(5) Consultant Compliance Process. Consultants who are subject to this Rule must demonstrate compliance with this Rule in their initial Financial Screening Application. The consultant's will then be required to demonstrate the offer of health insurance that meets the requirements outlined in Section 72-6-107.5. During the procurement process and no later than the execution of the contract with the consultant, the consultant will confirm the prime is still in compliance with this Rule and the subconsultants of the consultant will certify through their prime consultant they meet the requirements of this Rule. The written contract will contain a provision where the consultant confirms compliance with this Rule by both the consultant and applicable subconsultants.

(6) Contractors Compliance Process. Contractors who are subject to this Rule must demonstrate compliance with this Rule. The contractor will indicate in the Pre-qualification Application that the contractor will offer health insurance which meets the requirements outlines in Section 72-6-107.5. When a contract is written, contractors may confirm the prime contractor is still in compliance with this Rule and their subcontractors will certify through their contractor they meet the requirements of this Rule. The written contract shall contain a provision where the contractor confirms compliance with this Rule by both the contractor and applicable subcontractors.

(7) Must be in Compliance at the Time the Contract is executed. Notwithstanding any prequalification of a contractor, subcontractor, consultant or subconsultant that is subject to this Rule, the contractor subcontractor, consultant or subconsultant must agree to the language in the executed contract that requires the contractor to be in compliance with this Rule at the time of the execution of the contract and throughout the duration of the contract.

R916-5-8. Department Hearing and Penalties.

(1) Hearing. Any hearing regarding the failure to comply with this Rule shall be held in accordance with the Utah Administrative Procedures Act and Rule 907-1 unless specifically stated otherwise in a governing statute.

(2) Penalties. The penalties that may be imposed if a contractor, consultant, subcontractor or subconsultant, at any tier intentionally violates the provisions of this Rule. May include:

(a) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation, regardless of which tier the contractor or subcontractor is involved with the future design and/or construction contract;

(b) a six-month suspension of the contractor, subcontractor, consultant or subconsultant from entering into future contracts with the state upon the second violation, regardless of which tier the contractor or subcontractor is involved with the future design and/or construction contract;

(c) an action for debarment of the contractor, subcontractor , consultant or subconsultant in accordance with Section 63G-6-804 upon the third or subsequent violation; and

(d) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for an employee and the dependents of an employee of the contractor, subcontractor, consultant or subconsultant who was not offered qualified health insurance coverage during the duration of the contract.

(e) a prime contractor or consultant will not be subject to penalties for the failure of a subcontractor or subconsultant to meet the requirement of maintaining their offer of qualified health care coverage.

R916-5-9. Does Not Create Any Contractual Relationship With Any Subcontractor or Subconsultant.

Nothing in this Rule shall be construed as to create any contractual relationship whatsoever between the Department or the State with any subcontractor or subconsultant at any tier.

KEY: contracts, health insurance, health insurance in state contracts, health reform
Date of Enactment or Last Substantive amendment: 2009
Authorizing, and Implemented or Interpreted Law: 72-6-107.5

Workforce Services, Employment Development
R986-200-218
Exceptions to the Time Limit

NOTICE OF PROPOSED RULE

(Amendment)
DAR FILE NO.: 32864
FILED: 7/30/09 2:58 PM

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this amendment is to provide an extension for people who have been laid off due to a reduction in force; it is a response to the current recession.

SUMMARY OF THE RULE OR CHANGE: The Department can grant extensions to the 36-month time limit for the Family Employment Program based on hardship. This proposed amendment adds another category to the hardship extensions for parents who have been laid off their jobs due to a reduction in force.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 35A-1-104 and Subsection 35A-1-104(4) and Subsection 35A-3-302(5)(b)

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: This is a federally-funded program so there are no costs or savings to the state budget.
♦ LOCAL GOVERNMENTS: This is a federally-funded program so there are no costs or savings to any local government.
♦ SMALL BUSINESSES: There will be no costs to small businesses to comply with these changes because this is a federally-funded program.
♦ PERSONS OTHER THAN BUSINESS: There will be no costs of any persons to comply with these changes because there are no costs or fees associated with these proposed changes.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs associated with these changes for any persons because this is a federally-funded program and there are no fees or costs associated with these proposed changes.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There are no compliance costs associated with this change. There are no fees associated with this change. There will be no cost to anyone to comply with these changes. There will be no fiscal impact on any business.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
WORKFORCE SERVICES
EMPLOYMENT DEVELOPMENT
140 E 300 S
SALT LAKE CITY, UT 84111-2333
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Suzan Pixton by phone at 801-526-9645, by FAX at 801-526-9211, or by Internet E-mail at spixton@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 5:00 PM ON 09/14/2009

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2009

AUTHORIZED BY: Kristen Cox,

R986. Workforce Services, Employment Development.
R986-200. Family Employment Program.
R986-200-218. Exceptions to the Time Limit.

Exceptions to the time limit may be allowed for up to 20% of the average monthly number of families receiving financial assistance from FEP and FEPTP during the previous Federal fiscal year for the following reasons:

(1) A hardship under Section 35A-3-306 is determined to exist when a parent:

(a) is determined to be medically unable to work. The client must provide proof of inability to work in one of the following ways:

(i) receipt of disability benefits from SSA;

(ii) receipt of VA Disability benefits based on the parent being 100% disabled;

(iii) placement on the Division of Services to People with Disabilities' waiting list. Being on the waiting list indicates the person has met the criteria for a disability; or

(iv) is currently receiving Temporary Total or Permanent Total disability Workers' Compensation benefits;

(v) a medical statement completed by a medical doctor, a licensed Advanced Practice Registered Nurse, a licensed Physician's Assistant, or a doctor of osteopathy, stating the parent has a medical condition supported by medical evidence, which prevents the parent from engaging in work activities capable of generating income of at least $500 a month. The statement must be completed by a professional skilled in both the diagnosis and treatment of the condition; or

(vi) a statement completed by a licensed clinical social worker, licensed psychologist, licensed Mental Health Therapist as defined in UCA Section 58-60-102, or psychiatrist stating that the parent has been diagnosed with a mental health condition that prevents the parent from engaging in work activities capable of generating income of at least $500 a month. Substance abuse is considered the same as mental health condition;

(b) is under age 19 through the month of their nineteenth birthday;

(c) is currently engaged in an approved full-time job preparation, educational or training activity which the parent was expected to complete within the 36 month time limit but completion within the 36 months was not possible through no fault of the parent. Additionally, if the parent has previously received, beginning with the month of January 1997, 24 months of financial assistance while attending educational or training activities, good cause for additional months must be shown and approved;

(d) was without fault and a delay in the delivery of services provided by the Department occurred. The delay must have had an adverse effect on the parent causing a hardship and preventing the parent from obtaining employment. An extension under this section cannot be granted for more than the length of the delay;

(e) moved to Utah after exhausting 36 months of assistance in another state or states and the parent did not receive supportive services in that state or states as required under the provisions of PRWORA. To be eligible for an extension under this section, the failure to receive supportive services must have occurred through no fault of the parent and must contribute to the parent's inability to work. An extension under this section can never be for longer than the delay in services;

(f) completed an educational or training program at the 36th month and needs additional time to obtain employment;

(g) is unable to work because the parent is required in the home to meet the medical needs of a dependent. Dependent for the purposes of this paragraph means a person who the parent claims as a dependent on his or her income tax filing. Proof, consisting of a medical statement from a health care professional listed in subparagraph (1)(a)(v) or (vi) of this section is required unless the dependent is on the Travis C medicaid waiver program. The medical statement must include all of the following:

(i) the diagnosis of the dependent's condition,

(ii) the recommended treatment needed or being received for the condition,

(iii) the length of time the parent will be required in the home to care for the dependent, and

(iv) whether the parent is required to be in the home full-time or part-time; or

(h) is currently receiving assistance under one of the exceptions in this section and needs additional time to obtain employment. A client can only receive assistance for one month under this subparagraph. If the Department determines that granting an exception under this subparagraph adversely impacts its federally mandated participation rate requirements or might otherwise jeopardize its funding, the one month exception will not be granted[-] or

(i) is no longer employed due to a verified reduction in force (layoff) and needs additional time to find work. Participation in eligible activities is required for an exception under this subparagraph. This exception is only available for parents who were laid off on or after January 1, 2008. This exception will not be available after December 31, 2011.

(2) Additional months of financial assistance may be provided if the family includes an individual who has been battered or subjected to extreme cruelty which is a barrier to employment and the implementation of the time limit would make it more difficult to escape the situation. Battered or subjected to extreme cruelty means:

(a) physical acts which resulted in, or threatened to result in, physical injury to the individual;

(b) sexual abuse;

(c) sexual activity involving a dependent child;

(d) threats of, or attempts at, physical or sexual abuse;

(e) mental abuse which includes stalking and harassment; or

(f) neglect or deprivation of medical care.

(3) An exception to the time limit can be granted for a maximum of an additional 24 months if:

(a) during the previous two months, the parent client was employed for no less than 20 hours per week. The employment can consist of self-employment if the parent's net income from that self-employment is at or above minimum wage; and

(b) If, at the end of the 24-month extension, the parent client qualifies for an extension under Sections (1) or (2) of this rule, an additional extension can be granted under the provisions of those sections.

(4) All clients receiving an extension must continue to participate, to the maximum extent possible, in an employment plan. This includes cooperating with ORS in the collection, establishment, and enforcement of child support and the establishment of paternity, if necessary.

(5) If a household filing unit contains more than one parent, and one parent has received at least 36 months of assistance as a parent, then the entire filing unit is ineligible unless both parents meet one of the exceptions listed above. Both parents need not meet the same exception.

(6) A family in which the only parent or both parents are ineligible aliens cannot be granted an extension under Section (3) above or for any of the reasons in Subsections (1)(c), (d), (e) or (f). This is because ineligible aliens are not legally able to work and supportive services for work, education and training purposes are inappropriate.

(7) A client who is no longer eligible for financial assistance may be eligible for other kinds of public assistance including food stamps, Child Care Assistance and medical coverage. The client must follow the appropriate application process to determine eligibility for assistance from those other programs.

(8) Exceptions are subject to a review at least once every six months.

KEY: family employment program
Date of Enactment or Last Substantive Amendment: [~~February 12~~], 2009
Notice of Continuation: September 14, 2005
Authorizing, and Implemented or Interpreted Law: 35A-3-301 et seq.

Workforce Services, Employment Development
R986-400
General Assistance and Working Toward Employment

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 32857
FILED: 7/29/09 4:23 PM

RULE ANALYSIS
PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this changes is to reflect reduction in benefits due to budgetary cuts in the 2009 General Session under S.B. 2. (DAR NOTE: S.B. 2 (2009) is found at Chapter 396, Laws of Utah 2009, and was effective 07/01/2009.)

SUMMARY OF THE RULE OR CHANGE: The Utah Legislature cut funding for the General Assistance program in the 2009 General Session. To meet the loss of funding, the Department has changed the time limit for General Assistance to 6 or 12 months instead of 24 months. These changes also require the impairment prevents any type of work and be expected to last 60 days or longer. These changes also eliminate the Working Toward Employment program entirely. An emergency rule was filed with these exact changes to be effective 07/31/2009. This change will make those changes permanent. (DAR NOTE: The corresponding 120-day (emergency) rule is under DAR No. 32856 in this issue, August 15, 2009, of the Bulletin, and was effective 07/31/2009.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 35A-1-104 and Subsection 35A-1-104(4)

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: It is expected that these changes will save the necessary amount to meet the lower budget approved by the legislature.
♦ LOCAL GOVERNMENTS: There will be no costs or savings to local governments as this is a state-funded program.
♦ SMALL BUSINESSES: There will be no affect to small businesses as this is a state-funded program.
♦ PERSONS OTHER THAN BUSINESS: This will affect a portion of the population currently eligible for General Assistance or Working Toward Employment as the time limit is being changed for General Assistance and Working Toward Employment is being eliminated. Some individuals who were previously ineligible may be eligible under these changed as the requirements have changed for obtaining PCN and participation.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs for any persons associated with this proposed rule change.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There are no compliance costs associated with this change. There are no fees associated with this change. There will be no cost to anyone to comply with these changes. There will be no fiscal impact on any business.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
WORKFORCE SERVICES
EMPLOYMENT DEVELOPMENT
140 E 300 S
SALT LAKE CITY, UT 84111-2333
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Suzan Pixton by phone at 801-526-9645, by FAX at 801-526-9211, or by Internet E-mail at spixton@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN 09/14/2009 5:00 PM

INTERESTED PERSONS MAY ATTEND A PUBLIC HEARING REGARDING THIS RULE:
♦ 08/26/2009 5:00 PM, Metro Office, 720 S 200 E, Room 100, Salt Lake City, UT

THIS RULE MAY BECOME EFFECTIVE ON: 09/21/2009

AUTHORIZED BY: Kristen Cox, Executive Director

R986. Workforce Services, Employment Development.
R986-400. General Assistance[~~and Working Toward Employment~~].
R986-400-402. General Provisions.

(1) GA provides temporary financial assistance to single persons and married couples who have no dependent children residing with them 50% or more of the time and who have[~~are unemployable due to~~] a physical or mental health [~~condition~~]impairment that prevents basic work activities in any occupation. This means that the applicant or client is unable to work any number of hours at all in any occupation.

(2) [~~Unemployable is defined to mean the individual is not capable of earning $500 per month in the Utah labor market. The incapacity~~]The impairment must be expected to last at least 6[~~3~~]0 days after the date of application[~~ or more~~].

(3) Drug addiction and/or alcoholism alone is insufficient to [~~prove the unemployable~~]meet the impairment requirement for GA as defined in Public Law 104-121.

(4) [~~For a married couple living together only one must meet the unemployable criteria. The spouse who is employable will be required to meet the work requirements of WTE unless the spouse can provide medical proof that he or she is needed at home to care for the unemployable spouse. Medical proof, consisting of a medical statement from a medical doctor, a doctor of osteopathy, a licensed Advanced Practice Registered Nurse, a licensed Physician's Assistant, a licensed Mental Health Therapist as defined in UCA 58-60-102, or a licensed psychologist, is required. The medical statement must include all of the following:~~

~~(a) the diagnosis of the spouse's condition;~~

~~(b) the recommended treatment needed or being received for the condition;~~

~~(c) the length of time the client will be required in the home to care for the spouse; and~~

~~(d) whether the client is required to be in the home full time or part time.~~]Married couples meet the impairment criteria and time limits on an individual basis. If the household includes an ineligible spouse, the income and assets of the ineligible spouse

must be counted when determining the eligibility of the household and the ineligible spouse will not be included in the financial payment. The household can consist of any combination of impaired, non-impaired, short term disabled, or long term disabled as long as at least one spouse meets the eligibility requirements.

(5) GA is only available to a client who is at least 18 years old or legally or factually emancipated. Factual emancipation means the client has lived independently from his or her parents or guardians and has been economically self-supporting for a period of at least twelve consecutive months, and the client's parents have refused financial support.

(6) A client claiming factual emancipation must cooperate with the Department in locating his or her parents. The parents, once located, will be contacted by the Department. If the parents continue to refuse to support the client, a referral will be made to ORS to enforce the parents' child support obligations.

(7) A person eligible for Bureau of Indian Affairs assistance is not eligible for GA financial assistance.

(8) In addition to the residency requirements in R986-100-106, residents in a group home that is administered under a contract with a governmental unit or administered by a governmental unit are not eligible for financial assistance.

(9) An individual receiving SSI is not eligible for GA. This ineligibility includes persons whose SSI is in suspense status, as defined by 20 CFR Part 416.1321 through 416.1330. An individual whose SSI benefits are suspended because he or she has not attained U.S. citizenship, may be eligible for GA if the individual actively pursues U.S. citizenship to regain SSI eligibility.

R986-400-403. Proof of [~~Unemployability~~]Impairment.

(1) An applicant must provide current medical evidence [~~that he or she is not capable of working and earning $500 per month~~]of an impairment that prevents basic work activities in any occupation due to a physical or mental health condition and that the [~~condition~~]impairment is expected to last at least [~~3~~]60 days from the date of application. Evidence consists of a statement from a medical doctor, a doctor of osteopathy, a licensed Advanced Practice Registered Nurse, a licensed Physician's Assistant, a licensed Mental Health Therapist as defined in UCA 58-60-102. If an applicant has been approved for SSI/SSDI, and is waiting for the first check, no further medical evidence of impairment is necessary. Verification and evidence of social security approval must be included in the case record.

(2) An applicant must cooperate in the obtaining of a second opinion if requested by the Department. Only the costs associated with a second opinion requested by the Department will be paid for by the Department. The Department will not pay the costs associated with obtaining a second opinion if the client requests the second opinion.[

~~(3) If the illness or incapacity is expected to last longer than 12 months, the client must apply for SSDI/SSI benefits.~~

~~(4) Full-time or part-time participation in post-high school education or training is considered evidence of employability rendering the client ineligible for GA financial assistance. If the Department believes work readiness or occupational skills enhancement opportunities will lead to employability, those services can be offered for a maximum of three months if the client is otherwise eligible.~~]

R986-400-404. Participation Requirements.

(1) [~~The client and spouse must participate, to the maximum extent possible, in an assessment and an employment plan as provided in R986-200. The only education or training supported by an employment plan for GA recipients is short term skills training as described in R986-400-403.~~]All GA clients are required to meet with an employment counselor and sign the General Assistance Agreement Form within 30 days after the initial financial benefit has been issued.

(2) [~~The employment plan must include obtaining appropriate medical or mental health treatment, or both, to overcome the limitations preventing the client from becoming employable. The employment plan must provide that all adults age 19 and above who do not qualify for coverage under any other category of Medicaid and who are not covered by or do not have access to private health insurance, Medicare or the Veterans Administration Health Care System must enroll in the Primary Care Network (PCN) through the Department of Health. If a client cannot enroll in PCN because the Department of Health has placed a cap on PCN enrollment, the requirement will be excused during the period enrollment is impossible. The Department may, at its discretion, develop a program whereby eligible clients will be allowed to pay the enrollment fee in installments.~~]The requirement to complete an assessment and employment plan is limited to clients with impairments expected to last 12 months or longer.

(3) If the impairment is expected to last 12 months or longer, the client must apply for SSI/SSDI benefits.

(4[~~3~~]) A client must accept any and all offers of appropriate employment as determined by the Department. "Appropriate employment" means employment that pays a wage [~~which~~]that meets or exceeds the applicable federal or state minimum wage law and has daily and weekly hours customary to the occupation. If the minimum wage laws do not apply, the wage must equal what is normally paid for similar work and in no case less than three-fourths of the minimum wage rate. The employment is not appropriate employment if the client is unable, due to physical or mental limitations, to perform the work.[

~~(4) A client is exempt from the requirements of paragraphs (1) and (2) of this section if the client has been approved for SSI, is waiting for the first check, and has signed an "Agreement to Repay Interim Assistance" Form.~~]

(5) A client must cooperate in obtaining any and all other sources of income to which the client may be entitled including, [~~but not limited to UI, ~~]SSI/SSDI, VA Benefits, and Workers' Compensation.

(6) A client who meets the eligible alien status requirements for GA but does not meet the eligible alien requirements for SSI can participate in activities that may help them to become eligible for SSI such as pursuing citizenship.

R986-400-405. Interim Aid for SSI Applicants.

(1) A client who has applied for SSI or SSDI benefits may be provided with GA financial assistance pending a determination on the application for SSI or SSDI. If the client is applying for SSI, he or she must sign an "Agreement to Repay Interim Assistance" form and agree to reimburse, or allow SSA to reimburse, the [~~Department~~]state of Utah for any and all GA financial assistance advanced pending a determination from SSA.

(2) Financial assistance will be immediately terminated without advance notice when SSA issues a payment or if the client fails to cooperate to the maximum extent possible in pursuing the application which includes cooperating fully with SSA and providing all necessary documentation to insure receipt of SSI or SSDI benefits.

(3) A client must fully cooperate in prosecuting an appeal of an SSI or SSDI denial at least to the Social Security ALJ level. If the ALJ issues an unfavorable decision, the client is not eligible for financial assistance unless an unrelated physical or mental health condition develops and is verified.

(4) If a client's SSI or SSDI benefits have been terminated due to a physical or mental health condition, the client is ineligible unless an unrelated physical or mental health condition develops and is verified.

R986-400-406. Failure to Comply with the Requirements of an Employment Plan.

(1) If a client fails to comply with the requirements of the employment plan without reasonable cause, financial assistance will be terminated immediately. Reasonable cause under this section means the client was prevented from participating through no fault of his or her own or failed to participate for reasons that are reasonable and compelling and may include reasons like verified illness or extraordinary transportation problems.

(2) If a client's financial assistance has been terminated under this section, the client is not eligible for further assistance as follows:

(a) the first time financial assistance is terminated, the client must resolve the reason for the termination and participate to the maximum extent possible in all of the required activities of the employment plan. The client does not need to reapply if he or she resolves the reason for termination by the end of the month following the termination;

(b) the second time financial assistance is terminated, the client will be ineligible for financial assistance for a minimum of one month and can only become eligible again upon completing a new application and participating to the maximum extent possible in the required employment activity; and

(c) the third and subsequent time financial assistance is terminated, the client will be ineligible for a minimum of six months and can only become eligible again upon completing a new application and actively participating in the required employment activity.[

~~3. If a client has had his or her financial assistance terminated because the client did not enroll in PCN, the client will not be eligible for GA until the client enrolls in PCN or obtains other medical coverage. This is true even if the client cannot enroll in PCN because there is no open enrollment.~~

~~4. An application for GA will be denied if the applicant's employment plan requires the applicant to enroll in PCN but he or she fails to do so during the application period. However, if there is no open enrollment during the application period, the PCN requirement will be waived until the next open enrollment period.~~]

R986-400-408. Time Limits.

(1) An individual cannot receive GA financial assistance for more than [~~24~~]12 months out of a[~~ny~~] rolling 60-month period. Any month in which a client received a full or partial GA financial assistance payment count toward the 12 month limit.[~~Months which count toward the 24-month limit include any and all months during which any client who currently resides in the household received a full or partial financial assistance payment beginning with the month of March, 1998~~].

(a) A client with a short term impairment that prevents basic work activities in any occupation lasting at least 60 days from the date of application but less than 12 months can receive up to six months of GA financial benefits in a rolling 12 month period. Clients are limited to a total of 12 months of financial assistance within a rolling 60-month period.

(b) A client with a long term impairment that prevents basic work activities in any occupation and the impairment is expected to last 12 months or more, can receive a total of 12 months of GA financial benefits in a rolling 60 month period.

(2) There are no exceptions or extensions to the time limit.

(3) Advanced written notice for termination of GA financial assistance due to time limits is not required.

~~**[R986-400-451. Authority for Working Toward Employment (WTE) and Other Applicable Rules.**~~

~~(1) The Department provides WTE financial assistance pursuant to Section 35A-3-401 et seq. as funding permits.~~

~~(2) Rule R986-100 applies to WTE.~~

~~(3) Applicable provisions of R986-200 apply to WTE except as noted in this rule.~~

~~(4) The citizenship and alienage requirements of the Food Stamp Program apply to WTE.~~

~~**R986-400-452. General Provisions.**~~

~~(1) Working Toward Employment (WTE) provides financial assistance on a short term basis to single persons and married couples who have no dependent children residing with them 50% or more of the time and who are unemployable because they lack employment skills.~~

~~(2) At least one household member must be at least 18 years old or legally or factually emancipated. Factual emancipation is defined in R986-400-402.~~

~~(3) As a condition of eligibility, a client claiming factual emancipation must cooperate with the Department in locating his or her parents. The parents, once located, will be contacted by the Department. If the parents continue to refuse to support the client, a referral will be made to ORS to enforce the parents' child support obligations.~~

~~(4) All clients must cooperate in obtaining any and all other benefits or sources of income to which the client may be entitled except that a client who has applied for SSI benefits is ineligible for WTE. If a client applies for SSI, WTE financial assistance is terminated.~~

~~(5) A person eligible for Bureau of Indian Affairs assistance is not eligible for WTE financial assistance.~~

~~(6) If an applicant appears to be eligible for the Refugee Resettlement Program (RRP) the applicant must comply with the requirements of RRP and will be paid out of funds for that program. If found eligible for RRP, the applicant is ineligible for WTE.~~

~~R986-400-453. Participation Requirements.~~

~~(1) All applicants and spouses must participate in an assessment and an employment plan as found in R986-200. In addition to the requirements of an employment plan as found in R986-200-210, a client must, as a condition of receipt of financial assistance, register for work and accept any and all offers of appropriate employment, as determined by the Department. Appropriate employment is defined in R986-400-404.~~

~~(2) The employment plan of each recipient of WTE financial assistance must contain the requirement that the client participate 40 hours per week in eligible activities. A list of approved eligible activities is available at each employment center. Married couples cannot share the performance requirements and each client must participate a minimum of 40 hours per week. The 40 hours must be spent in the following activities:~~

~~(a) At least 16 hours must be spent in an approved insternship or in paid employment. Some basic educational activities are also available; and~~

~~(b) eight hours a week participating in job search activities. The Department may reduce the number of hours spent in job search activities if it is determined the client has explored all local employment options. A reduction in the number of hours of job search will not reduce the total requirement of 40 hours of participation.~~

~~(3) Participation may be excused only if the client can show reasonable cause as defined in R986-400-406(1).~~

~~R986-400-454. Failure to Comply with the Requirements of an Employment Plan.~~

~~(1) If a client fails to comply with the requirements of the employment plan without reasonable cause as defined in R986-400-406(a), financial assistance will be terminated immediately.~~

~~(2) Advanced notice of termination is not required.~~

~~(3) If there are two clients in the household and only one client fails to comply, financial assistance for both will be terminated.~~

~~(4) Once a client or household's financial assistance has been terminated for failure to comply with the employment plan, the client is not eligible for further assistance as follows:~~

~~(a) the first time financial assistance is terminated, the client or couple must reapply and actively participate in all of the required activities of the employment plan;~~

~~(b) the second time financial assistance is terminated, the client or couple will be ineligible for financial assistance for a minimum of one month and can only become eligible again upon completing a new application and actively participating in the required employment activity;~~

~~(c) the third time financial assistance is terminated, the client will be ineligible for a minimum of six months and can only become eligible again upon completing a new application and actively participating in the required employment activity.~~

~~R986-400-455. Income and Assets Limits and Calculation of Assistance Payment.~~

~~(1) Income and asset determination and limits are the same as for FEP found in R986-200 except one vehicle with a maximum of $8,000 equity value is not counted. The entire equity value of one vehicle equipped to transport a disabled individual is exempt from the asset limit even if the vehicle has a value in excess of $8,000. Beginning October 1, 2007, all motorized vehicles will be exempt.~~

~~(2) The amount of financial assistance available for payment to a client is based on the number of hours of participation. Payment is made twice per month and only after proof of participation. The base amount of assistance is equal to the GA financial assistance payment for the household size. The base GA payment is then prorated based on the number of hours of participation for each household member, up to a maximum of 40 hours of participation per household member per week. In no event can the financial assistance payment per month for a WTE household be more than for the same size household receiving financial assistance under GA. Payment of financial assistance cannot be made for any period during which the client does not participate.~~

~~(3) The base GA financial assistance payment level is determined by the State Legislature and available upon request.~~

~~(4) Each WTE household member will receive the sum of $45 per month regardless of number of hours the client participates. This sum is intended to be used for participation expenses.~~

~~R986-400-456. Time Limits.~~

~~(1) An individual cannot receive WTE financial assistance for more than seven months out of any 18-month period.~~

~~(2) In addition to the seven months out of any 18-month period time limit, there is a 24-month life time limit for WTE financial assistance.~~

~~(3) Months which count toward the seven month time limit and the 24-month limit include any and all months during which any client who currently resides in the household received a full or partial financial assistance payment.~~

~~(4) There are no exceptions or extensions to the time limit.~~

~~(5) If WTE financial assistance is terminated due to the time limit, advanced written notice is not required.~~]

KEY: general assistance[~~, working toward employment~~]
Date of Enactment or Last Substantive Amendment: [~~May 1, 2008~~]2009
Notice of Continuation: September 14, 2005
Authorizing, and Implemented or Interpreted Law: 35A-3-401; 35A-3-402

End of the Notices of Proposed Rules Section

NOTICES OF
120-DAY (EMERGENCY) RULES

An agency may file a **120-Day (Emergency) Rule** when it finds that the regular rulemaking procedures would:

(a) cause an imminent peril to the public health, safety, or welfare;
(b) cause an imminent budget reduction because of budget restraints or federal requirements; or
(c) place the agency in violation of federal or state law (Subsection 63G-3-304(1)).

As with a **Proposed Rule**, a **120-Day Rule** is preceded by a **Rule Analysis**. This analysis provides summary information about the **120-Day Rule** including the name of a contact person, justification for filing a **120-Day Rule**, anticipated cost impact of the rule, and legal cross-references. A row of dots in the text (**. . . . . .**) indicates that unaffected text was removed to conserve space.

A **120-Day Rule** is effective at the moment the Division of Administrative Rules receives the filing, or on a later date designated by the agency. A **120-Day Rule** is effective for 120 days or until it is superseded by a permanent rule.

Because **120-Day Rules** are effective immediately, the law does not require a public comment period. However, when an agency files a **120-Day Rule**, it usually files a **Proposed Rule** at the same time, to make the requirements permanent. Comment may be made on the proposed rule. Emergency or **120-Day Rules** are governed by Section 63G-3-304; and Section R15-4-8.

Workforce Services, Employment Development
R986-400
General Assistance

NOTICE OF 120 DAY RULE
(Emergency Rule)
DAR FILE NO.: 32856
FILED: 7/29/09 4:13 PM

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this changes is to reflect reduction in benefits due to budgetary cuts in the 2009 General Session under S.B. 2. (DAR NOTE: S.B. 2 (2009) is found at Chapter 396, Laws of Utah 2009, and was effective 07/01/2009.)

SUMMARY OF THE RULE OR CHANGE: The Utah Legislature cut funding for the General Assistance program in the 2009 General Session. To meet the loss of funding, the Department has changed the time limit for General Assistance to 6 or 12 months instead of 24 months. These changes also require that the customer's impairment prevents any type of work and is expected to last 60 days or longer. These changes also eliminate the Working Toward Employment program entirely. (DAR NOTE: A corresponding proposed amendment is under DAR No. 32857 in this issue, August 15, 2009, of the Bulletin.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 35A-1-104 and Subsection 35A-1-104(4)

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: It is expected that these changes will save the $3,000,000 necessary to meet the lower budget as approved by the legislature.
♦ LOCAL GOVERNMENTS: There will be no costs or savings to local governments as this is a state-funded program.
♦ SMALL BUSINESSES: There will be no affect to small businesses as this is a state-funded program.
♦ PERSONS OTHER THAN BUSINESS: A portion of the population currently eligible for General Assistance will lose their benefits as the time limit is being shortened. Some individuals who were previously ineligible may be eligible under these changed as the requirements have changed for obtaining PCN and participation. All customers previously eligible for Working Toward Employment will no longer be eligible as the program is being eliminated.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs associated with this program for any affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There are no compliance costs associated with this change. There are no fees associated with this change. There will be no cost to anyone to comply with these changes. There will be no fiscal impact on any business.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
WORKFORCE SERVICES
EMPLOYMENT DEVELOPMENT
140 E 300 S
SALT LAKE CITY, UT 84111-2333
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Suzan Pixton by phone at 801-526-9645, by FAX at 801-526-9211, or by Internet E-mail at spixton@utah.gov

EFFECTIVE: 07/31/2009

AUTHORIZED BY: Kristen Cox, Executive Director

R986. Workforce Services, Employment Development.
R986-400. General Assistance[~~and Working Toward Employment~~].
R986-400-402. General Provisions.

(1) GA provides temporary financial assistance to single persons and married couples who have no dependent children residing with them 50% or more of the time and who have[~~are unemployable due to~~] a physical or mental health [~~condition~~]impairment that prevents basic work activities in any occupation. This means that the applicant or client is unable to work any number of hours at all in any occupation.

(2) [~~Unemployable is defined to mean the individual is not capable of earning $500 per month in the Utah labor market. The incapacity~~]The impairment must be expected to last at least 6[~~3~~]0 days after the date of application[~~or more~~].

(3) Drug addiction and/or alcoholism alone is insufficient to [~~prove the unemployable~~]meet the impairment requirement for GA as defined in Public Law 104-121.

(4) [~~For a married couple living together only one must meet the unemployable criteria. The spouse who is employable will be required to meet the work requirements of WTE unless the spouse can provide medical proof that he or she is needed at home to care for the unemployable spouse. Medical proof, consisting of a medical statement from a medical doctor, a doctor of osteopathy, a licensed Advanced Practice Registered Nurse, a licensed Physician's Assistant, a licensed Mental Health Therapist as defined in UCA 58-60-102, or a licensed psychologist, is required. The medical statement must include all of the following:~~

~~(a) the diagnosis of the spouse's condition;~~

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~~(3) If the illness or incapacity is expected to last longer than 12 months, the client must apply for SSDI/SSI benefits.~~

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(1) An individual cannot receive GA financial assistance for more than [~~24~~]12 months out of a[~~ny~~] rolling 60-month period. Any month in which a client received a full or partial GA financial assistance payment count toward the 12 month limit.[~~Months which count toward the 24-month limit include any and all months during which any client who currently resides in the household received a full or partial financial assistance payment beginning with the month of March, 1998~~].

(a) A client with a short term impairment that prevents basic work activities in any occupation lasting at least 60 days from the date of application but less than 12 months can receive up to six months of GA financial benefits in a rolling 12 month period. Clients are limited to a total of 12 months of financial assistance within a rolling 60-month period.

(b) A client with a long term impairment that prevents basic work activities in any occupation and the impairment is expected to last 12 months or more, can receive a total of 12 months of GA financial benefits in a rolling 60 month period.

(2) There are no exceptions or extensions to the time limit.

(3) Advanced written notice for termination of GA financial assistance due to time limits is not required.

~~**[R986-400-451. Authority for Working Toward Employment (WTE) and Other Applicable Rules.**~~

~~(1) The Department provides WTE financial assistance pursuant to Section 35A-3-401 et seq. as funding permits.~~

~~(2) Rule R986-100 applies to WTE.~~

~~(3) Applicable provisions of R986-200 apply to WTE except as noted in this rule.~~

~~(4) The citizenship and alienage requirements of the Food Stamp Program apply to WTE.~~

~~**R986-400-452. General Provisions.**~~

~~(1) Working Toward Employment (WTE) provides financial assistance on a short term basis to single persons and married couples who have no dependent children residing with them 50% or more of the time and who are unemployable because they lack employment skills.~~

~~(2) At least one household member must be at least 18 years old or legally or factually emancipated. Factual emancipation is defined in R986-400-402.~~

~~(3) As a condition of eligibility, a client claiming factual emancipation must cooperate with the Department in locating his or her parents. The parents, once located, will be contacted by the Department. If the parents continue to refuse to support the client, a referral will be made to ORS to enforce the parents' child support obligations.~~

~~(4) All clients must cooperate in obtaining any and all other benefits or sources of income to which the client may be entitled except that a client who has applied for SSI benefits is ineligible for WTE. If a client applies for SSI, WTE financial assistance is terminated.~~

~~(5) A person eligible for Bureau of Indian Affairs assistance is not eligible for WTE financial assistance.~~

~~(6) If an applicant appears to be eligible for the Refugee Resettlement Program (RRP) the applicant must comply with the requirements of RRP and will be paid out of funds for that program. If found eligible for RRP, the applicant is ineligible for WTE.~~

~~**R986-400-453. Participation Requirements.**~~

~~(1) All applicants and spouses must participate in an assessment and an employment plan as found in R986-200. In addition to the requirements of an employment plan as found in R986-200-210, a client must, as a condition of receipt of financial assistance, register for work and accept any and all offers of appropriate employment, as determined by the Department. Appropriate employment is defined in R986-400-404.~~

~~(2) The employment plan of each recipient of WTE financial assistance must contain the requirement that the client participate 40 hours per week in eligible activities. A list of approved eligible activities is available at each employment center. Married couples cannot share the performance requirements and each client must participate a minimum of 40 hours per week. The 40 hours must be spent in the following activities:~~

~~(a) At least 16 hours must be spent in an approved internship or in paid employment. Some basic educational activities are also available; and~~

~~(b) eight hours a week participating in job search activities. The Department may reduce the number of hours spent in job search activities if it is determined the client has explored all local employment options. A reduction in the number of hours of job search will not reduce the total requirement of 40 hours of participation.~~

~~(3) Participation may be excused only if the client can show reasonable cause as defined in R986-400-406(1).~~

~~**R986-400-454. Failure to Comply with the Requirements of an Employment Plan.**~~

~~(1) If a client fails to comply with the requirements of the employment plan without reasonable cause as defined in R986-400-406(a), financial assistance will be terminated immediately.~~

~~(2) Advanced notice of termination is not required.~~

~~(3) If there are two clients in the household and only one client fails to comply, financial assistance for both will be terminated.~~

~~(4) Once a client or household's financial assistance has been terminated for failure to comply with the employment plan, the client is not eligible for further assistance as follows:~~

~~(a) the first time financial assistance is terminated, the client or couple must reapply and actively participate in all of the required activities of the employment plan;~~

~~(b) the second time financial assistance is terminated, the client or couple will be ineligible for financial assistance for a minimum of one month and can only become eligible again upon completing a new application and actively participating in the required employment activity;~~

~~(c) the third time financial assistance is terminated, the client will be ineligible for a minimum of six months and can only become eligible again upon completing a new application and actively participating in the required employment activity.~~

~~**R986-400-455. Income and Assets Limits and Calculation of Assistance Payment.**~~

~~(1) Income and asset determination and limits are the same as for FEP found in R986-200 except one vehicle with a maximum of $8,000 equity value is not counted. The entire equity value of one vehicle equipped to transport a disabled individual is exempt from the asset limit even if the vehicle has a value in excess of $8,000. Beginning October 1, 2007, all motorized vehicles will be exempt.~~

~~(2) The amount of financial assistance available for payment to a client is based on the number of hours of participation. Payment is made twice per month and only after proof of~~

~~participation. The base amount of assistance is equal to the GA financial assistance payment for the household size. The base GA payment is then prorated based on the number of hours of participation for each household member, up to a maximum of 40 hours of participation per household member per week. In no event can the financial assistance payment per month for a WTE household be more than for the same size household receiving financial assistance under GA. Payment of financial assistance cannot be made for any period during which the client does not participate.~~

~~(3) The base GA financial assistance payment level is determined by the State Legislature and available upon request.~~

~~(4) Each WTE household member will receive the sum of $45 per month regardless of number of hours the client participates. This sum is intended to be used for participation expenses.~~

~~R986-400-456. Time Limits.~~

~~(1) An individual cannot receive WTE financial assistance for more than seven months out of any 18-month period.~~

~~(2) In addition to the seven months out of any 18-month period time limit, there is a 24-month life time limit for WTE financial assistance.~~

~~(3) Months which count toward the seven month time limit and the 24-month limit include any and all months during which any client who currently resides in the household received a full or partial financial assistance payment.~~

~~(4) There are no exceptions or extensions to the time limit.~~

~~(5) If WTE financial assistance is terminated due to the time limit, advanced written notice is not required.~~]

KEY: general assistance[~~, working toward employment~~]
Date of Enactment or Last Substantive Amendment: July 31, 2009
Notice of Continuation: September 14, 2005
Authorizing, and Implemented or Interpreted Law: 35A-3-401; 35A-3-402

End of the Notices of 120-Day (Emergency) Rules Section

FIVE-YEAR NOTICES OF REVIEW AND STATEMENTS OF CONTINUATION

Within five years of an administrative rule's original enactment or last five-year review, the agency is required to review the rule. This review is intended to remove obsolete rules from the Utah Administrative Code. Upon reviewing a rule, an agency may: repeal the rule by filing a **Proposed Rule**; continue the rule as it is by filing a **Notice of Review and Statement of Continuation (Notice)**; or amend the rule by filing a **Proposed Rule** and by filing a **Notice**. By filing a Notice, the agency indicates that the rule is still necessary.

Notices are not followed by the rule text. The rule text that is being continued may be found in the most recent edition of the *Utah Administrative Code*. The rule text may also be inspected at the agency or the Division of Administrative Rules. **Notices** are effective upon filing.

Notices are governed by Section 63G-3-305.

Commerce, Occupational and Professional Licensing
R156-60
Mental Health Professional Practice Act Rule

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 32843
FILED: 7/27/09 2:42 PM

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Title 58, Chapter 60, provides for the licensure of various classifications of mental health therapists. Subsection 58-1-106(1)(a) provides that the Division may adopt and enforce rules to administer Title 58. This rule was enacted to clarify the provisions of Title 58, Chapter 60, with respect to the various classifications of mental health therapists.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: Since this rule was last reviewed in October 2004, no amendments have been made to the rule nor have any written comments with respect to this rule been received by the Division.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule should be continued as it provides a mechanism to inform potential licensees and licensed mental health therapists of the requirements for licensure as allowed under statutory authority provided in Title 58, Chapter 60. The rule should also be continued as it provides information to ensure applicants for licensure are adequately trained and meet minimum licensure requirements and to ensure that licensed mental health therapists meet minimum renewal requirements.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
COMMERCE
OCCUPATIONAL AND PROFESSIONAL LICENSING
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY, UT 84111-2316
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Rich Oborn by phone at 801-530-6767, by FAX at 801-530-6511, or by Internet E-mail at roborn@utah.gov

AUTHORIZED BY: Mark Steinagel, Director

EFFECTIVE: 07/27/2009

Education, Administration
R277-402
Online Testing

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 32830
FILED: 7/16/09 3:34 PM

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Subsection 53A-1-708(5) directs the Utah State Board of Education to specify procedures and accountability for online summative testing by school districts and charter schools, and Subsection 53A-1-401(3) allows the Utah State Board of Education to adopt rules in accordance with its responsibilities.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule continues to be necessary because it provides for implementation of an educational technology infrastructure for school districts and charter schools to satisfy testing requirements under state law. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
EDUCATION
ADMINISTRATION
250 E 500 S
SALT LAKE CITY, UT 84111-3272
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Coordinator School Law and Legislation

EFFECTIVE: 07/16/2009

Education, Administration
R277-609
Standards for School District, School and Charter School Discipline Plans

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 32834
FILED: 7/23/09 1:17 PM

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Subsection 53A-1-401(3) allows the Utah State Board of Education to adopt rules in accordance with its responsibilities, and Subsection 53A-1-402(1)(b) requires the Utah State Board of Education to establish rules concerning discipline and control of students.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule continues to be necessary because it provides standards and procedures for school districts, schools, and charter schools when developing and implementing school discipline policies for students required by state law. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
EDUCATION
ADMINISTRATION
250 E 500 S
SALT LAKE CITY, UT 84111-3272
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Coordinator School Law and Legislation

EFFECTIVE: 07/23/2009

EFFECTIVE: 07/23/2009

Education, Administration
R277-800
Administration of the Utah School for the Deaf and the Utah School for the Blind

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

DAR FILE NO.: 32835
FILED: 7/23/09 1:20 PM

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Section 53A-25b-201 vests the Utah State Board of Education with governance and supervision of the Utah Schools for the Deaf and the Blind.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule continues to be necessary because it provides procedures for governance, student eligibility, fiscal responsibility, as well as other standards for operation of the Utah Schools for the Deaf and the Utah Schools for the Blind. This rule will be continued but will have significant substantive changes in the near future as a result of 2009 legislation.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

EDUCATION
ADMINISTRATION
250 E 500 S
SALT LAKE CITY, UT 84111-3272
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Coordinator School Law and Legislation

Education, Rehabilitation
R280-150
Adjudicative Proceedings Under the Vocational Rehabilitation Act

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

DAR FILE NO.: 32836
FILED: 7/23/09 1:21 PM

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Section 53A-24-103 places the Utah State Office of Rehabilitation under the policy direction of the Utah State Board of Education and general supervision of the State Superintendent of Public Instruction, and Subsection 53A-1-401(3) allows the Utah State Board of Education to adopt rules in accordance with its responsibilities.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule continues to be necessary because it provides and incorporates by reference the federal laws and requirements for adjudicative proceedings to which the Utah State Office of Rehabilitation is subject. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

EDUCATION
REHABILITATION
250 E 500 S
SALT LAKE CITY, UT 84111-3272
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Carol Lear by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

AUTHORIZED BY: Carol Lear, Coordinator School Law and Legislation

EFFECTIVE: 07/23/2009

Health, Health Systems Improvement, Emergency Medical Services
R426-11
General Provisions

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 32845
FILED: 7/28/09 2:13 PM

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Section 26-8a-105, Department Powers, states that the department shall: "(4) adopt rules...to: (a) license ambulance providers and paramedic providers; (b) permit ambulances and emergency response vehicles; (c) establish application, submissions, and procedural requirements for licenses, designations, certificates, and permits; and (d) establish and implement the programs, plans, and responsibilities as specified in other sections of this chapter."

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: Significant public comment has not been received opposing Rule R426-11. Changes have been suggested and included as part of the amendment process as directed by the Department and the Emergency Medical Services (EMS) Committee.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The rule is a basis for defining terms used in subsequent rules. The process for quality assurance is established for the department, and the role of the Critical Incident Stress Management team are given. These processes and standards are acceptable to the Department and serve as the foundation for implementation of the services rendered. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HEALTH
HEALTH SYSTEMS IMPROVEMENT,
EMERGENCY MEDICAL SERVICES
3760 S HIGHLAND DR
SALT LAKE CITY, UT 84106
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Guy Dansie by phone at 801-273-6671, by FAX at 801-273-4165, or by Internet E-mail at gdansie@utah.gov

AUTHORIZED BY: David Sundwall, Executive Director

EFFECTIVE: 07/28/2009

Health, Health Systems Improvement, Emergency Medical Services
R426-12
Emergency Medical Services Training and Certification Standards

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 32855
FILED: 7/29/09 2:49 PM

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Section 26-8a-302 authorizes the Emergency Medical Services (EMS) Committee to establish initial and ongoing certification and training requirements for emergency medical services personnel and requires the Department to develop, conduct and authorize training and testing for emergency medical services personnel, and to certify EMS personnel.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: In early 2007, a rule change was proposed and made effective on 07/16/2007. Comments were made during the public comment period by Hunter Finch, Governor's Office of Planning and Budget. He stated that it appeared that a citation was incorrect in the rules. This

was later changed with a nonsubstantive rule change. Comments were made by Ernie Williams, EMT Coordinator, Snow College: He stated that the word "bieannually" is misspelled and should be "biennially". This was later changed in a nonsubstantive rule change. In September 2008, a proposed rule change received the following comments: Michelle Andersen, Summit County, stated that she thinks "EMTs should have experience before advancing to the next level. Experience is the best teacher, perfects skills on real people, and confidence builder." Dana Cox, Training Officer, Paramedic, stated "The changes that eliminate the required field time for advanced level of certifications is a mistake." Russ Malone, Course Coordinator, SLCC, stated "I have seen first hand the poor patient care given in the field by EMT-Is that have no experience. I know of agencies that have had trouble and had to fire paramedics that passed their paramedic course, but had no field experience. The lack of experience is a critical problem that needs to be addressed." Russ also stated: "To eliminate the one year requirement can only hurt the quality of our EMTs. Let's not shoot ourselves in the foot, lets leave the one year requirement in place." Kerry Dayley, Newton First Responders stated that he approves of the changes. Merilee Mecham, EMS Instructor, stated they sounded great to her. Chad Tucker, Ogden Fire stated that he supports the changes and hopes they pass. Von Johnson, Uintah Basin Medical Center (UBMC), stated he thinks the changes are good. "The only comment he has is regarding TB tests. The rule says that they must submit a statement from a physician confirming the applicant's results of a TB test within one year prior to completing the course. I think that it should just say that they submit results of a TB test. We do TB tests here at the hospital and they are never read by a physician usually by an RN." Karla Rickards, Unified Fire Agency stated: "The only problem I see at first reading is in R425-12-505(4) where it states that if a paramedic fails the recertification written or practical . . . there is no longer a requirement for recertification written, right? " A letter was also received signed by 61 people stating: "The undersigned persons are in support of the amendment to the rule by which the EMT-Basic may continue to the intermediate level without the one year field experience." Von Johnson, UBMC stated: He does not believe that TB tests need to be read by a physician, but could be read by an R.N. Chad Tucker, Ogden Fire Deputy Chief stated: "I support the changes and hope they pass. I am particularly concerned with the change in the internet recert hours. Changing this to 50 hours will greatly assist my department in staying within their districts for training". Merilee Mecham, EMT, Test Team -- Thanks for keeping us in the loop. Kerry Dayley, Newton First Responders, stated: I approve of the changes. Kim Jensen, K & B Training -- "I do think that it would be helpful for EMTs to be able to go right to Intermediate, as it is difficult to find work here in this state as a basic". Mike Snow -- "I have no issues with the changes". Jeff Grunow -- Weber State University -- "We agree with all changes. This change was not made effective. We are in the process of having new changes out for public comment".

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The rule establishes the minimum certification and recertification requirements for EMS personnel and must be continued to protect the health and safety of the citizens of Utah who receive pre-hospital care. The Department does not agree with some of the comments that were made above, but has re-worked the rule and it is out for public comment at the present time. The 1-year requirement will also be deleted in the rule change, because it was felt that there are more people in favor of the 12-month deletion than opposed. It is also felt that the Intermediate training is needed in order for a person to get a job working as an EMT for an agency. Most agencies will not hire Basic EMTs, but will hire Intermediates. In the case of the IA and Paramedic levels, it would take a person approximately one year to complete these additional trainings, and people get experience while they are taking the courses.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HEALTH
HEALTH SYSTEMS IMPROVEMENT,
EMERGENCY MEDICAL SERVICES
3760 S HIGHLAND DR
SALT LAKE CITY, UT 84106
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Leslie Johnson by phone at 801-273-6636, by FAX at 801-273-0744, or by Internet E-mail at lesliejjohnson@utah.gov

AUTHORIZED BY: David Sundwall, Executive Director

EFFECTIVE: 07/29/2009

Health, Health Systems Improvement, Emergency Medical Services
R426-13
Emergency Medical Services Provider Designations

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 32846
FILED: 7/28/09 2:22 PM

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Section 26-8a-105, Department Powers, states that the department shall: "(4) adopt rules...to: (a) license ambulance providers and paramedic providers; (b) permit ambulances and emergency response vehicles; (c) establish application, submissions, and procedural requirements for licenses, designations, certificates, and permits; and (d) establish and implement the programs, plans, and responsibilities as specified in other sections of this chapter."

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: Significant public comment has not been received opposing Rule R426-13. Changes have been suggested and included as part of the amendment process as directed by the department and the Emergency Medical Services (EMS) Committee.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The rule is a basis for defining what types of providers may be designated to perform emergency medical service response and care. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HEALTH
HEALTH SYSTEMS IMPROVEMENT,
EMERGENCY MEDICAL SERVICES
3760 S HIGHLAND DR
SALT LAKE CITY, UT 84106
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Guy Dansie by phone at 801-273-6671, by FAX at 801-273-4165, or by Internet E-mail at gdansie@utah.gov

AUTHORIZED BY: David Sundwall, Executive Director

EFFECTIVE: 07/28/2009

Health, Health Systems Improvement, Emergency Medical Services
R426-14

Ambulance Service and Paramedic Service Licensure

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

DAR FILE NO.: 32847
FILED: 7/28/09 2:28 PM

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Section 26-8a-105, Department Powers, states that the department shall: "(4) adopt rules...to: (a) license ambulance providers and paramedic providers; (b) permit ambulances and emergency response vehicles; (c) establish application, submissions, and procedural requirements for licenses, designations, certificates, and permits; and (d) establish and implement the programs, plans, and responsibilities as specified in other sections of this chapter."

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: Significant public comment has not been received opposing Rule R426-14. Changes have been suggested and included as part of the amendment process as directed by the department and the Emergency Medical Services (EMS) Committee.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The rule has been modified as needed through the department processes including input from the public and the EMS Committee. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HEALTH
HEALTH SYSTEMS IMPROVEMENT,
EMERGENCY MEDICAL SERVICES
3760 S HIGHLAND DR
SALT LAKE CITY, UT 84106
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Guy Dansie by phone at 801-273-6671, by FAX at 801-273-4165, or by Internet E-mail at gdansie@utah.gov

AUTHORIZED BY: David Sundwall, Executive Director

EFFECTIVE: 07/28/2009

Health, Health Systems Improvement, Emergency Medical Services
R426-15
Licensed and Designate Provider Operations

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

DAR FILE NO.: 32848
FILED: 7/28/09 2:32 PM

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Section 26-8a-105, Department Powers, states that the department shall: "(4) adopt rules...to: (a) license ambulance providers and paramedic providers; (b) permit ambulances and emergency response vehicles; (c) establish application, submissions, and procedural requirements for licenses, designations, certificates, and permits; and (d) establish and implement the programs, plans, and responsibilities as specified in other sections of this chapter."

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: Public comment has received has been the basis for amending Rule R426-15. Changes have been suggested through task force input, subcommittee approval, the Emergency Medical Services (EMS) Committee, and by the Department.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The rule defines the criteria for licensed and designated providers. Criteria defines the type of service, consistency, quality, and ensures public safety. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HEALTH
HEALTH SYSTEMS IMPROVEMENT,
EMERGENCY MEDICAL SERVICES
3760 S HIGHLAND DR
SALT LAKE CITY, UT 84106
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Guy Dansie by phone at 801-273-6671, by FAX at 801-273-4165, or by Internet E-mail at gdansie@utah.gov

AUTHORIZED BY: David Sundwall, Executive Director

EFFECTIVE: 07/28/2009

Health, Health Systems Improvement, Emergency Medical Services
R426-16
Emergency Medical Service Ambulance Rates and Charges

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

DAR FILE NO.: 32849
FILED: 7/28/09 2:37 PM

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Section 26-8a-105, Department Powers, states that the department shall: "(4) adopt rules...to: (a) license ambulance providers and paramedic providers; (b) permit ambulances and emergency response vehicles; (c) establish application, submissions, and procedural requirements for licenses, designations, certificates, and permits; and (d) establish and implement the programs, plans, and responsibilities as specified in other sections of this chapter."

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: Public comment usually reflects rates should be lower. Fiscal reporting and comment from agencies indicate the rates are fair. Changes have been suggested and included as part of the amendment process as directed by the department based on past comments, and amendments to the actual rates and charges will continue to be made as economic factors change.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The rule is a basis for establishing statewide maximum rates and charges for ambulance and paramedic services. The process for fair and equitable rates is used by

the Department for this purpose. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HEALTH
HEALTH SYSTEMS IMPROVEMENT,
EMERGENCY MEDICAL SERVICES
3760 S HIGHLAND DR
SALT LAKE CITY, UT 84106
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO: ♦ Guy Dansie by phone at 801-273-6671, by FAX at 801-273-4165, or by Internet E-mail at gdansie@utah.gov

AUTHORIZED BY: David Sundwall, Executive Director

EFFECTIVE: 07/28/2009

Human Services, Recovery Services
R527-38
Unenforceable Cases

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 32844
FILED: 7/28/09 10:03 AM

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Federal regulations at 45 CFR 303.11 provide detailed case closure criteria for IV-D agencies. This criteria has been adopted by the Office of Recovery Services/Child Support Services (ORS/CSS) and incorporated by reference into rule. This rule is enacted under Section 62A-11-107, which authorizes the ORS/CSS to adopt, amend, and enforce rules necessary to carry out its necessary duties including closure of cases under appropriate circumstances.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No comments have been received.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The federally mandated case closure criteria is still in effect and does not appear in state statute, so the rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HUMAN SERVICES
RECOVERY SERVICES
515 E 100 S
SALT LAKE CITY, UT 84102-4211
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO: ♦ LeAnn Wilber by phone at 801-536-8950, by FAX at 801-536-8833, or by Internet E-mail at lwilber@utah.gov

AUTHORIZED BY: Mark Brasher, Director

EFFECTIVE: 07/28/2009

Public Safety, Homeland Security
R704-1
Search and Rescue Financial Assistance Program

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 32854
FILED: 7/29/09 2:35 PM

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: This rule is authorized by Subsection 53-2-107(7) which provides that the Division of Homeland Security, with the approval of the Search and Rescue Advisory Board, shall make rules consistent with the Homeland Security Act.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: The agency has not received any written comments regarding the rule either supporting or opposing the rule.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The rule should be continued because it is required by Subsection 53-2-107(7) and there have been no

written comments received since the last five-year review of the rule from interested persons opposing the rule.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

PUBLIC SAFETY
HOMELAND SECURITY
ROOM 1110 STATE OFFICE BUILDING
450 N STATE ST
SALT LAKE CITY, UT 84114-1201
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Kris Hamlet by phone at 801-538-9953, by FAX at 801-538-3770, or by Internet E-mail at khamlet@utah.gov

AUTHORIZED BY: Keith Squires, Deputy Commissioner

EFFECTIVE: 07/29/2009

End of the Five-Year Notices of Review and Statements of Continuation Section

NOTICES OF
RULE EFFECTIVE DATES

After a PROPOSED RULE or a CHANGE IN PROPOSED RULE has been published, and after any comment period has ended, the agency promulgating the rule may notify the Division of Administrative Rules of the effective date of the rule. A NOTICE OF EFFECTIVE DATE may provide for an effective date that after the public comment period designated by the agency, no fewer than 31 days nor more than 120 days from the publication date. Failure to file a NOTICE OF EFFECTIVE DATE within 120 days from its publication results in the rule lapsing and the agency must start the publication process over.

NOTICES OF EFFECTIVE DATE are governed by Subsection 63G-3-301(9), and Subsection R15-4-5.

Abbreviations
AMD = Amendment
CPR = Change in Proposed Rule
NEW = New Rule
R&R = Repeal & Reenact
REP = Repeal

Commerce
Occupational and Professional Licensing
No. 32680 (AMD): R156-70a. Physician Assistant Practice Act Rules
Published: 06/15/2009
Effective: 07/23/2009

No. 32675 (AMD): R156-71. Naturopathic Physician Practice Act Rule
Published: 06/15/2009
Effective: 07/23/2009

Health
Health Care Financing, Coverage and Reimbursement Policy
No. 32688 (REP): R414-7D. Intermediate Care Facility for the Mentally Retarded Transition Project
Published: 06/15/2009
Effective: 07/22/2009

No. 32660 (AMD): R414-60B-4. Service Coverage
Published: 06/01/2009
Effective: 07/22/2009

No. 32666 (AMD): R414-303-10. Refugee Medicaid
Published: 06/01/2009
Effective: 07/22/2009

Health Systems Improvement, Emergency Medical Services
No. 32689 (AMD): R426-12. Emergency Medical Services Training and Certification Standards
Published: 06/15/2009
Effective: 07/29/2009

Human Services
Aging and Adult Services
No. 32654 (R&R): R510-104. Nutrition Programs for the Elderly (NPE)
Published: 06/01/2009
Effective: 07/21/2009

Natural Resources
Wildlife Resources
No. 32677 (AMD): R657-5. Taking Big Game
Published: 06/15/2009
Effective: 07/27/2009

No. 32678 (AMD): R657-60. Aquatic Invasive Species Interdiction
Published: 06/15/2009
Effective: 07/27/2009

End of the Notices of Rule Effective Dates Section

RULES INDEX
BY AGENCY (CODE NUMBER)
AND
BY KEYWORD (SUBJECT)

The Rules Index is a cumulative index that reflects all effective changes to Utah's administrative rules. The current Index lists changes made effective from January 2, 2009, including notices of effective date received through July 31, 2009. The Rules Index is published in the Utah State Bulletin and in the annual Index of Changes. Nonsubstantive changes, while not published in the Bulletin, do become part of the Utah Administrative Code (Code) and are included in this Index, as well as 120-Day (Emergency) rules that do not become part of the Code. The rules are indexed by Agency (Code Number) and Keyword (Subject).

DAR NOTE: The index is not included in this issue of the Utah State Bulletin. The release of eRules version 2.0 has introduced different functionality with regards to the index; this functionality has yet to be fully tested. Persons interested in alternative methods of acquiring the same information should visit "Researching Administrative Rules" at: http://www.rules.utah.gov/research.htm

Questions regarding the index and the information it contains should be addressed to Nancy Lancaster (801-538-3218), Mike Broschinsky (801-538-3003), or Kenneth A. Hansen (801-538-3777).

A copy of the Rules Index is available for public inspection at the Division of Administrative Rules (4120 State Office Building, Salt Lake City, UT), or may be viewed online at the Division’s web site (http://www.rules.utah.gov/).