UTAH STATE BULLETIN

OFFICIAL NOTICES OF UTAH STATE GOVERNMENT
Filed October 16, 2013, 12:00 a.m. through November 01, 2013, 11:59 p.m.

Number 2013-22
November 15, 2013

Nancy L. Lancaster, Editor
Kenneth A. Hansen, Director
Kimberly K. Hood, Executive Director

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, PO Box 141007, Salt Lake City, Utah 84114-1007, telephone 801-538-3764. 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.
Semimonthly.
1. Delegated legislation--Utah--Periodicals. 2. Administrative procedure--Utah--Periodicals.
I. Utah. Office of Administrative Rules.

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SPECIAL NOTICES

Commerce
Occupational and Professional Licensing

Public Notice of 2014 Board and Committee Meeting Schedules

NOTE: Meetings are subject to change - contact the Division at 801-530-6628 to confirm meetings or check the Public Meeting Notice website (www.pmn.utah.gov). Most meetings are held in the Heber M. Wells Building, 160 East 300 South, Salt Lake City, Utah (updated October 22, 2013).

January
2 Nursing Education Peer Advisory Committee 8:30 a.m.
2 Alarm System Security and Licensing Board 9:00 a.m.
2 Hearing Instrument Specialist Licensing Board 9:00 a.m.
2 UBCC Plumbing Advisory Committee 9:00 a.m.
2 UBCC Structural Advisory Committee 3:00 p.m.
7 Psychologist Licensing Board 9:00 a.m.
7 Unified Code Analysis Council 9:00 a.m.
8 Residence Lien Recovery Fund Advisory Board 8:15 a.m.
8 Podiatric Physician Licensing Board 8:30 a.m.
8 Plumbers Licensing Board 9:00 a.m.
8 Uniform Building Code Commission 9:00 a.m.
8 Utah Board of Accountancy 1:30 p.m.
9 Board of Nursing 8:30 a.m.
9 Chiropractic Physician Licensing Board 9:00 a.m.
9 Radiology Technologist Licensing Board 1:00 p.m.
9 UBCC Electrical Advisory Committee 1:00 p.m.
14 UBCC Architectural Advisory Committee 9:00 a.m.
14 UBCC Mechanical Advisory Committee 1:00 p.m.
14 Controlled Substance Advisory Committee 4:00 p.m.
15 Professional Engineers and Professional Land Surveyors Licensing Board 9:00 a.m.
15 Speech-Language Pathology and Audiology Licensing Board 9:00 a.m.
15 Physicians Licensing Board 9:00 a.m.
16 Electricians Licensing Board 9:00 a.m.
16 Veterinary Licensing Board 9:00 a.m.
21 Board of Massage Therapy 9:00 a.m.
21 Acupuncture Licensing Board 9:00 a.m.
21 UBCC Education Advisory Committee 1:00 p.m.
21 Hunting Guides and Outfitters Licensing Board 1:00 p.m.
22 Substance Use Disorder Counselor Licensing Board 9:00 a.m.
22 Vocational Rehabilitation Counselor Licensing Board 2:00 p.m.
23 Contract Security Education Peer Committee 10:00 a.m.
28 Occupational Therapy Licensing Board 9:00 a.m.
28 Utah State Board of Pharmacy 8:30 a.m.
28 Optometrist Licensing Board 9:00 a.m.
29 Construction Services Commission 9:00 a.m.

February
4 Unified Code Analysis Council 9:00 a.m.
4 Certified Nurse Midwife Board 2:00 p.m.
5 Plumbers Licensing Board 9:00 a.m.
5 Utah Board of Accountancy 1:30 p.m.
6 Nursing Education Peer Advisory Committee 8:30 a.m.
6 Social Worker Licensing Board 9:00 a.m.
6 UBCC Plumbing Advisory Committee 9:00 a.m.
6 UBCC Structural Advisory Committee 3:00 p.m.
11 Online Prescribing, Dispensing and Facilitation Licensing Board 8:00 a.m.
11 UBCC Architectural Advisory Committee 9:00 a.m.

11 UBCC Mechanical Advisory Committee 1:00 p.m.
12 Residence Lien Recovery Fund Advisory Board 8:15 a.m.
12 Uniform Building Code Commission 9:00 a.m.
12 Architects Licensing Board 10:00 a.m.
13 Board of Nursing 8:30 a.m.
13 Security Services Licensing Board 9:00 a.m.
13 Osteopathic Physician and Surgeon's Licensing Board 9:00 a.m.
13 Professional Geologists Licensing Board 10:00 a.m.
13 UBCC Electrical Advisory Committee 1:00 p.m.
18 UBCC Education Advisory Committee 1:00 p.m.
19 Physicians Licensing Board 9:00 a.m.
19 Board of Funeral Service 9:00 a.m.
20 Electricians Licensing Board 9:00 a.m.
25 Utah State Board of Pharmacy 8:30 a.m.
25 Health Facility Administrator Licensing Board 9:00 a.m.
26 Construction Services Commission 9:00 a.m.

March
3 Barbering, Cosmetology/Barbering, Esthetics, Electrology and Nail Technology Licensing Board 9:00 a.m.
4 Unified Code Analysis Council 9:00 a.m.
5 Plumbers Licensing Board 9:00 a.m.
5 Utah Board of Accountancy 1:30 p.m.
6 Dentist and Dental Hygienist Licensing Board 8:00 a.m.
6 Nursing Education Peer Advisory Committee 8:30 a.m.
6 Alarm System Security and Licensing Board 9:00 a.m.
6 UBCC Plumbing Advisory Committee 9:00 a.m.
6 UBCC Structural Advisory Committee 3:00 p.m.
11 UBCC Architectural Advisory Committee 9:00 a.m.
11 UBCC Mechanical Advisory Committee 1:00 p.m.
11 Controlled Substance Advisory Committee 4:00 p.m.
12 Residence Lien Recovery Fund Advisory Board 8:15 a.m.
12 Uniform Building Code Commission 9:00 a.m.
13 Board of Nursing 8:30 a.m.
13 Radiology Technologist Licensing Board 1:00 p.m.
13 UBCC Electrical Advisory Committee 1:00 p.m.
14 Marriage and Family Therapist Licensing Board 9:00 a.m.
17 Physician Assistant Licensing Board 8:30 a.m.
18 Physical Therapy Licensing Board 9:00 a.m.
18 Board of Massage Therapy 9:00 a.m.
18 Clinical Mental Health Counselor Licensing Board 9:00 a.m.
18 Respiratory Therapy Licensing Board 9:00 a.m.
18 Building Inspector Licensing Board 10:00 a.m.
18 UBCC Education Advisory Committee 1:00 p.m.
19 Physicians Licensing Board 9:00 a.m.
19 Professional Engineers and Professional Land Surveyors Licensing Board 9:00 a.m.
19 Deception Detection Examiners Board 1:00 p.m.
20 Electricians Licensing Board 9:00 a.m.
25 Utah State Board of Pharmacy 8:30 a.m.
26 Construction Services Commission 9:00 a.m.

April
1 Unified Code Analysis Council 9:00 a.m.
2 Plumbers Licensing Board 9:00 a.m.
2 Utah Board of Accountancy 1:30 p.m.
3 Nursing Education Peer Advisory Committee 8:30 a.m.
3 Hearing Instrument Specialist Licensing Board 9:00 a.m.
3 UBCC Plumbing Advisory Committee 9:00 a.m.
3 UBCC Structural Advisory Committee 3:00 p.m.
7 Board of Recreational Therapy 8:00 a.m.

8 UBCC Architectural Advisory Committee 9:00 a.m.
8 UBCC Mechanical Advisory Committee 1:00 p.m.
9 Residence Lien Recovery Fund Advisory Board 8:15 a.m.
9 Podiatric Physician Licensing Board 8:30 a.m.
9 Uniform Building Code Commission 9:00 a.m.
9 Architects Licensing Board 10:00 a.m.
10 Board of Nursing 8:30 a.m.
10 Social Worker Licensing Board 9:00 a.m.
10 Security Services Licensing Board 9:00 a.m.
10 Chiropractic Physician Licensing Board 9:00 a.m.
10 UBCC Electrical Advisory Committee 1:00 p.m.
15 Psychologist Licensing Board 9:00 a.m.
15 Occupational Therapy Licensing Board 9:00 a.m.
15 UBCC Education Advisory Committee 1:00 p.m.
15 Hunting Guides and Outfitters Licensing Board 1:00 p.m.
16 Physicians Licensing Board 9:00 a.m.
16 Landscape Architects Licensing Board 1:00 p.m.
17 Electricians Licensing Board 9:00 a.m.
17 Certified Court Reporters Board 2:00 p.m.
22 Utah State Board of Pharmacy 8:30 a.m.
22 Athletic Trainers Licensing Board 9:00 a.m.
24 Genetic Counselor Licensing Board 9:00 a.m.
25 Substance Use Disorder Counselor Licensing Board 9:00 a.m.
28 Environmental Health Scientist Board 9:00 a.m.
29 Optometrist Licensing Board 9:00 a.m.
30 Construction Services Commission 9:00 a.m.

May
1 Nursing Education Peer Advisory Committee 8:30 a.m.
1 Alarm System Security and Licensing Board 9:00 a.m.
1 UBCC Plumbing Advisory Committee 9:00 a.m.
1 UBCC Structural Advisory Committee 3:00 p.m.
6 Unified Code Analysis Council 9:00 a.m.
6 Certified Nurse Midwife Board 2:00 p.m.
7 Plumbers Licensing Board 9:00 a.m.
7 Utah Board of Accountancy 1:30 p.m.
8 Board of Nursing 8:30 a.m.
8 Osteopathic Physician and Surgeon's Licensing Board 9:00 a.m.
8 Naturopathic Physician Licensing Board 9:00 a.m.
8 UBCC Electrical Advisory Committee 1:00 p.m.
13 Online Prescribing, Dispensing and Facilitation Licensing Board 8:00 a.m.
13 UBCC Architectural Advisory Committee 9:00 a.m.
13 UBCC Mechanical Advisory Committee 1:00 p.m.
14 Residence Lien Recovery Fund Advisory Board 8:15 a.m.
14 Uniform Building Code Commission 9:00 a.m.
14 Vocational Rehabilitation Counselor Licensing Board 2:00 p.m.
15 Dietitian Board 9:00 a.m.
15 Contract Security Education Peer Committee 10:00 a.m.
20 Board of Massage Therapy 9:00 a.m.
20 UBCC Education Advisory Committee 1:00 p.m.
20 Controlled Substance Advisory Committee 4:00 p.m.
21 Physicians Licensing Board 9:00 a.m.
21 Professional Engineers and Professional Land Surveyors Licensing Board 9:00 a.m.
21 Board of Funeral Service 9:00 a.m.
22 Electricians Licensing Board 9:00 a.m.
27 Utah State Board of Pharmacy 8:30 a.m.
28 Construction Services Commission 9:00 a.m.

June
2 Barbering, Cosmetology/Barbering, Esthetics, Electrology and Nail Technology Licensing Board 9:00 a.m.
3 Unified Code Analysis Council 9:00 a.m.
4 Plumbers Licensing Board 9:00 a.m.
4 Utah Board of Accountancy 1:30 p.m.
5 Nursing Education Peer Advisory Committee 8:30 a.m.
5 Social Worker Licensing Board 9:00 a.m.
5 Veterinary Licensing Board 9:00 a.m.
5 UBCC Plumbing Advisory Committee 9:00 a.m.
5 UBCC Structural Advisory Committee 3:00 p.m.
10 UBCC Architectural Advisory Committee 9:00 a.m.
10 UBCC Mechanical Advisory Committee 1:00 p.m.
11 Residence Lien Recovery Fund Advisory Board 8:15 a.m.
11 Uniform Building Code Commission 9:00 a.m.
11 Architects Licensing Board 10:00 a.m.
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12 Board of Nursing 8:30 a.m.
12 Security Services Licensing Board 9:00 a.m.
12 Professional Geologists Licensing Board 10:00 a.m.
12 UBCC Electrical Advisory Committee 1:00 p.m.
13 Marriage and Family Therapist Licensing Board 9:00 a.m.
16 Physician Assistant Licensing Board 8:30 a.m.
17 Clinical Mental Health Counselor Licensing Board 9:00 a.m.
17 Physical Therapy Licensing Board 9:00 a.m.
17 Respiratory Therapy Licensing Board 9:00 a.m.
17 Building Inspector Licensing Board 10:00 a.m.
17 UBCC Education Advisory Committee 1:00 p.m.
18 Physicians Licensing Board 9:00 a.m.
19 Electricians Licensing Board 9:00 a.m.
19 Private Probation Provider Licensing Board 10:00 a.m.
24 Utah State Board of Pharmacy 8:30 a.m.
25 Construction Services Commission 9:00 a.m.

July
1 Hearing Instrument Specialist Licensing Board 9:00 a.m.
1 Unified Code Analysis Council 9:00 a.m.
2 Plumbers Licensing Board 9:00 a.m.
2 Utah Board of Accountancy 1:30 p.m.
3 Nursing Education Peer Advisory Committee 8:30 a.m.
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15 Board of Massage Therapy 9:00 a.m.
15 Psychologist Licensing Board 9:00 a.m.
15 Occupational Therapy Licensing Board 9:00 a.m.
15 Acupuncture Licensing Board 9:00 a.m.
15 UBCC Education Advisory Committee 1:00 p.m.
16 Physicians Licensing Board 9:00 a.m.
16 Professional Engineers and Professional Land Surveyors Licensing Board 9:00 a.m.
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17 Electricians Licensing Board 9:00 a.m.
17 Contract Security Education Peer Committee 10:00 a.m.
22 Utah State Board of Pharmacy 8:30 a.m.
23 Substance Use Disorder Counselor Licensing Board 9:00 a.m.
29 Optometrist Licensing Board 9:00 a.m.
30 Construction Services Commission 9:00 a.m.

August
5 Unified Code Analysis Council 9:00 a.m.
5 Hunting Guides and Outfitters Licensing Board 1:00 p.m.
5 Certified Nurse Midwife Board 2:00 p.m.
6 Physicians Licensing Board 9:00 a.m.
6 Plumbers Licensing Board 9:00 a.m.
6 Utah Board of Accountancy 1:30 p.m.
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21 Electricians Licensing Board 9:00 a.m.
26 Utah State Board of Pharmacy 8:30 a.m.
26 Health Facility Administrator Licensing Board 9:00 a.m.
27 Construction Services Commission 9:00 a.m.

September
2 Unified Code Analysis Council 9:00 a.m.
2 Controlled Substance Advisory Committee 4:00 p.m.
3 Plumbers Licensing Board 9:00 a.m.
3 Utah Board of Accountancy 1:30 p.m.
4 Dentist and Dental Hygienist Licensing Board 8:00 a.m.
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16 Clinical Mental Health Counselor Licensing Board 9:00 a.m.
16 Respiratory Therapy Licensing Board 9:00 a.m.
16 Physical Therapy Licensing Board 9:00 a.m.

16 Building Inspector Licensing Board 10:00 a.m.
16 UBCC Education Advisory Committee 1:00 p.m.
17 Physicians Licensing Board 9:00 a.m.
17 Professional Engineers and Professional Land Surveyors Licensing Board 9:00 a.m.
17 Deception Detection Examiners Board 1:00 p.m.
17 Vocational Rehabilitation Counselor Licensing Board 2:00 p.m.
18 Electricians Licensing Board 9:00 a.m.
23 Utah State Board of Pharmacy 8:30 a.m.
24 Construction Services Commission 9:00 a.m.

October
1 Plumbers Licensing Board 9:00 a.m.
1 Utah Board of Accountancy 1:30 p.m.
2 Nursing Education Peer Advisory Committee 8:30 a.m.
2 Social Worker Licensing Board 9:00 a.m.
2 Hearing Instrument Specialist Licensing Board 9:00 a.m.
2 Veterinary Licensing Board 9:00 a.m.
2 UBCC Plumbing Advisory Committee 9:00 a.m.
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14 UBCC Mechanical Advisory Committee 1:00 p.m.
15 Physicians Licensing Board 9:00 a.m.
15 Landscape Architects Licensing Board 1:00 p.m.
16 Electricians Licensing Board 9:00 a.m.
16 Certified Court Reporters Board 2:00 p.m.
21 Occupational Therapy Licensing Board 9:00 a.m.
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28 Utah State Board of Pharmacy 8:30 a.m.
28 Optometrist Licensing Board 9:00 a.m.
28 Athletic Trainers Licensing Board 9:00 a.m.
29 Construction Services Commission 9:00 a.m.

November
4 Online Prescribing, Dispensing and Facilitation Licensing Board 8:00 a.m.
4 Unified Code Analysis Council 9:00 a.m.
5 Plumbers Licensing Board 9:00 a.m.
5 Utah Board of Accountancy 1:30 p.m.
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18 Hunting Guides and Outfitters Licensing Board 1:00 p.m.
18 Certified Nurse Midwife Board 2:00 p.m.
19 Physicians Licensing Board 9:00 a.m.
19 Naturopathic Physician Licensing Board 9:00 a.m.
19 Professional Engineers and Professional Land Surveyors Licensing Board 9:00 a.m.
19 Board of Funeral Service 9:00 a.m.
20 Electricians Licensing Board 9:00 a.m.
20 Contract Security Education Peer Committee 10:00 a.m.
25 Utah State Board of Pharmacy 8:30 a.m.
26 Construction Services Commission 9:00 a.m.

December
1 Barbering, Cosmetology/Barbering, Esthetics, Electrology and Nail Technology Licensing Board 9:00 a.m.
2 Unified Code Analysis Council 9:00 a.m.
3 Plumbers Licensing Board 9:00 a.m.
3 Utah Board of Accountancy 1:30 p.m.
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16 Utah State Board of Pharmacy 8:30 a.m.
16 Physical Therapy Licensing Board 9:00 a.m.
16 Respiratory Therapy Licensing Board 9:00 a.m.
16 Clinical Mental Health Counselor Licensing Board 9:00 a.m.
16 Building Inspector Licensing Board 10:00 a.m.
16 UBCC Education Advisory Committee 1:00 p.m.
16 Physicians Licensing Board 9:00 a.m.
18 Electricians Licensing Board 9:00 a.m.
18 Private Probation Provider Licensing Board 10:00 a.m.
31 Construction Services Commission 9:00 a.m.

Environmental Quality
Air Quality

Notice of Public Comment Period for Wildfire Exceptional Event: Event Dates August 7 and 8, 2012

Federal regulations, 40 Code of Federal Regulations (CFR) Part 50, allow states to exclude air quality data that exceed or violate a National Ambient Air Quality Standard (NAAQS) if they can demonstrate that an "exceptional event" has caused the

exceedance or violation. Exceptional events are unusual or naturally occurring events that can affect air quality but are not reasonably controllable or preventable using techniques implemented to attain and maintain the NAAQS.

Exceptional events may be caused by human activity that is unlikely to recur at a particular location, or may be due to a natural event. The Environmental Protection Agency (EPA) defines a "natural event" as an event in which human activity plays little or no direct causal role to the event in question. For example, a natural event could include such things as high winds, wild fires, and seismic/volcanic activity. In addition, the EPA will allow states to exclude data from regulatory determinations on a case-by-case basis for monitoring stations that measure values that exceed or violate the NAAQS due to emissions from fireworks displays from cultural events.

Federal regulations (40 CFR Part 50.14 (c) (3)(i)) require that all relevant flagged data, the reasons for the data being flagged, and a demonstration that the flagged data are caused by exceptional events be made available by the state for 30 days of public review and comment. These comments will be considered in the final demonstration of the event that is submitted to EPA.

On August 7 and 8, 2012, the Beach monitoring station recorded ozone levels that exceeded the NAAQS due to smoke from western wildfires:

Date	**Ozone (ppb)**	**Standard (ppb)**
8/7/2012	82.1	75
8/8/2012	83	75

The documentation for public review and comment to support removing these data from use in regulatory determinations will be available beginning November 15, 2013, at: www.airquality.utah.gov\Public-Interest\Public-Commen-Hearings\Exceptional_Events\Exceptional_Events.htm or at the Multi-Agency State Office Building, 195 North 1950 West in Salt Lake City.

In compliance with the American with Disabilities Act, individuals with special needs (including auxiliary communicative aids and services) should contact Brooke Baker, Office of Human Resources at 801-536-4412 (TDD 536-4414).

The comment period will close at 5:00 p.m. on December 16, 2013. Comments postmarked on or before that date will be accepted. Comments may be submitted by electronic mail to jkarmazyn@utah.gov or may be mailed to: Joel Karmazyn, Utah Division of Air Quality, PO Box 144820, 195 N 1950 W, Salt Lake City, UT 84114-4820.

Health
Health Care Financing, Coverage and Reimbursement Policy

Notice for December 2013 Medicaid Rate Changes

Effective December 1, 2013, Utah Medicaid will adjust its rates consistent with approved methodologies. Rate adjustments include new codes priced consistent with approved Medicaid methodologies as well as potential adjustments to existing codes. 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

EXECUTIVE DOCUMENTS

As part of his or her constitutional duties, the Governor periodically issues **Executive Documents** comprised of Executive Orders, Proclamations, and Declarations. "Executive Orders" set policy for the Executive Branch; create boards and commissions; provide for the transfer of authority; or otherwise interpret, implement, or give administrative effect to a provision of the Constitution, state law or executive policy. "Proclamations" call special or extraordinary legislative sessions; designate classes of cities; publish states-of-emergency; promulgate other official formal public announcements or functions; or publicly avow or cause certain matters of state government to be made generally known. "Declarations" designate special days, weeks or other time periods; call attention to or recognize people, groups, organizations, functions, or similar actions having a public purpose; or invoke specific legislative purposes (such as the declaration of an agricultural disaster).

The Governor's Office staff files **Executive Documents** that have legal effect with the Division of Administrative Rules for publication and distribution. All orders issued by the Governor not in conflict with existing laws have the full force and effect of law during a state of emergency when a copy of the order is filed with the Division of Administrative Rules. (See Section 63K-4-401).

Governor's Executive Order EO/010/2013: Lieutenant Governor's State Building Ownership Authority Powers

EXECUTIVE ORDER

Lieutenant Governor's State Building Ownership Authority Powers

I, GARY R. HERBERT, GOVERNOR OF THE STATE OF UTAH, AUTHORIZE Lieutenant Governor Spencer J. Cox to sign State Building Ownership Authority documents for me, vote on my behalf as a member of the Authority, and act in all other respects as my agent and proxy on the authority. The State Building Ownership Authority is created by Section 63B-1-304, Utah Code Annotated 1953, as amended.

IN TESTIMONY, WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Utah this 29th day of October 2013.

(State Seal)

Gary R. Herbert
Governor

ATTEST:

Spencer J. Cox
Lieutenant Governor

EO/010/2013

Governor's Executive Order EO/011/2013: Lieutenant Governor's State Bonding Commission Powers

EXECUTIVE ORDER

Lieutenant Governor's State Bonding Commission Powers

I, GARY R. HERBERT, GOVERNOR OF THE STATE OF UTAH, AUTHORIZE Lieutenant Governor Spencer J. Cox to sign State Bonding Commission documents for me, vote on my behalf as a Member of the Commission, to act in all other respects as my agent and proxy on the Commission. The State Bonding Commission is created by Section 63B-1-201, Utah Code Annotated 1953, as amended.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Utah this 29th day of October 2013.

(State Seal)

Gary R. Herbert
Governor

ATTEST:

Spencer J. Cox
Lieutenant Governor

EO/011/2013

End of the Executive Documents 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 October 16, 2013, 12:00 a.m., and November 01, 2013, 11:59 p.m. are included in this, the November 15, 2013 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 December 16, 2013. 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 March 15, 2014, 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; 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

Administrative Services, Archives
R17-6-3
Records Storage and Disposal -- Archives Responsibility

NOTICE OF PROPOSED RULE

(Amendment)
DAR FILE NO.: 38062
FILED: 10/16/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The reference to a period of time such as less than 100 years is deleted as not essential to the definition of semi-active records. Regardless of the period of retention, records may be stored at the Records Center and then either destroyed or moved to the Archives if they are to be kept permanently. If the Records Center is unable to locate an authorized agency or if an agency is obsolete, the records will become the official custody of the Archives and the State Archivist will determine the disposition of the records.

SUMMARY OF THE RULE OR CHANGE: This rule summarizes the responsibilities of the State Archives with regards to the storage and disposition of the records created and maintained by governmental entities. The records are governed by approved retention schedules. Creating agencies have a responsibility to authorize destruction of the records in accordance with approved retention schedules or to accept their maintenance. Lacking authorization from the creating agency or if the Records Center cannot locate an authorized agency, or if an agency has become obsolete, the records become the custody of the Utah State Archives and the State Archivist will determine their disposition.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 63A-12-101

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: The state budget is not affected by these changes. The Records Center functions under the State Archives and stores semi-active records from agencies and governmental entities throughout the state regardless of changes to the storage and disposal of the records of particular agencies.
♦ LOCAL GOVERNMENTS: Local governments may use the storage facilities of the Records Center in the same way as has been possible before the change in the rule. The change defines the responsibility of the State Archives to assume responsibility for the records when an authorizing agency is lacking.
♦ SMALL BUSINESSES: Small businesses are not affected by the rule change. Because these are not substantive changes, are clarifying only, and because they had no original business impact, there will be no impact to business with any of these changes.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Persons are not affected by the rule change. Because these are not substantive changes, are clarifying only, and because they had no original impact, there will be no impact to persons as a result of these changes.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs for affected persons. Because these are not substantive changes, are clarifying only, and because there were no original costs associated with the rule, there will be no costs for affected persons with these changes.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: I have reviewed the changes and agree there is no impact to business.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ADMINISTRATIVE SERVICES
ARCHIVES
346 S RIO GRANDE
SALT LAKE CITY, UT 84101-1106
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Susan Mumford by phone at 801-531-3861, by FAX at 801-531-3867, or by Internet E-mail at smumford@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 12/23/2013

AUTHORIZED BY: Kimberly Hood, Executive Director

R17. Administrative Services, Archives and Records Service.
R17-6. Records Storage and Disposal at the State Records Center.
R17-6-1. Authority and Purpose.

In accordance with Subsection 63A-12-104(1), this rule establishes a procedure for the storage and disposal of records at the State Records Center.

R17-6-2. Records Storage and Disposal -- Agency Responsibility.

(1) An agency may transfer semi-active records to the Records Center for storage.

(2) Prior to transfer, the agency must verify that records have a State Archives record series number, an approved retention schedule, and have met all in office retention requirements.

(3) Records stored in the State Records Center remain in the official custody of the agency that transferred them.

(4) In the event that an agency has not transferred records to the Records Center, it is the agency's responsibility to manage, maintain, and destroy records in its custody in accordance with the records series' approved retention schedule and to document the records destruction.

R17-6-3. Records Storage and Disposal -- Archives Responsibility.

(1) The State Archives stores semi-active records[~~ with a scheduled retention of less than 100 years~~] at the State Records Center in accordance with the approved retention schedule. The State Records Center may accept records for which a proposed retention has been presented to the State Records Committee with the provision that if the committee does not approve the retention, the records will be returned to the agency.

(2) The State Archives destroys records stored at the Records Center in accordance with the approved retention schedule and upon authorization from the creating agency. If the creating agency does not respond to the second request for authorized destruction within ninety (90) days, the records may be returned to the agency.

(3) In the event that a record has met its scheduled retention requirements and the Records Center is unable to locate an authorized agency to provide destruction approval or the agency is obsolete, the records will become the official custody of the Utah State Archives and the State [~~a~~]Archivist will determine the disposition of the records.

KEY: records retention, public information, access to information
Date of Enactment or Last Substantive Amendment: [~~August 20, 2008~~]2013
Notice of Continuation: May 17, 2013
Authorizing, and Implemented or Interpreted Law: 63A-12-104

Administrative Services, Archives
R17-8-2
Micrographic Standards

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38064
FILED: 10/16/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of the amendment is to clarify the language of Subsection R17-8-2(3). The statement that "The State Archives is the official custodian of all master microfilm" does not gain clarity by the addition of the phrase "of permanent and long term records". In fact, the Archives is the custodian of all microfilm masters regardless of the approved retention of the records. Therefore the qualifying phrase is deleted and the statement stands.

SUMMARY OF THE RULE OR CHANGE: The change is meant to clarify that the State Archives is the custodian of all master microfilm regardless of the retention of the original records.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 63A-12-101

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: The state budget is not affected by this change. Because these are not substantive changes, are clarifying only, and because they had no original impact on the state budget, there will be no impact to the budget with these changes.
♦ LOCAL GOVERNMENTS: Local government is not affected by the change. Because these are not substantive changes, are clarifying only, and because they had no original impact on local government, there will be no impact to local government with these changes.
♦ SMALL BUSINESSES: Small business is not affected by the change. Because these are not substantive changes, are clarifying only, and because they had no original business impact, there will be no impact to business with these changes.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Persons are not affected by the change. Because these are not substantive changes, are clarifying only, and because they had no original impact on persons, there will be no impact to persons with these changes.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs associated with this change. Because these are not substantive changes, are clarifying only, and because there were no compliance costs associated with the rule originally, there will be no impact or costs with these changes.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: I have reviewed the changes and agree there is no impact to business.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ADMINISTRATIVE SERVICES
ARCHIVES
346 S RIO GRANDE
SALT LAKE CITY, UT 84101-1106
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Susan Mumford by phone at 801-531-3861, by FAX at 801-531-3867, or by Internet E-mail at smumford@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 12/23/2013

AUTHORIZED BY: Kimberly Hood, Executive Director

R17. Administrative Services, Archives and Records Service.
R17-8. Application of Microfilm Standards.
R17-8-1. Authority and Purpose.

In accordance with Subsection 63A-12-104(1), this rule establishes a procedure for the microfilming standards of permanent and long-term records.

R17-8-2. Micrographic Standards.

(1) Anyone microfilming Utah state and local government documents for retention purposes shall microfilm these records in conformity with the ANSI/AIIM Imaging Guidelines 2004, which are incorporated by reference.

(2) The State Archives must certify that each roll of microfilm complies with these Imaging Guidelines prior to the destruction of the original records.

(3) The State Archives is the official custodian of all master microfilm[~~ of permanent and long-term records~~].

(4) Access to microfilmed records is permitted in accordance with the approved retention and classification for the records series.

KEY: records retention, public information, access to information
Date of Enactment or Last Substantive Amendment: [~~August 20, 2008~~|2013
Notice of Continuation: May 17, 2013
Authorizing, and Implemented or Interpreted Law: 63A-12-104

Administrative Services, Fleet Operations
R27-7-3
Driver Eligibility to Operate a State Vehicle

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38073
FILED: 10/24/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The changes noted below to Section R27-7-3 highlight the shift to focus on just the risk to the State of Utah by employees driving state-owned vehicles.

SUMMARY OF THE RULE OR CHANGE: Changes Subsection R27-7-3(3)(b) to read: "(b) The authorized driver has 3 or more moving violations while driving a state vehicle within a 12 month period; or". The intent of the language is to reduce the scope of examination by the State of Utah Driver Eligibility Board, to only those moving violations incurred by state employees while driving a State of Utah vehicle, and not those violations that are incurred while state employees are driving their personal vehicles.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 63A-9-401(1)(d)

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: Because the new language eliminates time and effort to review violations related to personal time and personal vehicles, there may be a limited, and undetermined, benefit to the state budget.
♦ LOCAL GOVERNMENTS: This rule only deals with state employees driving State of Utah vehicles; local governments are not affected.
♦ SMALL BUSINESSES: This rule only deals with state employees driving State of Utah vehicles; small businesses are not affected.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: This rule only deals with state employees driving State of Utah vehicles; no other persons or entities outside state government are affected.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no known costs to the State of Utah or other persons or entities outside of state government, for any type of compliance related to the proposed language.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The rule only affects state vehicle use by a state employee and will not have a fiscal impact on businesses.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ADMINISTRATIVE SERVICES
FLEET OPERATIONS
ROOM 4120 STATE OFFICE BLDG
450 N STATE ST
SALT LAKE CITY, UT 84114-1201
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Gary Robertson by phone at 801-538-3792, by FAX at 801-359-0759, or by Internet E-mail at garyrobertson@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 12/31/2013

AUTHORIZED BY: Sam Lee, Director

R27. Administrative Services, Fleet Operations.
R27-7. Safety and Loss Prevention of State Vehicles.
R27-7-3. Driver Eligibility to Operate a State Vehicle.

(1) The authority to operate a state vehicle is subject to withdrawal, suspension or revocation.

(2) The authority to operate a state vehicle shall be automatically withdrawn, suspended or revoked in the event that an authorized driver's license is not in a valid status.

(a) The authority to operate a state vehicle shall, at a minimum, be withdrawn, suspended or revoked for the period of

denial, cancellation, disqualification, suspension or revocation of the authorized driver's license.

(b) The authority to operate a state vehicle shall not be reinstated until such time as the individual provides proof that his or her driver license has been reinstated or DFO verifies the license has been reinstated.

(3) The authority to operate a state vehicle may be suspended or revoked for up to three years by the Driver Eligibility Board for any of the following reasons:

(a) The authorized driver, while acting within the scope of employment, has been involved in 3 or more preventable accidents during a three (3) year period; or

(b) The authorized driver has [~~4~~]3 or more moving violations while driving a state vehicle within a 12 month period; or

(c) The authorized driver has been convicted of any of the following:

(i) Alcohol related driving violations;

(ii) reckless, careless, or negligent driving (including excessive speed violations);

(iii) driving violations that have resulted in injury or death;

(iv) felony related driving violations;

(v) hit and run violations;

(vi) impaired driving;

(vii) or any other driving violation determined by the Driver Eligibility Board as posing a significant risk to the safety or loss prevention of state vehicles.

(d) The unauthorized use, misuse, abuse or neglect of a state vehicle as validated by the driver's agency; or

(e) On the basis of citizen complaints validated by the agency, the authorized driver, while acting within the scope of employment has been found, pursuant to 63A-9-501,to have misused or illegally operated a vehicle three (3) times during a three

(3) year period.

(4) The withdrawal of authority to operate a state vehicle imposed by the Driver Eligibility Board shall be in addition to agency-imposed discipline, corrective or remedial action, if any.

(5) Drivers declared ineligible to operate a state vehicle by the Driver Eligibility Board may appeal to the Director of the Department of Administrative Services (DAS) or his/her designee. Any appeal to the Executive Director of DAS or his/her designee must be made in writing within 30 days from the date the Driver Eligibility Board declared a state driver ineligible to operate a vehicle.

(6) Effective Date

(a) Phase in - current state employees shall be subjected to R27-7-3(3) as of the effective date of the rules as published by the Division of Administrative Rules.

(b) State employees hired after the effective date of this administrative rule will be subject to the Driver Eligibility standards in R27-7-3(3) for three years previous to the hire date.

KEY: accidents, incidents, tickets, ARC
Date of Enactment or Last Substantive Amendment: [~~June 28, 2012~~]2013
Notice of Continuation November 29, 2010
Authorizing, and Implemented or Interpreted Law: 63A-9-401(1)(d)(iii)

Agriculture and Food, Conservation Commission

R64-3

Utah Environmental Stewardship Certification Program (UESCP), a.k.a. Agriculture Certificate of Environmental Stewardship (ACES)

NOTICE OF PROPOSED RULE

(New Rule)
DAR FILE NO.: 38071
FILED: 10/23/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule establishes general practices and procedures for implementing the Agriculture Certificate of Environmental Stewardship (ACES) and is required by Section 4-18-107 and S.B. 57 (passed in the 2013 General Legislative Session).

SUMMARY OF THE RULE OR CHANGE: This rule contains a list of terms and definitions used in the ACES program, followed by requirements and procedures to qualify for certification and requirements and procedures for renewing, investigation of, revoking, or extending certification.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 4-18-107

ANTICIPATED COST OR SAVINGS TO:

♦ THE STATE BUDGET: Cost of signs: $200/sign, one sign per operation who finish certification in all sectors. Cost for education materials and workshops: $30,000. Cost of certified planners will be managed by changing work plans. Administration/Verification: $50,000

♦ LOCAL GOVERNMENTS: Local government will not be affected since they have no responsibility with the Certification Program in any way.

♦ SMALL BUSINESSES: Agricultural operations choosing to participate in the program will be affected between $100 to $250, depending on the number of sectors they want to be certified in.

♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: This impact would be the same as identified under small businesses above.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The cost associated to this rule is between $100 to $250, depending on the number of sectors agricultural operations want to be certified in.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This is a totally voluntary program and the rule does not create any direct financial impact on any farmer or rancher. If they decide to ask for the ACES Certification there will be a cost of $100 to $250, depending on the number of sectors certified. Most of this fee will be used to pay for the ACES sign that will be awarded to the farm or ranch. Depending on the current practices and conditions on the farm/ranch, the owner may have costs to update their operation to meet the best management practices required by ACES, which will bring them into compliance with state and federal environmental regulations. A substantial portion of these costs can generally be offset with grants from USDA programs. In addition, most, best management practices will increase profitability of the farm or ranch while improving their environmental stewardship.

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

AGRICULTURE AND FOOD
CONSERVATION COMMISSION
350 N REDWOOD RD
SALT LAKE CITY, UT 84116-3034
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

♦ Jay Olsen by phone at 801-538-7174, by FAX at 801-538-9436, or by Internet E-mail at jayolsen@utah.gov
♦ Kathleen Mathews by phone at 801-538-7103, by FAX at 801-538-7126, or by Internet E-mail at kmathews@utah.gov
♦ Kyle Stephens by phone at 801-538-7102, by FAX at 801-538-7126, or by Internet E-mail at kylestephens@utah.gov
♦ Thayne Mickelson by phone at 801-538-7171, by FAX at 801-538-9436, or by Internet E-mail at tmickelson@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 12/23/2013

AUTHORIZED BY: Leonard Blackham, Commissioner

R64. Agriculture and Food, Conservation Commission.

R64-3. Utah Environmental Stewardship Certification Program (UESCP), a.k.a. Agriculture Certificate of Environmental Stewardship (ACES).

R64-3-1. Authority and Purpose.

Pursuant to Section 4-18-107, this rule establishes general operating practices and procedures for implementing the Agriculture Certificate of Environmental Stewardship (ACES).

R64-3-2. Definitions.

(1) "ACES Technical Standards": means a collection of practices adopted by the Commission that will protect the environment in a reasonable and economical manner while still protecting the sustainability of agriculture.

(2) "ACES workbook": means the best management practices, education requirements and information required for certification. The workbook is considered property of the owner/operator and remains in their possession. Only the Certification Forms are retained at the Department. The workbook must be retained by the owner/operator and available for review by the Department upon request.

(3) "Agriculture Sectors": means; a Farmstead, Animal Feeding Operation, Grazing or Pasture Operation, and Cropping System.

(4) "Animal Feeding Operation" (AFO): means a lot or facility where the following conditions are met: animals have been, are, or will be stabled, housed, or confined and fed or maintained for a total of forty-five (45) days or more in any 12-month period; crops, vegetation, forage growth, or post-harvest residues are not sustained in the normal growing season over any portion of the lot or facility; and two or more AFOs under common ownership are considered to be a single AFO if they adjoin each other or if they use a common area or system for the storage or disposal of waste

(5) "Best Management Practices" (BMP): means common acceptable practices, including but not limited to management policies and the use of technology, used by sectors of agriculture in the production of food and fiber that protect and sustain natural resources.

(6) "Certification Forms": means contact information and sector(s) verification page(s) that are reviewed by the planner and verified by the Department.

(7) "Certified Planner": means a planner of a local conservation district, or other qualified planner, that has been certified by NRCS and is approved by the commission to certify an agriculture operation under the ACES program.

(8) "Commission": means the (Utah) Conservation Commission (UCC).

(9) "Comprehensive Nutrient Management Plan or Nutrient Management Plan" (CNMP/NMP): means a plan to properly store, handle, and spread manure and other agriculture byproducts to protect the environment and provide nutrients for the production of crops (plants).

(10) "Cropping": is the area where crops are planted, raised, and harvested. This includes but is not limited to fruits, vegetables, grain, oil seeds and alfalfa.

(11) "Department": means the (Utah) Department of Agriculture and Food (UDAF).

(12) "DEQ": means the (Utah) Department of Environmental Quality.

(13) "Education modules": means education materials which provide information on best management practices either in workshops and/or online at ACES site. They will inform and/or educate the producer on requirements in ACES.

(14) "Farmstead": is considered to be the central area of operation which may include but not limited to home/office, yards, storage facilities, and other buildings.

(15) "Grazing and Pasture": is considered to be any vegetated land that is grazed or has the potential to be grazed by animals.

(16) "NRCS": means the Natural Resources Conservation Service.

(17) "Review/Verification": means an audit performed by the Department of Agriculture and Food.

R64-3-3. Requirements and Procedure to Qualify for the Agriculture Certificate of Environmental Stewardship (ACES).

(1) Owner/operator shall complete the workbook for each desired sector (farmstead, animal feeding operation, grazing and pasture, and cropping) available at the department's website.

(2) Certified Planners shall be available from conservation districts to aid owner/operators in meeting the requirements of ACES.

(3) Workbooks shall be reviewed and verified by a certified planner, in preparation for Commission certification.

(4) Owner/operator shall complete education requirements prior to certification either by:

(a) completing workshops sponsored by ACES or

(b) by completing education modules found on the department's website under the ACES program.

(5) When an operation is certified for a given sector, the Department shall provide a certificate for that sector

(6) After completion of all sectors the operation is involved in the Department shall provide a sign.

(7) Owner/operator shall be charged $100 for each sector certified, not to exceed $250 total.

R64-3-4. Requirements and Procedures for Renewing, Investigation of, Revoking or Extending the Agriculture Certificate of Environmental Stewardship (ACES).

(1) Prior to the five (5) year extension date, the Department shall send a certified letter to the operation. The owner/operator has 120 days to respond to the extension notice. If no response is received the operation's certification shall expire. The owner/operator shall meet all requirements of the original certification to receive the extension. Such verification shall be made by a certified planner and by the Department.

(a) If any requirement is found in non-compliance, the certified planner shall review with the owner/operator what changes must be met for the operation to retain certification.

(b) The owner/operator shall have 120 days to respond to the request to maintain program certification in that sector.

(i) If not, the sign shall be removed by the owner/operator and returned to the Department.

(2) If the operation is certified in more than one sector only the sector in which they are in non-compliance shall the certification be revoked and the sign removed and returned to the Department.

(3) Owner/operator may request a variance by notifying the Commission Chair, in writing, stating the reason they could not comply within the 120 days.

(4) The Commission Chair has 30 days to respond to the request.

(5) Prior to the ten (10) year termination date of a certificate, the Department will send a certified letter to the operation. Re-certification will require the completion of a current ACES workbook and verification.

(6) Investigation: The department shall review any concerns brought by either DEQ, or a citizen environmental complaint. If the complaint is not found to be a significant violation of the certification program then no action will be taken.

(a) If it is determined that a significant violation has occurred.

(i) Department shall report the operation to the Commission Chair.

(ii) Commission chair shall then take one of the following actions:

(A) Inform the commission.

(B) List of corrective actions necessary and establish time frame for compliance to address the complaint and still maintain certification.

(7) The Commission Chair shall then inform the operation by certified letter which action was taken.

(8) If the certified operation does not comply within a reasonable time to rectify the concerns stated in the commission's letter.

(a) The department shall make a report to the Commission stating reasons for non-compliance.

(9) Commission shall review department reports and may revoke certification.

(a) If certification is revoked the operation shall not be allowed to participate in the certification program for 2 years.

(10) If an operation denies the department access to a site visit and/or review of records after 3 attempts (one of which is by certified letter), the Commission shall revoke the certification.

(11) If the operation is sold and/or under new management the current certification shall be revoked and the new owner/operator will need to go thru the certification process with a current workbook.

(12) The department shall give a yearly report on the ACES program to the Commission.

KEY: environment, stewardships, certifications
Date of Enactment or Last Substantive Amendment: 2014
Authorizing, and Implemented or Interpreted Law: 4-18-107

Commerce, Occupational and Professional Licensing

R156-17b

Pharmacy Practice Act Rule

NOTICE OF PROPOSED RULE

(Amendment)
DAR FILE NO.: 38075
FILED: 10/29/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The changes are because of the passage of S.B. 14 and S.B. 194 during the 2013 General Legislative Session. S.B. 14 (2013) exempted research using pharmaceuticals from licensure to engage in the practice of pharmacy, telepharmacy, or the practice of pharmacy technician. S.B. 194 (2013) amended the following: 1) definition of pharmaceutical wholesaler or distributor; 2) definition of the "practice as a licensed pharmacy technician"; and 3) pharmacy technician licensure qualifications. Both S.B. 14

and S.B. 194 granted authority to the Division to adopt amendments and this rule filing establishes those amendments. Other amendments are proposed at the request of the Utah State Board of Pharmacy.

SUMMARY OF THE RULE OR CHANGE: In Section R156-17b-102, Subsections (18), (19), and (33) are added due to statutory amendments made in S.B. 194 to the definition of pharmaceutical wholesaler or distributor. These amendments granted the Division authority to define the following terms: "entities under common administrative control", "entities under common ownership", and "other health care facilities". Subsection R156-17b-102(42) is added due to statutory amendments made in S.B. 14 to exempt research using pharmaceuticals from licensure to engage in the practice of pharmacy, telepharmacy, or the practice of pharmacy technician. These amendments granted the Division authority to define the term "research facility". In Subsection R156-17b-102(47), the term "expiration date" is removed and replaced with "beyond use date" to be consistent with terminology used in federal law. Subsection R156-17b-102(50) is updated to reflect the 12/01/2013 edition of Supplement 2 to the United States Pharmacopeia (USP) 36-National Formulary (NF) 31. In Section R156-17b-105, the proposed amendment corrects an incorrect citation. In Section R156-17b-303a, under S.B. 194, pharmacy technician programs no longer require Division approval; however, acceptable programs must meet standards established by Division rule. The proposed standards allow pharmacy technician programs already approved by the Division to continue until 01/01/2016. In order to continue as a pharmacy technician program after 01/01/2016, programs must be accredited or conducted by the American Society of Health System Pharmacists, the National Technician Association, or a branch of the Armed Forces of the United States. Under the proposed change, the Division will continue to approve programs until 04/30/2014. In Sections R156-17b-303b and R156-17b-305, the proposed amendments correct grammatical errors. In Section R156-17b-304, the proposed amendments allow the Division to issue a temporary pharmacist license to a student who has not yet graduated but who is in the second year of a pharmacy graduate residency program. In Section R156-17b-310, the proposed amendment corrects an incorrect citation and clarifies standards relating to when a prescribing practitioner can prescribe and dispense a cancer drug treatment regimen. In Section R156-17b-402, the proposed amendment adds the word "Subsection" as needed. In Subsection R156-17b-402(58), the minimum fine for an initial offense for violating or aiding or abetting any other person to violate any statute, rule, or order regulating pharmacy is reduced to $100. In Subsection R156-17b-502(17), the proposed amendment makes it unprofessional conduct for a pharmacy, pharmacist, or pharmacy technician to fail to adhere to institutional policies and procedures related to technician checking of medications when technician checking is utilized. The passing of S.B. 194 (2013) prompted this rule amendment. In Subsection R156-17b-502(24), the proposed amendment makes it unprofessional conduct for a pharmacy or pharmacist to fail to comply with prescription container label standards established in USP-NF Chapter 17. Most pharmacies and pharmacists already comply with USP-NF Chapter 17; however, those that currently do not are given until 11/30/2014 to comply. In Subsection R156-17b-601(1), the proposed amendments establish when a pharmacy technician is permitted to conduct a final review of a prescribed drug prepared for dispensing. S.B. 194 (2013) granted the Division the authority to establish these amendments. The proposed amendments also correct incorrect citations. In Subsections R156-17b-601(2) and R156-17b-601(3), the operating standards of a pharmacy technician are further clarified and defined. In Section R156-17b-602, the proposed amendments correct incorrect citations. In Section R156-17b-603, the proposed amendment corrects a grammatical error. In Section R156-17b-605, the proposed amendments restructure the inventory requirements to make them consistent with 21 CFR 1304.11 and with how the Division currently interprets requirements. In Subsection R156-17b-612(15), the proposed amendment requires that prescription container labels comply with standards established in USP-NF Chapter 17. In Section R156-17b-613, the proposed amendments correct incorrect citations. In Section R156-17b-614a, the term "expiration date" is removed and replaced with "beyond use date" throughout the section to be consistent with terminology used in federal law. In Subsection R156-17b-614a(1), the proposed amendments clarify that all Class A and B pharmacies are required to comply with general operating standards established in this section. In Subsection R156-17b-614a(3), it is clarified that only pharmacies engaged in moderate or complex non-sterile or any level of sterile compounding shall be subject to standards established in this subsection. A typographical error is corrected in Subsection R156-17b-614a(4). The proposed amendments to Subsection R156-17b-614a(9) clarify that pharmacies may maintain permanent logs of the initials or identification codes which identify each dispensing pharmacist by name at the parent company rather than only at the actual pharmacy where drugs are dispensed. The proposed amendments to Subsection R156-17b-614a(12) and R156-17b-614a(13) remove the requirement that pharmacies maintain suppliers' invoices and credit memos for legend drugs. In Sections R156-17b-615 and R156-17b-616, incorrect rule titles and citations are corrected throughout these sections. In Subsection R156-17b-617e(2), a typographical error is corrected.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 58-17b-101 and Section 58-37-1 and Subsection 58-1-106(1)(a) and Subsection 58-1-202(1)(a) and Subsection 58-17b-601(1)

MATERIALS INCORPORATED BY REFERENCES:

- Updates United States Pharmacopeia-National Formulary (USP 36-NF 31) Supplement 2, published by United States Pharmacopeia, December 1, 2013

ANTICIPATED COST OR SAVINGS TO:

♦ THE STATE BUDGET: Under amendments to Section R156-17b-303a, beginning 03/31/2014, the Division will no longer approve individual pharmacy technician training programs. Shifting the responsibility to approve programs from the Division to the American Society of Health System Pharmacists (ASHSP), the National Pharmacy Technician Association, or a branch of the Armed Forces of the United States will result in a small reduction in work for the Division. This is because the Division and Board will no longer be required to review applications for approval of programs. In this case, the cost savings is minimal because the Division currently receives a small number of applications each year. In Subsection R156-17b-402(58), the minimum fine for an initial offense for violating or aiding or abetting any other person to violate any statute, rule, or order regulating pharmacy is reduced to $100. Reducing this amount will: 1) reduce the potential fine charged for this violation; and 2) result in the Division being more likely to issue fines to licensees who violate their disciplinary orders. The Division will incur minimal costs of approximately $100 to print and distribute the rule once the proposed amendments are made effective. The Division also incurs a yearly cost of approximately $1,700 to maintain two subscription renewals to the USP-NF. Any additional cost impact to the state budget results from statutory amendments and was covered in the fiscal note completed for S.B. 14 and S.B. 194 (2013).

♦ LOCAL GOVERNMENTS: The proposed amendments only apply to licensed pharmacies, pharmacists, pharmacy technicians, pharmacy interns, and applicants for licensure in those classifications. As a result, the proposed amendments do not apply to local governments.

♦ SMALL BUSINESSES: Amendments to the pharmacy technician education requirement in Section R156-17b-303a will have cost impact on schools with pharmacy technician programs and pharmacies with pharmacy technician on-the-job training programs. To obtain accreditation from the American Society of Health System Pharmacists (ASHSP) before 01/01/2016, schools must pay an initial application fee of $475. To maintain ASHSP accreditation, schools pay an annual assessment fee of anywhere between $2,200 and $4,400 depending on the number of training sites they use. Retail chain-based pharmacies that choose to have their own on-the-job training programs will pay a $10,000 initial application fee to ASHSP. To maintain accreditation, retail chain-based pharmacies pay an $8,400 annual assessment fee. Smaller pharmacies will direct students to either enroll in a ASHSP accredited school or in the National Pharmacy Technician Association (NPTA) Online Program. Proposed amendments to Section R156-17b-601 establish when a pharmacy technician is permitted to conduct a final review of a prescribed drug prepared for dispensing. These amendments will likely result in a cost savings for facilities that decide to allow pharmacy technicians to conduct a final review of a prescribed drug prepared for dispensing. The amount of the cost savings depends on several factors such as the number of pharmacy technicians allowed to conduct final reviews at particular pharmacies. Furthermore, amending Subsection R156-17b-601(3) to require general supervision rather than direct supervision will likely result in a cost savings for some pharmacies. In Subsection R156-17b-612(15), the proposed amendments require that pharmacies create prescription container labels that comply with standards established in USP-NF Chapter 17. Many pharmacies already comply with these standards; however, those that do not must comply by 11/30/2014. The cost impact of this rule amendment to these pharmacies will depend on the degree to which they currently comply with USP-NF Chapter 17. In Subsection R156-17b-614a(9), the proposed amendments allow pharmacies to maintain suppliers' invoices at a parent company rather than at the actual pharmacy. Furthermore, supplier invoices for legend drugs are no longer required to be maintained. These amendments will likely result in cost savings for some pharmacies but the Division is unable to estimate a cost savings amount due to varying circumstances. It should also be noted that licensed pharmacies are required to maintain a copy of the USP-NF books at an annual subscription cost of approximately $850.

♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Amendments to the pharmacy technician education requirement in Section R156-17b-303a will have cost impact on some individuals seeking to be trained as pharmacy technicians. Some schools may increase their tuition fees once they are required to obtain ASHSP accreditation and this will result in cost impact to students. The Division is unable to estimate a cost impact amount due to varying circumstances. Under these amendments, some pharmacies may choose to no longer have an on-the-job training program. Individuals completing on-the-job training programs at these pharmacies will either have to complete the program at a different pharmacy or complete an online program through the National Pharmacy Technician Association (NPTA). If they choose to complete the NPTA online program, tuition is currently $2,241 for 9 courses. In Subsection R156-17b-402(58), the minimum fine for an initial offense for violating or aiding or abetting any other person to violate any statute, rule, or order regulating pharmacy is reduced to $100. Reducing this amount will result in the Division being more likely to issue fines to licensees who violate their disciplinary orders.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Amendments to the pharmacy technician education requirement in Section R156-17b-303a will have cost impact on some individuals seeking to be trained as pharmacy technicians. Some schools may increase their tuition fees once they are required to obtain ASHSP accreditation and this will result in cost impact to students. The Division is unable to estimate a cost impact. Under these amendments, some pharmacies may choose to no longer have an on-the-job training program. Individuals completing on-the-job training programs at these pharmacies will either have to complete the program at a different pharmacy or complete an online program through the National Pharmacy Technician Association (NPTA). If they choose to complete the NPTA online program, tuition is currently $2,241 for 9 courses. In

Subsection R156-17b-402(58), the minimum fine for an initial offense for violating or aiding or abetting any other person to violate any statute, rule, or order regulating pharmacy is reduced to $100. Reducing this amount will result in the Division being more likely to issue fines to licensees who violate their disciplinary orders. It should also be noted that licensed pharmacies are required to maintain a copy of the USP-NF books at an annual subscription cost of approximately $850.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This comprehensive rule filing updates and clarifies existing provisions and makes technical corrections as to grammar, numbering, and internal citations. No fiscal impact to businesses is anticipated from these changes. In addition, the filing responds to S.B. 14 and S.B. 194 (2013), which exempt certain pharmaceutical research from licensing requirements, require that certain terms be defined in rule, and remove from the Board the authority to approve pharmacy technician education programs, thus turning the approval process over to nationally-recognized accrediting bodies. No fiscal impact to businesses is anticipated from these changes beyond that considered by the Legislature in determining to pass the bills. Finally, the proposed amendments incorporate into the professional conduct sections national standards for prescription labeling and inventory monitoring. Businesses that do not already comply with these standards might experience costs to change their internal policies and procedures. Those costs will vary and cannot be estimated.

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

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

INTERESTED PERSONS MAY ATTEND A PUBLIC HEARING REGARDING THIS RULE:
♦ 11/19/2013 09:00 AM, Heber Wells Bldg, 160 E 300 S, Conference Room 474 (fourth floor), Salt Lake City, UT

THIS RULE MAY BECOME EFFECTIVE ON: 12/23/2013

AUTHORIZED BY: Mark Steinagel, Director

R156. Commerce, Occupational and Professional Licensing.
R156-17b. Pharmacy Practice Act Rule.
R156-17b-102. Definitions.

In addition to the definitions in Title 58, Chapters 1 and 17b, as used in Title 58, Chapters 1 and 17b or this rule:

(1) "ACPE" means the American Council on Pharmaceutical Education or Accreditation Council for Pharmacy Education.

(2) "Analytical laboratory":

(a) means a facility in possession of prescription drugs for the purpose of analysis; and

(b) does not include a laboratory possessing prescription drugs used as standards and controls in performing drug monitoring or drug screening analysis if the prescription drugs are pre-diluted in a human or animal body fluid, human or animal body fluid components, organic solvents, or inorganic buffers at a concentration not exceeding one milligram per milliliter when labeled or otherwise designated as being for in-vitro diagnostic use.

(3) "Authorized distributor of record" means a pharmaceutical wholesaler with whom a manufacturer has established an ongoing relationship to distribute the manufacturer's prescription drugs. An ongoing relationship is deemed to exist between such pharmaceutical wholesaler and a manufacturer, as defined in Section 1504 of the Internal Revenue Code, when the pharmaceutical wholesaler has a written agreement currently in effect with the manufacturer evidencing such ongoing relationship, and the pharmaceutical wholesaler is listed on the manufacturer's current list of authorized distributors of record.

(4) "Authorized personnel" means any person who is a part of the pharmacy staff who participates in the operational processes of the pharmacy and contributes to the natural flow of pharmaceutical care.

(5) "Centralized Prescription Filling" means the filling by a pharmacy of a request from another pharmacy to fill or refill a prescription drug order.

(6) "Centralized Prescription Processing" means the processing by a pharmacy of a request from another pharmacy to fill or refill a prescription drug order or to perform processing functions such as dispensing, drug utilization review (DUR), claims adjudication, refill authorizations, and therapeutic interventions.

(7) "Chain pharmacy warehouse" means a physical location for prescription drugs that acts as a central warehouse and performs intracompany sales or transfers of the prescription drugs to a group of chain pharmacies that have the same common ownership and control.

(8) "Co-licensed partner or product" means an instance where two or more parties have the right to engage in the manufacturing and/or marketing of a prescription drug, consistent with FDA's implementation of the Prescription Drug Marketing Act.

(9) "Cooperative pharmacy warehouse" means a physical location for drugs that acts as a central warehouse and is owned, operated or affiliated with a group purchasing organization (GPO) or pharmacy buying cooperative and distributes those drugs exclusively to its members.

(10) "Counterfeit prescription drug" has the meaning given that term in 21 USC 321(g)(2), including any amendments thereto.

(11) "Counterfeiting" means engaging in activities that create a counterfeit prescription drug.

(12) "Dispense", as defined in Subsection 58-17b-102(22), does not include transferring medications for a patient from a legally dispensed prescription for that particular patient into a daily or weekly drug container to facilitate the patient taking the correct medication.

(13) "Device" means an instrument, apparatus, implement, machine, contrivance, implant, or other similar or related article, including any component part or accessory, which is required under Federal law to bear the label, "Caution: Federal or State law requires dispensing by or on the order of a physician."

(14) "Drop shipment" means the sale of a prescription drug to a pharmaceutical wholesaler by the manufacturer of the drug; by the manufacturer's co-licensed product partner, third party logistics provider, or exclusive distributor; or by an authorized distributor of record that purchased the product directly from the manufacturer or from one of these entities; whereby:

(a) the pharmaceutical wholesale distributor takes title to but not physical possession of such prescription drug;

(b) the pharmaceutical wholesale distributor invoices the pharmacy, pharmacy warehouse, or other person authorized by law to dispense to administer such drug; and

(c) the pharmacy, pharmacy warehouse, or other person authorized by law to dispense or administer such drug receives delivery of the prescription drug directly from the manufacturer; from the co-licensed product partner, third party logistics provider, or exclusive distributor; or from an authorized distributor of record that purchases the product directly from the manufacturer or from one of these entities.

(15) "Drug therapy management" means the review of a drug therapy regimen of a patient by one or more pharmacists for the purpose of evaluating and rendering advice to one or more practitioners regarding adjustment of the regimen.

(16) "Drugs", as used in this rule, means drugs or devices.

(17) "Durable medical equipment" or "DME" means equipment that:

(a) can withstand repeated use;

(b) is primarily and customarily used to serve a medical purpose;

(c) generally is not useful to a person in the absence of an illness or injury;

(d) is suitable for use in a health care facility or in the home; and

(e) may include devices and medical supplies.

(18) "Entities under common administrative control" means an entity holds the power, actual as well as legal to influence the management, direction, or functioning of a business or organization.

(19) "Entities under common ownership" means entity assets are held indivisibly rather than in the names of individual members.

([~~18~~]20) "ExCPT", as used in this rule, means the Exam for the Certification of Pharmacy Technicians.

([~~19~~]21) "FDA" means the United States Food and Drug Administration and any successor agency.

([~~20~~]22) "High-risk, medium-risk, and low-risk drugs" refers to the risk to a patient's health from compounding sterile preparations, as referred to in USP-NF Chapter 797, for details of determining risk level.

([~~21~~]23) "Hospice facility pharmacy" means a pharmacy that supplies drugs to patients in a licensed healthcare facility for terminal patients.

([~~22~~]24) "Hospital clinic pharmacy" means a pharmacy that is located in an outpatient treatment area where a pharmacist or pharmacy intern is compounding, admixing, or dispensing prescription drugs, and where:

(a) prescription drugs or devices are under the control of the pharmacist, or the facility for administration to patients of that facility;

(b) prescription drugs or devices are dispensed by the pharmacist or pharmacy intern; or

(c) prescription drugs are administered in accordance with the order of a practitioner by an employee or agent of the facility.

([~~23~~]25) "Legend drug" or "prescription drug" means any drug or device that has been determined to be unsafe for self-medication or any drug or device that bears or is required to bear the legend:

(a) "Caution: federal law prohibits dispensing without prescription";

(b) "Caution: federal law restricts this drug to use by or on the order of a licensed veterinarian"; or

(c) "Rx only".

([~~24~~]26) "Maintenance medications" means medications the patient takes on an ongoing basis.

([~~25~~]27) "Manufacturer's exclusive distributor" means an entity that contracts with a manufacturer to provide or coordinate warehousing, distribution, or other services on behalf of a manufacturer and who takes title to that manufacturer's prescription drug, but who does not have general responsibility to direct the drug's sale or disposition. Such manufacturer's exclusive distributor shall be licensed as a pharmaceutical wholesaler under this chapter and be an "authorized distributor of record" to be considered part of the "normal distribution channel".

([~~26~~]28) "Medical supplies" means items for medical use that are suitable for use in a health care facility or in the home and that are disposable or semi-disposable and are non-reusable.

([~~27~~]29) "MPJE" means the Multistate Jurisprudence Examination.

([~~28~~]30) "NABP" means the National Association of Boards of Pharmacy.

([~~29~~]31) "NAPLEX" means North American Pharmacy Licensing Examination.

([~~30~~]32) "Normal distribution channel" means a chain of custody for a prescription drug that goes directly, by drop shipment as defined in Subsection (14), or via intracompany transfer from a manufacturer; or from the manufacturer's co-licensed partner, third-party logistics provider, or the exclusive distributor to:

(a) a pharmacy or other designated persons authorized under this chapter to dispense or administer prescription drugs to a patient;

(b) a chain pharmacy warehouse that performs intracompany sales or transfers of such drugs to a group of pharmacies under common ownership and control;

(c) a cooperative pharmacy warehouse to a pharmacy that is a member of the pharmacy buying cooperative or GPO to a patient;

(d) an authorized distributor of record, and then to either a pharmacy or other designated persons authorized under this chapter to dispense or administer such drug for use by a patient;

(e) an authorized distributor of record, and then to a chain pharmacy warehouse that performs intracompany sales or transfers of such drugs to a group of pharmacies under common ownership and control; or

(f) an authorized distributor of record to another authorized distributor of record to a licensed pharmaceutical facility or a licensed healthcare practitioner authorized under this chapter to dispense or administer such drug for use by a patient.

(33) "Other health care facilities" means any entity as defined in Utah Code Subsection 26-21-2(13)(a) or Utah Administrative Code R432-1-3(55).

([~~31~~]34) "Parenteral" means a method of drug delivery injected into body tissues but not via the gastrointestinal tract.

([~~32~~]35) "Pedigree" means a document or electronic file containing information that records each distribution of any given prescription drug.

([~~33~~]36) "PIC", as used in this rule, means the pharmacist-in-charge.

([~~34~~]37) "Prescription files" means all hard-copy and electronic prescriptions that includes pharmacist notes or technician notes, clarifications or information written or attached that is pertinent to the prescription.

([~~35~~]38) "PTCB" means the Pharmacy Technician Certification Board.

([~~36~~]39) "Qualified continuing education", as used in this rule, means continuing education that meets the standards set forth in Section R156-17b-309.

([~~37~~]40) "Refill" means to fill again.

([~~38~~]41) "Repackage" means repackaging or otherwise changing the container, wrapper, or labeling to further the distribution of a prescription drug, excluding that completed by the pharmacist responsible for dispensing the product to a patient.

(42) "Research facility" means a facility in which research takes place that has policies and procedures describing such research.

([~~39~~]43) "Reverse distributor" means a person or company that retrieves unusable or outdated drugs from a pharmacy or pharmacist for the purpose of removing those drugs from stock and destroying them.

([~~40~~]44) "Sterile products preparation facility" means any facility, or portion of the facility, that compounds sterile products using aseptic technique.

([~~41~~]45) "Supervisor" means a licensed pharmacist in good standing with the Division.

([~~42~~]46) "Third party logistics provider" means anyone who contracts with a prescription drug manufacturer to provide or coordinate warehousing, distribution, or other similar services on behalf of a manufacturer, but does not take title to the prescription drug or have any authoritative control over the prescription drug's sale. Such third party logistics provider shall be licensed as a pharmaceutical wholesaler under this chapter and be an "authorized distributor of record" to be considered part of the "normal distribution channel".

([~~43~~]47) "Unauthorized personnel" means any person who is not participating in the operational processes of the pharmacy who in some way would interrupt the natural flow of pharmaceutical care.

([~~44~~]48) "Unit dose" means the ordered amount of a drug in a dosage form prepared for a one-time administration to an individual and indicates the name, strength, lot number and [~~expiration~~]beyond use date for the drug.

([~~45~~]49) "Unprofessional conduct", as defined in Title 58, Chapters 1 and 17b, is further defined, in accordance with Subsection 58-1-203(1)(e), in Section R156-17b-502.

([~~46~~]50) "USP-NF" means the United States Pharmacopeia-National Formulary (USP 36-NF 31), 2013 edition, which is official from May 1, 2013 through Supplement 2, dated December 1, [~~2012~~]2013, which is hereby adopted and incorporated by reference.

([~~47~~]51) "Wholesaler" means a wholesale distributor who supplies or distributes drugs or medical devices that are restricted by federal law to sales based on the order of a physician to a person other than the consumer or patient.

([~~48~~]52) "Wholesale distribution" means the distribution of drugs to persons other than consumers or patients, but does not include:

(a) intracompany sales or transfers;

(b) the sale, purchase, distribution, trade, or other transfer of a prescription drug for emergency medical reasons, as defined under 21 CFR 203.3(m), including any amendments thereto;

(c) the sale, purchase, or trade of a drug pursuant to a prescription;

(d) the distribution of drug samples;

(e) the return or transfer of prescription drugs to the original manufacturer, original wholesale distributor, reverse distributor, or a third party returns processor;

(f) the sale, purchase, distribution, trade, or transfer of a prescription drug from one authorized distributor of record to one additional authorized distributor of record during a time period for which there is documentation from the manufacturer that the manufacturer is able to supply a prescription drug and the supplying authorized distributor of record states in writing that the prescription drug being supplied had until that time been exclusively in the normal distribution channel;

(g) the sale, purchase or exchange of blood or blood components for transfusions;

(h) the sale, transfer, merger or consolidation of all or part of the business of a pharmacy;

(i) delivery of a prescription drug by a common carrier; or

(j) other transactions excluded from the definition of "wholesale distribution" under 21 CFR 203.3 (cc), including any amendments thereto.

R156-17b-105. Licensure - Administrative Inspection.

In accordance with Subsection 58-17b-103(3)([e]f), the procedure for disposing of any drugs or devices seized by the Division during an administrative inspection will be handled as follows:

(1) Any legal drugs or devices found and temporarily seized by the Division that are found to be in compliance with this chapter will be returned to the PIC of the pharmacy involved at the conclusion of any investigative or adjudicative proceedings and appeals.

(2) Any drugs or devices that are temporarily seized by the Division that are found to be unlawfully possessed, adulterated, misbranded, outdated, or otherwise in violation of this rule shall be destroyed by Division personnel at the conclusion of any investigative or adjudicative proceedings and appeals. The destruction of any seized controlled substance drugs will be witnessed by two Division individuals. A controlled substance destruction form will be completed and retained by the Division.

(3) An investigator may, upon determination that the violations observed are of a nature that pose an imminent peril to the public health, safety and welfare, recommend to the Division Director to issue an emergency licensure action, such as cease and desist.

(4) In accordance with Subsections 58-17b-103(1) and 58-17b-601(1), a secure email address must be established by the PIC and responsible party for the pharmacy to be used for self-audits or pharmacy alerts initiated by the Division. The PIC and responsible party shall cause the Division's Licensing Bureau to be notified on the applicable form prescribed by the Division of the secure email address or any change thereof within seven days of any email address change. Only one email address shall be used for each pharmacy.

R156-17b-303a. Qualifications for Licensure - Education Requirements.

(1) In accordance with Subsections 58-17b-303(2) and 58-17b-304(7)(b), the credentialing agency recognized to provide certification and evaluate equivalency of a foreign educated pharmacy graduate is the Foreign Pharmacy Graduate Examination Committee (FPGEC) of the National Association of Boards of Pharmacy Foundation.

(2) In accordance with Subsection 58-17b-304(7), an applicant for a pharmacy intern license shall demonstrate that he meets one of the following education criteria:

(a) current admission in a College of Pharmacy accredited by the ACPE by written verification from the Dean of the College;

(b) a graduate degree from a school or college of pharmacy which is accredited by the ACPE; or

(c) a graduate degree from a foreign pharmacy school as established by a certificate of equivalency from an approved credentialing agency defined in Subsection (1).

(3) In accordance with Subsection 58-17b-305(1)(f), a pharmacy technician shall complete [~~an approved program of education and training that~~]a training program that is accredited or conducted by the American Society of Health System Pharmacists, the National Pharmacy Technician Association, or a branch of the Armed Forces of the United States, and meets the following standards:[

~~(a) The didactic training program shall be approved by the Division in collaboration with the Board and shall address, at a minimum, the following topics:~~

~~(i) legal aspects of pharmacy practice including federal and state laws and rules governing practice;~~

~~(ii) hygiene and aseptic techniques;~~

~~(iii) terminology, abbreviations and symbols;~~

~~(iv) pharmaceutical calculations;~~

~~(v) identification of drugs by trade and generic names, and therapeutic classifications;~~

~~(vi) filling of orders and prescriptions including packaging and labeling;~~

~~(vii) ordering, restocking, and maintaining drug inventory;~~

~~(viii) computer applications in the pharmacy; and~~

~~(ix) non-prescription products including cough and cold, nutritional, analgesics, allergy, diabetic testing supplies, first aid, ophthalmic, family planning, foot, feminine hygiene, gastrointestinal preparations, and pharmacy care over-the-counter drugs, except those over-the-counter drugs that are prescribed by a practitioner.~~

~~(b) This training program's curriculum and a copy of the final examination shall be submitted to the Division for approval by the Board prior to starting any training session with a pharmacy technician in training. The final examination shall include questions covering each of the topics listed in Subsection (3)(a) above.~~

~~(c) Approval shall be granted by the Division in collaboration with the Board before a student may start a program of study. An individual who completes a non-approved program is not eligible for licensure.~~

~~(d) The training program shall include:~~]

([~~i~~]a) completion of at least 180 [~~but not more than 360~~] hours of directly supervised practical training in a licensed pharmacy as determined appropriate by [~~the supervisor~~]a licensed pharmacist in good standing; and

([~~ii~~]b) written protocols and guidelines for the teaching pharmacist outlining the utilization and supervision of pharmacy technicians in training that address:

([~~A~~]i) the specific manner in which supervision will be completed; and

([~~B~~]ii) an evaluative procedure to verify the accuracy and completeness of all acts, tasks and functions performed by the pharmacy technician in training.

[~~(c)(i)~~](4) An individual shall complete [~~an approved~~]a pharmacy technician training program and successfully pass the required examinations as listed in Subsection R156-17b-303c [~~(b)~~] (4) within two years from the date of the first day of the training program, unless otherwise approved by the Division in collaboration with the Board.

([~~ii~~]a) An individual who [~~has completed an approved program, but did not seek licensure within the two-year time frame~~]fails to apply for and obtain a pharmacy technician license within the two-year time frame or within six months after completion of a pharmacy technician training program, whichever comes first:

([~~A~~]i) is no longer eligible for employment as a technician-in-training and shall work in the pharmacy only as supportive personnel; and

([~~B~~]ii) shall repeat a[~~n approved~~] pharmacy technician training program in its entirety if the individual pursues licensure as a pharmacy technician.

(5) Pharmacy technician training programs that receive Division approval on or before April 30, 2014 are exempt from

satisfying standards established in Subsection R156-17b-303a(3) until January 1, 2016. The Division will accept and review applications for approval of pharmacy technician training programs submitted on or before March 31, 2014. The criteria used by the Division to determine whether a pharmacy technician program is approved shall be the criteria established in Subsection R156-17b-303a(2) of the rule effective immediately prior to this rule.

([4]6) An applicant for licensure as a pharmacy technician is deemed to have met the qualifications for licensure in Subsection 58-17b-305(1)(f) and 58-17b-305(1)(g) if the applicant:

(a) is currently licensed and in good standing in another state and has not had any adverse action taken on that license;

(b) has engaged in the practice as a pharmacy technician for a minimum of 1,000 hours in that state within the past two years or equivalent experience as approved by the Division in collaboration with the Board;

(c) has passed and maintained current PTCB or ExCPT certification; and

(d) has passed the Utah Pharmacy Technician Law and Rule Examination.

R156-17b-303b. Licensure - Pharmacist - Pharmacy Internship Standards.

(1) In accordance with Subsection 58-17b-303(1)(g), the standards for the pharmacy internship required for licensure as a pharmacist for graduates of all U.S. and foreign pharmacy schools, include the following:

(a) At least 1,740 hours of practice supervised by a pharmacy preceptor shall be obtained in Utah or another state or territory of the United States, or a combination of both according to the Accreditation Council for Pharmacy Education (ACPE), Accreditation Standards and Guidelines for the Professional Program in Pharmacy Leading to the Doctor of Pharmacy Degree Guidelines Version 2.0 Effective February 14, 2001, which is hereby incorporated by reference.

(i) Introductory pharmacy practice experiences (IPPE) shall account for not less than 300 hours over the first three professional years.

(ii) A minimum of 150 hours shall be balanced between community pharmacy and institutional health system settings.

(iii) Advanced pharmacy practice experiences (APPE) shall include at least 1,440 hours (i.e., 36 weeks) during the last academic year and after all IPPE requirements are completed.

(iv) Required experiences shall:

(A) include primary, acute, chronic, and preventive care among patients of all ages; and

(B) develop pharmacist-delivered patient care competencies in the community pharmacy, hospital or health-system pharmacy, ambulatory care, inpatient/acute care, and general medicine settings.

(v) Internship hours completed in another state or territory of the United States shall be accepted based on the approval of the hours by the pharmacy board in the jurisdiction where the hours were obtained.

(b) Evidence of completed internship hours shall be documented to the Division by the pharmacy intern at the time application is made for a Utah pharmacist license.

(c) Pharmacy interns participating in internships may be credited no more than 50 hours per week of internship experience.

(d) No credit will be awarded for didactic experience.

(2) If a pharmacy intern is suspended or dismissed from an approved College of Pharmacy, the intern shall notify the Division within 15 days of the suspension or dismissal.

(3) If a pharmacy intern ceases to meet all requirements for intern licensure, the pharmacy intern shall surrender the pharmacy intern license to the Division within 60 days unless an extension is requested and granted by the Division in collaboration with the Board.

R156-17b-304. Temporary Licensure.

(1) In accordance with Subsection 58-1-303(1), the Division may issue a temporary pharmacist license to a person who meets all qualifications for licensure as a pharmacist except for the passing of the required examination, if the applicant:

(a) is a graduate of an ACPE accredited pharmacy school within two months immediately preceding application for licensure or enrolled in the second year of a pharmacy graduate residency program;

(b) submit a complete application for licensure as a pharmacist except the passing of the NAPLEX and MJPE examinations;

(c) submits evidence of having secured employment conditioned upon issuance of the temporary license, and the employment is under the direct, on-site supervision of a pharmacist with an active, non-temporary license that may or may not include a controlled substance license; and

(d) has registered to take the required licensure examinations.

(2) A temporary pharmacist license issued under Subsection (1) expires the earlier of:

(a) six months from the date of issuance;

(b) the date upon which the Division receives notice from the examination agency that the individual has failed either examination twice; or

(c) the date upon which the Division issues the individual full licensure.

(3) An individual who has failed either examination twice shall meet with the Board to request an additional authorization to test. The Division, in collaboration with the Board, may require additional training as a condition for approval of an authorization to retest.

(4) A pharmacist temporary license issued in accordance with this section cannot be renewed or extended.

R156-17b-305. Licensure - Pharmacist by Endorsement.

(1) In accordance with Subsections 58-17b-303(3) and 58-1-301(3), an applicant for licensure as a pharmacist by endorsement shall apply through the "Licensure Transfer Program" administered by NABP.

(2) An applicant for licensure as a pharmacist by endorsement does not need to provide evidence of intern hours if that applicant has:

(a) lawfully practiced as a licensed pharmacist a minimum of 2,000 hours in the four years immediately preceding application in Utah;

(b) obtained sufficient continuing education credits required to maintain a license to practice pharmacy in the state of practice; and

(c) not had a pharmacist license suspended, revoked, canceled, surrendered, or otherwise restricted for any reason in any state for ten years prior to application in Utah, unless otherwise approved by the Division in collaboration with the Board.

R156-17b-310. Exemption from Licensure - Dispensing of Cosmetic, Injectable Weight Loss, or Cancer Drug Treatment Regimen Drugs.

(1) A cosmetic drug that can be dispensed by a prescribing practitioner or optometrist in accordance with Subsection 58-17b-309 is limited to Latisse.

(2) An injectable weight loss drug that can be dispensed by a prescribing practitioner in accordance with Subsection 58-17b-309 is limited to human chorionic gonadotropin.

(3) A cancer drug treatment regimen that can be dispensed by a prescribing practitioner or an individual employed by the prescribing practitioner in accordance with Subsection 58-17b-309.5(1) and (2) means a prescription drug used to treat cancer, manage its symptoms, or provide continuity of care for a cancer patient.

(a) A prescribing practitioner who chooses to dispense prescription medications shall disclose to the patient that the cancer drug treatment regimen may be obtained from a pharmacy unaffiliated with the prescribing practitioner and offer to the patient the opportunity to consult with a pharmacist of the patient's choosing if the patient desires patient counseling.

(b) Practitioners are required to document this interaction by keeping a signature log of all patients who have received this written information. These records are required to be kept for a period of five years and shall be readily available for inspection.

(4) A prescribing practitioner who chooses to dispense prescription medications shall meet the standards set forth in R156-17b-60[~~2~~]3 through R156-17b-605 and R156-17b-609 through R156-17b-611; however, a prescribing practitioner is not required to employ a pharmacist in charge.

(5) In accordance with Subsections 58-17b-309(4)(c) and 58-17b-309.5(2)(b)(viii), a prescribing practitioner or optometrist who chooses to dispense a cosmetic drug, a prescribing practitioner who chooses to dispense an injectable weight loss drug, as listed in Subsections (1) and (2), or a prescribing practitioner or the prescribing practitioner's employee who chooses to dispense drugs used to treat cancer, manage its symptoms, or provide continuity of care for a cancer patient to the prescribing practitioner's or optometrist's patients shall have a label securely affixed to the container indicating the following minimum information:

(a) the name, address and telephone number of the prescribing practitioner or optometrist prescribing and dispensing the drug;

(b) the serial number of the prescription as assigned by the dispensing prescribing practitioner or optometrist;

(c) the filling date of the prescription or its last dispensing date;

(d) the name of the patient;

(e) the directions for use and cautionary statements, if any, which are contained in the prescription order or are needed;

(f) the trade, generic or chemical name, amount dispensed and the strength of dosage form; and

(g) the beyond use date.

(6) A prescribing practitioner or optometrist who chooses to dispense a cosmetic drug, or a prescribing practitioner who chooses to dispense an injectable weight loss drug, as listed in Subsections (1) and (2), or a prescribing practitioner or the prescribing practitioner's employee who chooses to dispense drugs used to treat cancer, manage its symptoms, or provide continuity of care for a cancer patient shall keep inventory records for each drug dispensed pursuant to R156-17b-605 and a prescription dispensing medication profile for each patient receiving a drug dispensed by the prescribing practitioner or optometrist pursuant to R156-17b-609. Those records shall be made available to the Division upon request by the Division.

(a) The general requirements for an inventory of drugs dispensed by a prescribing practitioner, the prescribing practitioner's employee, or optometrist include:

(i) the prescribing practitioner or optometrist shall be responsible for taking all required inventories, but may delegate the performance of taking the inventory to another person;

(ii) the inventory records shall be maintained for a period of five years and be readily available for inspection;

(iii) the inventory records shall be filed separately from all other records;

(iv) the person taking the inventory and the prescribing practitioner or optometrist shall indicate the time the inventory was taken and shall sign and date the inventory with the date the inventory was taken. The signature of the prescribing practitioner or optometrist and the date of the inventory shall be documented within 72 hours or three working days of the completed initial, annual, change of ownership and closing inventory;

(v) the initial inventory shall be completed within three working days of the date on which the prescribing practitioner or optometrist begins to dispense a drug under Sections 58-17b-309 and 58-17b-309.5; and

(vi) the annual inventory shall be within 12 months following the inventory date of each year and may be taken within four days of the specified inventory date and shall include all stocks including out-of-date drugs.

(b) A prescription dispensing medication profile shall be maintained for every patient receiving a drug that is dispensed by a prescribing practitioner or optometrist in accordance with Sections 58-17b-309 and 58-17b-309.5 for a period of at least one year from the date of the most recent prescription fill or refill. The medication profile shall be kept as part of the patient's medical record and include, as a minimum, the following information:

(i) full name of the patient, address, telephone number, date of birth or age, and gender;

(ii) patient history where significant, including known allergies and drug reactions; and

(iii) a list of drugs being dispensed including:

(A) name of prescription drug;

(B) strength of prescription drug;

(C) quantity dispensed;

(D) prescription drug lot number and name of manufacturer;

(E) date of filling or refilling;

(F) charge for the prescription drug as dispensed to the patient;

(G) any additional comments relevant to the patient's drug use; and

(H) documentation that patient counseling was provided in accordance with Subsection (7).

(7) A prescribing practitioner or optometrist who is dispensing a cosmetic drug or injectable weight loss drug listed in Subsections (1) and (2) in accordance with Subsection 58-17b-309(4)(c), or a prescribing practitioner or the prescribing practitioner's employee who chooses to dispense drugs used to treat cancer, manage its symptoms, or provide continuity of care for a cancer patient in accordance with Section 58-17b-309.5, shall include the following elements when providing patient counseling:

(a) the name and description of the prescription drug;

(b) the dosage form, dose, route of administration and duration of drug therapy;

(c) intended use of the drug and expected action;

(d) special directions and precautions for preparation, administration and use by the patient;

(e) common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur;

(f) techniques for self-monitoring drug therapy;

(g) proper storage;

(h) prescription refill information;

(i) action to be taken in the event of a missed dose;

(j) prescribing practitioner or optometrist comments relevant to the individual's drug therapy, including any other information specific to the patient or drug; and

(k) the date after which the prescription should not be taken or used, or the beyond use date.

(8) In accordance with Subsection 58-17b-309(4)(c), the medication storage standards that shall be maintained by a prescribing practitioner or optometrist who dispenses a drug under Subsections (1) and (2), or a prescribing practitioner or the prescribing practitioner's employee who chooses to dispense drugs used to treat cancer, manage its symptoms, or provide continuity of care for a cancer patient in accordance with Section 58-17b-309.5, provides that the storage space shall be:

(a) kept in an area that is well lighted, well ventilated, clean and sanitary;

(b) equipped to permit the orderly storage of prescription drugs in a manner to permit clear identification, separation and easy retrieval of products and an environment necessary to maintain the integrity of the drug inventory;

(c) equipped with a security system to permit detection of entry at all times when the prescribing practitioner's or optometrist's office or clinic is closed;

(d) at a temperature which is maintained within a range compatible with the proper storage of drugs; and

(e) securely locked with only the prescribing practitioner or optometrist having access when the prescribing practitioner's or optometrist's office or clinic is closed.

(9) In accordance with Subsections 58-17b-309(5) and 58-17b-309.5(1)(b), if a cosmetic drug or a weight loss drug listed in Subsections (1) and (2), or a drug used to treat cancer, manage its symptoms, or provide continuity of care for a cancer patient requires reconstitution or compounding to prepare the drug for administration, the prescribing practitioner or optometrist shall follow the USP-NF 797 standards for sterile compounding.

(10) In accordance with Subsection 58-17b-309(5), factors that shall be considered by licensing boards when determining if a drug may be dispensed by a prescribing practitioner, the prescribing practitioner's employee or optometrist, include whether:

(a)(i) the drug has FDA approval;

(ii)(A) is prescribed and dispensed for the conditions or indication for which the drug was approved to treat; or

(B) the prescribing practitioner or optometrist takes full responsibility for prescribing and dispensing a drug for off-label use;

(b) the drug has been approved for self administration by the FDA;

(c) the stability of the drug is adequate for the supply being dispensed; and

(d) the drug can be safely dispensed by a prescribing practitioner or optometrist.

(11) Standards for reporting to the Utah Controlled Substance Database shall be the same standards as set forth in the Utah Controlled Substance Database Act, Title 58, Chapter 37f, and the Utah Controlled Substance Database Act Rule, R156-37f.

R156-17b-402. Administrative Penalties.

In accordance with Subsection 58-17b-401(6) and Sections 58-17b-501 and 58-17b-502, unless otherwise ordered by the presiding officer, the following fine and citation schedule shall apply:

(1) preventing or refusing to permit any authorized agent of the Division to conduct an inspection, in violation of Subsection 58-17b-501(1):

initial offense: $500 - $2,000

subsequent offense(s): $5,000

(2) failing to deliver the license or permit or certificate to the Division upon demand, in violation Subsection 58-17b-501(2):

initial offense: $100 - $1,000

subsequent offense(s): $500 - $2,000

(3) using the title pharmacist, druggist, pharmacy intern, pharmacy technician or any other term having a similar meaning or any term having similar meaning when not licensed to do so, in violation of Subsection 58-17b-501(3)(a):

initial offense: $500 - $2,000

subsequent offense(s): $2,000 - $10,000

(4) conducting or transacting business under a name which contains as part of that name the words drugstore, pharmacy, drugs, medicine store, medicines, drug shop, apothecary, prescriptions or any other term having a similar meaning or in any manner advertising otherwise describing or referring to the place of the conducted business or profession when not licensed to do so, in violation of Subsection 58-17b-501(3)(b):

initial offense: $500 - $2,000

subsequent offense(s): $2,000 - $10,000

(5) buying, selling, causing to be sold, or offering for sale any drug or device which bears the inscription sample, not for resale, investigational purposes, or experimental use only or other similar words inspection, in violation of Subsection 58-17b-501(4):

initial offense: $1,000 - $5,000

subsequent offense(s): $10,000

(6) using to the licensee's own advantage or revealing to anyone other than the Division, Board or its authorized

representatives, any information acquired under the authority of this chapter concerning any method or process which is a trade secret, in violation of Subsection 58-17b-501(5):

initial offense: $100 - $500

subsequent offense(s): $200 - $1,000

(7) illegally procuring or attempting to procure any drug for the licensee or to have someone else procure or attempt to procure a drug, in violation of Subsection 58-17b-501(6):

initial offense: $500 - $2,000

subsequent offense(s): $2,000 - $10,000

(8) filling, refilling or advertising the filling or refilling of prescription drugs when not licensed do to so, in violation of Subsection 58-17b-501(7):

initial offense: $500 - $2,000

subsequent offense(s): $2,000 - $10,000

(9) requiring any employed pharmacist, pharmacy intern, pharmacy technician or authorized supportive personnel to engage in any conduct in violation of this chapter, in violation of Subsection 58-17b-501(8):

initial offense: $500 - $2,000

subsequent offense(s): $2,500 - $10,000

(10) being in possession of a drug for an unlawful purpose, in violation of Subsection 58-17b-501(9):

initial offense: $500 - $1,000

subsequent offense(s): $1,500 - $5,000

(11) dispensing a prescription drug to anyone who does not have a prescription from a practitioner or to anyone who is known or should be known as attempting to obtain drugs by fraud or misrepresentation, in violation of Subsection 58-17b-501(10):

initial offense: $500 - $2,000

subsequent offense(s): $2,500 - $10,000

(12) selling, dispensing or otherwise trafficking in prescription drugs when not licensed to do so or when not exempted from licensure, in violation of Subsection 58-17b-501(11):

initial offense: $1,000 - $5,000

subsequent offense(s): $10,000

(13) using a prescription drug or controlled substance for the licensee that was not lawfully prescribed for the licensee by a practitioner, in violation of Subsection 58-17b-501(12):

initial offense: $100 - $500

subsequent offense(s): $1,000 - $2,5000

(14) willfully deceiving or attempting to deceive the Division, the Board or its authorized agents as to any relevant matter regarding compliance under this chapter, in violation of Subsection 58-17b-502(1):

initial offense: $500 - $2,000

subsequent offense(s): $2,500 - $10,000

(15) paying rebates to practitioners or any other health care provider, or entering into any agreement with a medical practitioner or any other person for the payment or acceptance of compensation for recommending the professional services of either party, in violation of Subsection 58-17b-502(2):

initial offense:$2,500 - $5,000

subsequent offense(s):$5,500 - $10,000

(16) misbranding or adulteration of any drug or device or the sale, distribution or dispensing of any outdated, misbranded, or adulterated drugs or devices, in violation of Subsection 58-17b-502(3):

initial offense: $1,000 - $5,000

subsequent offense(s): $10,000

(17) engaging in the sale or purchase of drugs that are samples or packages bearing the inscription "sample" or "not for resale" or similar words or phrases, in violation of Subsection 58-17b-502(4):

initial offense: $500 - $2,000

subsequent offense(s): $2,500 - $10,000

(18) accepting back and redistributing any unused drugs, with the exception as provided in Section 58-17b-503, in violation of Subsection 58-17b-502(5):

initial offense: $1,000 - $5,000

subsequent offense(s): $10,000

(19) engaging in an act in violation of this chapter committed by a person for any form of compensation if the act is incidental to the person's professional activities, including the activities of a pharmacist, pharmacy intern, or pharmacy technician, in violation of Subsection 58-17b-502(6):

initial offense: $500 - $2,000

subsequent offense(s): $2,500 - $10,000

(20) violating Federal Title II, PL 91, Controlled Substances Act or Title 58, Chapter 37, Utah Controlled Substances Act, or rules and regulations adopted under either act, in violation of Subsection 58-17b-502(7):

initial offense: $500 - $2,000

subsequent offense(s): $2,500 - $10,000

(21) requiring or permitting pharmacy interns or technicians to engage in activities outside the scope of practice for their respective license classifications, or beyond their scopes of training and ability, in violation of Subsection 58-17b-502(8):

initial offense: $100 - $500

subsequent offense(s): $500 - $1,000

(22) administering without appropriate training, guidelines, lawful order, or in conflict with a practitioner's written guidelines or protocol for administering, in violation of Subsection 58-17b-502(9):

initial offense: $500 - $2,000

subsequent offense(s): $2,000 - $10,000

(23) disclosing confidential patient information in violation of the provision of the Health Insurance Portability and Accountability Act of 1996 or other applicable law, in violation of Subsection 58-17b-502(10):

initial offense: $100 - $500

subsequent offense(s): $500 - $1,000

(24) engaging in the practice of pharmacy without a licensed pharmacist designated as the PIC, in violation of Subsection 58-17b-502(11):

initial offense: $100 - $500

subsequent offense(s): $2,000 - $10,000

(25) failing to report to the Division any adverse action taken by another licensing jurisdiction, government agency, law enforcement agency or court, in violation of Subsection 58-17b-502(12):

initial offense: $100 - $500

subsequent offense(s): $500 - $1,000

(26) preparing a prescription drug, including compounding a prescription drug, for sale to another pharmacist or pharmaceutical facility, in violation of Subsection 58-17b-502(13):

initial offense: $100 - $500
subsequent offense(s): $500 - $1,000

(27) preparing a prescription drug in a dosage form which is regularly and commonly available from a manufacturer in quantities and strengths prescribed by a practitioner, in violation of Subsection 58-17b-502(14):
initial offense: $500 - $1,000
subsequent offense(s): $2,500 - $5,000

(28) violating any ethical code provision of the American Pharmaceutical Association Code of Ethics for Pharmacists, October 27, 1994, in violation of Subsection R156-17b-502(1):
initial offense: $250 - $500
subsequent offense(s): $2,000 - $10,000

(29) failing to comply with USP-NF Chapter 795 guidelines, in violation of Subsection R156-17b-502(2):
initial offense: $250 - $500
subsequent offense(s): $500 - $750

(30) failing to comply with USP-NF Chapter 797 guidelines, in violation of Subsection R156-17b-502(2):
initial offense: $500 - $2,000
subsequent offense(s): $2,500 - $10,000

(31) failing to comply with the continuing education requirements set forth in this rule, in violation of Subsection R156-17b-502(3):
initial offense: $100 - $500
subsequent offense(s): $500 - $1,000

(32) failing to provide the Division with a current mailing address within 10 days following any change of address, in violation of Subsection R156-17b-502(4):
initial offense: $50 - $100
subsequent offense(s): $200 - $300

(33) defaulting on a student loan, in violation of Subsection R156-17b-502(5):
initial offense: $100 - $200
subsequent offense(s): $200 - $500

(34) failing to abide by all applicable federal and state law regarding the practice of pharmacy, in violation of Subsection R156-17b-502(6):
initial offense: $500 - $1,000
subsequent offense(s): $2,000 - $10,000

(35) failing to comply with administrative inspections, in violation of Subsection R156-17b-502(7):
initial offense: $500 - $2,000
subsequent offense(s): $2,000 - $10,000

(36) failing to return or providing false information on a self-inspection report, in violation of Subsection R156-17b-502(8):
initial offense: $100 - $250
subsequent offense(s): $300 - $500

(37) violating the laws and rules regulating operating standards in a pharmacy discovered upon inspection by the Division, in violation of Subsection R156-17b-502(9):
initial violation: $50 - $100
failure to comply within determined time: $250 - $500
subsequent violations: $250 - $500
failure to comply within established time: $750 - $1,000

(38) abandoning a pharmacy and/or leaving drugs accessible to the public, in violation of Subsection R156-17b-502(10):
initial offense: $500 - $2,000
subsequent offense(s): $2,000 - $10,000

(39) failing to identify license classification when communicating by any means, in violation of Subsection R156-17b-502(11):
initial offense: $100 - $500
subsequent offense(s): $500 - $1,000

(40) failing to maintain an appropriate ratio of personnel, in violation of Subsection R156-17b-502(12):
Pharmacist initial offense: $100 - $250
Pharmacist subsequent offense(s): $500 - $2,500
Pharmacy initial offense: $250 - $1,000
Pharmacy subsequent offense(s): $500 - $5,000

(41) allowing any unauthorized persons in the pharmacy, in violation of Subsection R156-17b-502(13):
Pharmacist initial offense: $50 - $100
Pharmacist subsequent offense(s): $250 - $500
Pharmacy initial offense: $250 - $500
Pharmacy subsequent offense(s): $1,000 - $2,000

(42) failing to offer to counsel any person receiving a prescription medication, in violation of Subsection R156-17b-502(14):
Pharmacy personnel initial offense: $500 - $2,500
Pharmacy personnel subsequent offense(s): $5,000 - $10,000
Pharmacy: $2,000 per occurrence

(43) failing to pay an administrative fine within the time designated by the Division, in violation of Subsection R156-17b-502(15):
Double the original penalty amount up to $10,000

(44) failing to comply with the PIC standards as established in Section R156-17b-603, in violation of Subsection R156-17b-502(16):
initial offense: $500 - $2,000
subsequent offense(s) $2,000 - $10,000

(45) failing to take appropriate steps to avoid or resolve identified drug therapy management problems as referenced in Subsection R156-17b-611(3), in violation of Subsection R156-17b-502(17):
initial offense: $500 - $2,500
subsequent offense: $5,000 - $10,000

(46) dispensing a medication that has been discontinued by the FDA, in violation of Subsection R156-17b-502(18):
initial offense: $100 - $500
subsequent offense: $200 - $1,000

(47) failing to keep or report accurate records of training hours, in violation of Subsection R156-17b-502(19):
initial offense: $100 - $500
subsequent offense: $200 - $1,000

(48) failing to provide PIC information to the Division within 30 days of a change in PIC, in violation of Subsection R156-17b-502(20):
initial offense: $100 - $500
subsequent offense: $200 - $1,000

(49) requiring a pharmacy, PIC, or any other pharmacist to operate a pharmacy with unsafe personnel ratio, in violation of Subsection R156-17b-502(21):

initial offense: $500 - $2,000
subsequent offense: $2,000 - $10,000

(50) failing to update the Division within seven calendar days of any change in the email address designated for use in self-audits or pharmacy alerts, in violation of Subsection R156-17b-502(22):

Pharmacist initial offense: $100 - $300
Pharmacist subsequent offense(s): $500 - $1,000
Pharmacy initial offense: $250 - $500
Pharmacy subsequent offense(s): $500 - $1,250

(51) practicing or attempting to practice as a pharmacist, pharmacist intern, or pharmacy technician or operating a pharmacy without a license, in violation of Subsection 58-1-501(1)(a):

initial offense: $500 - $2,000
subsequent offense(s): $2,000 - $10,000

(52) impersonating a licensee or practicing under a false name, in violation of Subsection 58-1-501(1)(b):

initial offense: $500 - $2,000
subsequent offense(s): $2,000 - $10,000

(53) knowingly employing an unlicensed person, in violation of Subsection 58-1-501(1)(c):

initial offense: $500 - $1,000
subsequent offense(s): $1,000 - $5,000

(54) knowingly permitting the use of a license by another person, in violation of Subsection 58-1-501(1)(d):

initial offense: $500 - $1,000
subsequent offense(s): $1,000 - $5,000

(55) obtaining a passing score, applying for or obtaining a license or otherwise dealing with the Division or Board through the use of fraud, forgery, intentional deception, misrepresentation, misstatement, or omission, in violation of Subsection 58-1-501(1)(e):

initial offense: $100 - $2,000
subsequent offense(s): $2,000 - $10,000

(56) issuing a prescription without prescriptive authority conferred by a license or an exemption to licensure, in violation of Subsection 58-1-501(1)(f)(i)(A)and 58-1-501(2)(m)(i):

initial offense: $500 - $2,000
subsequent offense(s): $2,000 - $10,000

(57) issuing a prescription without prescriptive authority conferred by a license or an exemption to licensure without obtaining information sufficient to establish a diagnosis, identify underlying conditions and contraindications to treatment in a situation other than an emergency or an on-call cross coverage situation, in violation of Subsection 58-1-501(1)(f)(i)(B)and 58-1-501(2)(m)(ii):

initial offense: $500 - $2,000
subsequent offense(s): $2,000 - $10,000

(58) violating or aiding or abetting any other person to violate any statute, rule or order regulating pharmacy, in violation of Subsection 58-1-501(2)(a):

initial offense: $[~~500~~]100 - $2,000
subsequent offense(s): $2,000 - $10,000

(59) violating or aiding or abetting any other person to violate any generally accepted professional or ethical standard, in violation of Subsection 58-1-501(2)(b):

initial offense: $500 - $2,000
subsequent offense(s): $2,000 - $10,000

(60) engaging in conduct that results in conviction of, or a plea of nolo contendere, or a plea of guilty or nolo contendere held in abeyance to a crime, in violation of Subsection 58-1-501(2)(c):

initial offense: $500 - $2,000
subsequent offense(s): $2,000 - $10,000

(61) engaging in conduct that results in disciplinary action by any other jurisdiction or regulatory authority, that if the conduct had occurred in this state, would constitute grounds for denial of licensure or disciplinary action, in violation of Subsection 58-1-501(2)(d):

initial offense: $100 - $500
subsequent offense(s): $200 - $1,000

(62) engaging in conduct, including the use of intoxicants, drugs, or similar chemicals, to the extent that the conduct does or may impair the ability to safely engage in practice as a pharmacist, pharmacy intern or pharmacy technician, in violation of Subsection 58-1-501(2)(e):

initial offense: $100 - $500
subsequent offense(s): $200 - $1,000

(63) practicing or attempting to practice as a pharmacist, pharmacy intern or pharmacy technician when physically or mentally unfit to do so, in violation of Subsection 58-1-501(2)(f):

initial offense: $100 - $500
subsequent offense(s): $200 - $1,000

(64) practicing or attempting to practice as a pharmacist, pharmacy intern, or pharmacy technician through gross incompetence, gross negligence or a pattern of incompetency or negligence, in violation of Subsection 58-1-501(2)(g):

initial offense: $500 - $2,000
subsequent offense(s): $2,000 - $10,000

(65) practicing or attempting to practice as a pharmacist, pharmacy intern or pharmacy technician by any form of action or communication which is false, misleading, deceptive or fraudulent, in violation of Subsection 58-1-501(2)(h):

initial offense: $100 - $500
subsequent offense(s): $200 - $1,000

(66) practicing or attempting to practice as a pharmacist, pharmacy intern or pharmacy technician beyond the individual's scope of competency, abilities or education, in violation of Subsection 58-1-501(2)(i):

initial offense: $100 - $500
subsequent offense(s): $200 - $1,000

(67) practicing or attempting to practice as a pharmacist, pharmacy intern or pharmacy technician beyond the scope of licensure, in violation of Subsection 58-1-501(2)(j):

initial offense: $100 - $500
subsequent offense(s): $200 - $1,000

(68) verbally, physically or mentally abusing or exploiting any person through conduct connected with the licensee's practice, in violation of Subsection 58-1-501(2)(k):

initial offense: $100 - $1,000
subsequent offense(s): $500 - $2,000

(69) acting as a supervisor without meeting the qualification requirements for that position as defined by statute or rule, in violation of Subsection 58-1-501(2)(l):

initial offense: $100 - $500
subsequent offense(s): $200 - $1,000

(70) violating a provision of Section 58-1-501.5, in violation of Subsection 58-1-501(2)(n):
initial offense: $500 - $2,000
subsequent offense(s): $2,000 - $10,000
(71) surrendering licensure to any other licensing or regulatory authority having jurisdiction over the licensee or applicant in the same occupation or profession while an investigation or inquiry into allegations of unprofessional or unlawful conduct is in progress or after a charging document has been filed against the applicant or licensee alleging unprofessional or unlawful conduct, in violation of Subsection R156-1-501(1):
initial offense: $500 - $2,000
subsequent offense(s): $2,500 - $10,000
(72) practicing a regulated occupation or profession in, through, or with a limited liability company that has omitted the words, "limited company," "limited liability company," or the abbreviation "L.C." or "L.L.C." in the commercial use of the name of the limited liability company, in violation of Subsection R156-1-501 (2):
initial offense: $500 - $2,000
subsequent offense(s): $2,500 - $10,000
(73) practicing a regulated occupation or profession in, through, or with a limited partnership that has omitted the words, "limited partnership," "limited," or the abbreviation "L.P." or "L.td." in the commercial use of the name of the limited partnership, in violation of Subsection R156-1-501(3):
initial offense: $500 - $2,000
subsequent offense(s): $2,500 - $10,000
(74) practicing a regulated occupation or profession in, through, or with a professional corporation that has omitted the words "professional corporation" or the abbreviation "P.C." in the commercial use of the name of the professional corporation, in violation of Subsection R156-1-501(4):
initial offense: $500 - $2,000
subsequent offense(s): $2,500 - $10,000
(75) using a capitalized DBA (doing-business-as name) that has not been properly registered with the Division of Corporations and with the Division of Occupational and Professional Licensing, in violation of Subsection R156-1-501(5):
initial offense: $500 - $2,000
subsequent offense(s): $2,500 - $10,000
(76) failing, as a prescribing practitioner, to follow the "Model Policy for the Use of Controlled Substance[~~S~~]s for the Treatment of Pain," May 2004, established by the Federation of State Medical Boards of the United States, Inc., which is hereby adopted and incorporated by reference, in violation of R156-1-501(6):
initial offense: $500 - $2,000
subsequent offense(s): $2,500 - $10,000
(77) engaging in prohibited acts as defined in Section 58-37-8, in violation of Section 58-37-8:
initial offense: $1,000 - $5,000
subsequent offense(s) $5,000 - $10,000
(78) self-prescribing or self-administering by a licensee of any Schedule II or Schedule III controlled substance which is not prescribed by another practitioner having authority to prescribe the drug, in violation of Subsection R156-37-502(1)(a):
initial offense: $500 - $2,000
subsequent offense(s): $2,500 - $10,000
(79) prescribing or administering a controlled substance for a condition that the licensee is not licensed or competent to treat, in violation of Subsection R156-37-502(1)(b):
initial offense: $500 - $2,000
subsequent offense(s): $2,500 - $10,000
(80) violating any federal or state law relating to controlled substances, in violation of Subsection R156-37-502(2):
initial offense: $500 - $2,000
subsequent offense(s): $2,500 - $10,000
(81) failing to deliver to the Division all controlled substance certificates issued by the Division, to the Division, upon an action which revokes, suspends, or limits the license, in violation of R156-37-502(3):
initial offense: $500 - $2,000
subsequent offense(s): $2,500 - $10,000
(82) failing to maintain controls over controlled substances which would be considered by a prudent licensee to be effective against diversion, theft, or shortage of controlled substances, in violation of Subsection R156-37-502(4):
initial offense: $500 - $2,000
subsequent offense(s): $2,500 - $10,000
(83) being unable to account for shortages of controlled substances in any controlled substances inventory for which the licensee has responsibility, in violation of Subsection R156-37-502(5):
initial offense: $500 - $2,000
subsequent offense(s): $2,500 - $10,000
(84) knowingly prescribing, selling, giving away, or administering, directly or indirectly, or offering to sell, furnish, give away, or administer any controlled substance to a drug dependent person, as defined in Subsection 58-37-2(1)(s), except for legitimate medical purposes as permitted by law, in violation of Subsection R156-37-502(6):
initial offense: $500 - $2,000
subsequent offense(s): $2,500 - $10,000
(85) refusing to make available for inspection controlled substance stock, inventory, and records as required under this rule or other law regulating controlled substances and controlled substance records, in violation of Subsection R156-37-502(7):
initial offense: $500 - $2,000
subsequent offense(s): $2,500 - $10,000
(86) failing to submit controlled substance prescription information to the database manager after being notified in writing to do so, in violation of Subsection R156-37-502(8):
initial offense: $500 - $2,000
subsequent offense(s): $2,500 - $10,000
(87) any other conduct which constitutes unprofessional or unlawful conduct:
initial offense: $100 - $500
subsequent offense(s): $200 - $1,000

R156-17b-502. Unprofessional Conduct.

"Unprofessional conduct" includes:

(1) violating any provision of the American Pharmaceutical Association (APhA) Code of Ethics for Pharmacists, October 27, 1994, which is hereby incorporated by reference;

(2) failing to comply with the USP-NF Chapters 795 and 797;

(3) failing to comply with the continuing education requirements set forth in these rules;

(4) failing to provide the Division with a current mailing address within a 10 business day period of time following any change of address;

(5) defaulting on a student loan;

(6) failing to abide by all applicable federal and state law regarding the practice of pharmacy;

(7) failing to comply with administrative inspections;

(8) failing to return or providing false information on a self-inspection report;

(9) violating the laws and rules regulating operating standards in a pharmacy discovered upon inspection by the Division;

(10) abandoning a pharmacy or leaving prescription drugs accessible to the public;

(11) failing to identify licensure classification when communicating by any means;

(12) practicing pharmacy with an inappropriate pharmacist to pharmacy intern ratio established by Subsection R156-17b-606(1)(d) or pharmacist to pharmacy technician ratio as established by Subsection R156-17b-601(3);

(13) allowing any unauthorized persons in the pharmacy;

(14) failing to offer to counsel any person receiving a prescription medication;

(15) failing to pay an administrative fine that has been assessed in the time designated by the Division;

(16) failing to comply with the PIC standards as established in Section R156-17b-603;

(17) failing to adhere to institutional policies and procedures related to technician checking of medications when technician checking is utilized;

([~~17~~]18) failing to take appropriate steps to avoid or resolve identified drug therapy management problems as referenced in Subsection R156-17b-611(3);

([~~18~~]19) dispensing medication that has been discontinued by the FDA;

([~~19~~]20) failing to keep or report accurate records of training hours;

([~~20~~]21) failing to provide PIC information to the Division within 30 days of a change in PIC;

([~~21~~]22) requiring a pharmacy, PIC, or any other pharmacist to operate the pharmacy or allow operation of the pharmacy with a ratio of supervising pharmacist to pharmacy technician/pharmacy intern/support personnel which, under the circumstances of the particular practice setting, results in, or reasonably would be expected to result in, an unreasonable risk of harm to public health, safety, and welfare;[~~and~~]

([~~22~~]23) failing to update the Division within seven calendar days of any change in the email address designated for use in self-audits or pharmacy alerts; and

(24) effective November 30, 2014, failing to comply with prescription container label standards established in USP-NF Chapter 17.

R156-17b-601. Operating Standards - Pharmacy Technician.

In accordance with Subsection 58-17b-102([~~54~~]53), practice as a licensed pharmacy technician is defined as follows:

(1) The pharmacy technician may perform any task associated with the physical preparation and processing of prescription and medication orders including:

(a) receiving written prescriptions;

(b) taking refill orders;

(c) entering and retrieving information into and from a database or patient profile;

(d) preparing labels;

(e) retrieving medications from inventory;

(f) counting and pouring into containers;

(g) placing medications into patient storage containers;

(h) affixing labels;

(i) compounding;

(j) counseling for over-the-counter drugs and dietary supplements under the direction of the supervising pharmacist as referenced in Subsection 58-17b-102[~~(55)(b)(2)~~]53;

(k) accepting new prescription drug orders left on voicemail for a pharmacist to review;[~~and~~]

(l) performing checks of certain medications prepared for distribution filled or prepared by another technician within a Class B hospital pharmacy, such as medications prepared for distribution to an automated dispensing cabinet, cart fill, crash cart medication tray, or unit dosing from a prepared stock bottle, in accordance with the following operating standards:

(i) technicians authorized by a hospital to check medications shall have at least one year of experience working as a pharmacy technician and at least six months experience at the hospital where the technician is authorized to check medications;

(ii) technicians shall only check steps in the medication distribution process that do not require the professional judgment of a pharmacist and that are supported by sufficient automation or technology to ensure accuracy (e.g. barcode scanning, drug identification automation, checklists, visual aids);

(iii) hospitals that authorize technicians to check medications shall have a training program and ongoing competency assessment that is documented and retrievable for the duration of each technician's employment and at least three years beyond employment, and shall maintain a list of technicians on staff that are allowed to check medications;

(iv) hospitals that authorize technicians to check medications shall have a medication error reporting system in place and shall be able to produce documentation of its use;

(v) a supervising pharmacist shall be immediately available during all times that a pharmacy technician is checking medications;

(vi) hospitals that authorize technicians to check medications shall have comprehensive policies and procedures that guide technician checking that include the following:

(A) process for technician training and ongoing competency assessment and documentation;

(B) process for supervising technicians who check medications;

(C) list of medications, or types of medications that may or may not be checked by a technician;

(D) description of the automation or technology that will be utilized by the institution to augment the technician check;

(E) process for maintaining a permanent log of the unique initials or identification codes which identify each technician responsible for checked medications by name; and

(F) description of processes used to track and respond to medication errors; and

([~~I~~]m) additional tasks not requiring the judgment of a pharmacist.

(2) The pharmacy technician shall not receive new [~~verbal~~]prescriptions or medication orders as described in Subsection 58-17b-102(53)(b)(iv), clarify prescriptions or medication orders nor perform drug utilization reviews. A new prescription, as used in Subsection 58-17b-102(53)(b)(iv), does not include authorization of a refill of a legend drug.

(3) Pharmacy technicians, including no more than one pharmacy technician-in-training per shift, shall have [~~direct~~]general supervision by a pharmacist in accordance with Subsection R156-17b-603(2)(s).

R156-17b-602. Operating Standards - Pharmacy Intern.

A pharmacy intern may provide services including the practice of pharmacy under the supervision of an approved preceptor, as defined in Subsection 58-17b-102([~~50~~]48), provided the pharmacy intern met the criteria as established in Subsection R156-17b-306.

R156-17b-603. Operating Standards - Pharmacist-in-charge.

(1) The PIC shall have the responsibility to oversee the operation of the pharmacy in conformance with all laws and rules pertinent to the practice of pharmacy and the distribution of drugs, durable medical equipment and medical supplies. The PIC shall be personally in full and actual charge of the pharmacy.

(2) In accordance with Subsections 58-17b-103(1) and 58-17b-601(1), a secure email address shall be established by the PIC or responsible party for the pharmacy to be used for self-audits or pharmacy alerts initiated by the Division. The PIC or responsible party shall notify the Division of the pharmacy's secure email address initially as follows:

(a) at the September 30, 2013 renewal for all licensees; and

(b) thereafter, on the initial application for licensure.

(3) The duties of the PIC shall include:

(a) assuring that pharmacists and pharmacy interns dispense drugs or devices, including:

(i) packaging, preparation, compounding and labeling; and

(ii) ensuring that drugs are dispensed safely and accurately as prescribed;

(b) assuring that pharmacy personnel deliver drugs to the patient or the patient's agent, including ensuring that drugs are delivered safely and accurately as prescribed;

(c) assuring that a pharmacist, pharmacy intern or pharmacy technician communicates to the patient or the patient's agent information about the prescription drug or device or non-prescription products;

(d) assuring that a pharmacist or pharmacy intern communicates to the patient or the patient's agent, at their request, information concerning any prescription drugs dispensed to the patient by the pharmacist or pharmacy intern;

(e) assuring that a reasonable effort is made to obtain, record and maintain patient medication records;

(f) education and training of pharmacy technicians;

(g) establishment of policies for procurement of prescription drugs and devices and other products dispensed from the pharmacy;

(h) disposal and distribution of drugs from the pharmacy;

(i) bulk compounding of drugs;

(j) storage of all materials, including drugs, chemicals and biologicals;

(k) maintenance of records of all transactions of the pharmacy necessary to maintain accurate control over and accountability for all pharmaceutical materials required by applicable state and federal laws and regulations;

(l) establishment and maintenance of effective controls against theft or diversion of prescription drugs and records for such drugs;

(m) if records are kept on a data processing system, the maintenance of records stored in that system shall be in compliance with pharmacy requirements;

(n) legal operation of the pharmacy including meeting all inspection and other requirements of all state and federal laws, rules and regulations governing the practice of pharmacy;

(o) assuring that any automated pharmacy system is in good working order and accurately dispenses the correct strength, dosage form and quantity of the drug prescribed while maintaining appropriate record keeping and security safeguards;

(p) implementation of an ongoing quality assurance program that monitors performance of the automated pharmacy system, which is evidenced by written policies and procedures developed for pharmaceutical care;

(q) assuring that all relevant information is submitted to the Controlled Substance Database in the appropriate format and in a timely manner;

(r) assuring that all personnel working in the pharmacy have the appropriate licensure;

(s) assuring that no pharmacy or pharmacist operates the pharmacy or allows operation of the pharmacy with a ratio of pharmacist to pharmacy technician/pharmacy intern/support personnel which, under the circumstances of the particular practice setting, results in, or reasonably would be expected to result in, an unreasonable risk of harm to public health, safety, and welfare;

(t) assuring that the PIC assigned to the pharmacy is recorded with the Division and that the Division is notified of a change in PIC within 30 days of the change; and

(u) assuring with regard to the secure email address used for self-audits and pharmacy alerts that:

(i) the pharmacy uses a single email address; and

(ii) the pharmacy notifies the Division, on the form prescribed, of any change in the email address within seven calendar days of the change.

R156-17b-605. Operating Standards - Inventory Requirements.

[~~(1) General requirements for inventory of a pharmacy shall include the following:~~

~~(a) the PIC shall be responsible for taking all required inventories, but may delegate the performance of the inventory to another person or persons;~~

~~(b) the inventory records shall be maintained for a period of five years and be readily available for inspection;~~

~~(c) the inventory records shall be filed separately from all other records;~~

~~(d) the inventory records shall be in a typewritten or printed form and include all stocks of controlled substances on hand on the date of the inventory including any that are out of date drugs and drugs in automated pharmacy systems. An inventory taken by use of a verbal recording device shall be promptly transcribed;~~

~~(e) the inventory may be taken either as of the opening of the business or the close of business on the inventory date;~~

~~(f) the person taking the inventory and the PIC shall indicate the time the inventory was taken and shall sign and date the inventory with the date the inventory was taken. The signature of the PIC and the date of the inventory shall be documented within 72 hours or three working days of the completed initial, annual, change of ownership and closing inventory;~~

~~(g) the person taking the inventory shall make an exact count or measure all controlled substances listed in Schedule I or II;~~

~~(h) the person taking the inventory shall make an estimated count or measure all Schedule III, IV or V controlled substances, unless the container holds more than 1,000 tablets or capsules in which case an exact count of the contents shall be made;~~

~~(i) the inventory of Schedule I and II controlled substances shall be listed separately from the inventory of Schedule III, IV and V controlled substances;~~

~~(j) if the pharmacy maintains a perpetual inventory of any of the drugs required to be inventoried, the perpetual inventory shall be reconciled on the date of the inventory; and~~

] ([~~k~~]1) [~~all~~]All out of date legend drugs and controlled substances shall be removed from the inventory at regular intervals and in correlation to the beyond use date [~~of expiration~~]imprinted on the label.

(2) General requirements for inventory of a pharmacy shall include the following:

(a) the PIC shall be responsible for taking all required inventories, but may delegate the performance of the inventory to another person or persons;

(b) the inventory records shall be maintained for a period of five years and be readily available for inspection;

(c) the inventory records shall be filed separately from all other records;

(d) the inventory records shall be in a typewritten or printed form and include all stocks of controlled substances on hand on the date of the inventory including any that are out of date drugs and drugs in automated pharmacy systems. An inventory taken by use of a verbal recording device shall be promptly transcribed;

(e) the inventory may be taken either as the opening of the business or the close of business on the inventory date;

(f) the person taking the inventory and the PIC shall indicate the time the inventory was taken and shall sign and date the inventory with the date the inventory was taken. The signature of the PIC and the date of the inventory shall be documented within 72 hours or three working days of the completed initial, annual, change of ownership and closing inventory;

(g) the person taking the inventory shall make an exact count or measure all controlled substances listed in Schedule I or II;

(h) the person taking the inventory shall make an estimated count or measure of all Schedule III, IV or V controlled substances, unless the container holds more than 1,000 tablets or capsules in which case an exact count of the contents shall be made;

(i) the inventory of Schedule I and II controlled substances shall be listed separately from the inventory of Schedule III, IV and V controlled substances;

(j) if the pharmacy maintains a perpetual inventory of any of the drugs required to be inventories, the perpetual inventory shall be reconciled on the date of the inventory.

([~~2~~]3) Requirements for taking the initial controlled substances inventory shall include the following:

(a) all pharmacies having any stock of controlled substances shall take an inventory on the opening day of business. Such inventory shall include all controlled substances including any out-of-date drugs and drugs in automated pharmacy systems;

(b) in the event a pharmacy commences business with [~~none of the drugs specified in paragraph (2)(a) of this section~~]no controlled substances on hand, the pharmacy shall record this fact as the initial inventory. An inventory reporting no Schedule I and II controlled substances shall be listed separately from an inventory reporting no Schedule III, IV, and V controlled substances;

(c) the initial inventory shall serve as the pharmacy's inventory until the next completed inventory as specified in Subsection ([~~3~~]4) of this section; and

(d) when combining two pharmacies, each pharmacy shall:

(i) conduct a separate closing pharmacy inventory of controlled substances on the date of closure; and

(ii) conduct a combined opening inventory of controlled substances for the new pharmacy prior to opening.

([~~3~~]4) Requirement for annual controlled substances inventory shall be within 12 months following the inventory date of each year and may be taken within four days of the specified inventory date and shall include all stocks including out-of-date drugs and drugs in automated pharmacy systems.

([~~4~~]5) Requirements for change of ownership shall include the following:

(a) a pharmacy that changes ownership shall take an inventory of all legend drugs and controlled substances including out-of-date drugs and drugs in automated pharmacy systems on the date of the change of ownership;

(b) such inventory shall constitute, for the purpose of this section, the closing inventory for the seller and the initial inventory for the buyer; and

(c) transfer of Schedule I and II controlled substances shall require the use of official DEA order forms (Form 222).

([~~5~~]6) Requirement for taking inventory when closing a pharmacy includes the PIC, owner, or the legal representative of a pharmacy that ceases to operate as a pharmacy shall forward to the Division, within ten days of cessation of operation, a statement attesting that an inventory has been conducted, the date of closing and a statement attesting the manner by which legend drugs and controlled substances possessed by the pharmacy were transferred or disposed.

(7) All pharmacies shall maintain a perpetual inventory of all Schedule II controlled substances which shall be reconciled according to facility policy.

R156-17b-612. Operating Standards - Prescriptions.

In accordance with Subsection 58-17b-601(1), the following shall apply to prescriptions:

(1) Prescription orders for controlled substances (including prescription transfers) shall be handled according to the rules of the Federal Drug Enforcement Administration.

(2) A prescription issued by an authorized licensed practitioner, if verbally communicated by an agent of that practitioner upon that practitioner's specific instruction and authorization, may be accepted by a pharmacist or pharmacy intern.

(3) A prescription issued by a licensed prescribing practitioner, if electronically communicated by an agent of that practitioner, upon that practitioner's specific instruction and authorization, may be accepted by a pharmacist, pharmacy intern and pharmacy technician.

(4) In accordance with Sections 58-17b-609 and 58-17b-611, prescription files, including refill information, shall be maintained for a minimum of five years and shall be immediately retrievable in written or electronic format.

(5) Prescriptions for legend drugs having a remaining authorization for refill may be transferred by the pharmacist or pharmacy intern at the pharmacy holding the prescription to a pharmacist or pharmacy intern at another pharmacy upon the authorization of the patient to whom the prescription was issued or electronically as authorized under Subsection R156-17b-613(9). The transferring pharmacist or pharmacy intern and receiving pharmacist or pharmacy intern shall act diligently to ensure that the total number of authorized refills is not exceeded. The following additional terms apply to such a transfer:

(a) the transfer shall be communicated directly between pharmacists or pharmacy interns or as authorized under Subsection R156-17b-613(9);

(b) both the original and the transferred prescription drug orders shall be maintained for a period of five years from the date of the last refill;

(c) the pharmacist or pharmacy intern transferring the prescription drug order shall void the prescription electronically or write void/transfer on the face of the invalidated prescription manually;

(d) the pharmacist or pharmacy intern receiving the transferred prescription drug order shall:

(i) indicate on the prescription record that the prescription was transferred electronically or manually; and

(ii) record on the transferred prescription drug order the following information:

(A) original date of issuance and date of dispensing or receipt, if different from date of issuance;

(B) original prescription number and the number of refills authorized on the original prescription drug order;

(C) number of valid refills remaining and the date of last refill, if applicable;

(D) the name and address of the pharmacy and the name of the pharmacist or pharmacy intern to which such prescription is transferred; and

(E) the name of the pharmacist or pharmacy intern transferring the prescription drug order information;

(e) the data processing system shall have a mechanism to prohibit the transfer or refilling of legend drugs or controlled substance prescription drug orders which have been previously transferred; and

(f) a pharmacist or pharmacy intern may not refuse to transfer original prescription information to another pharmacist or pharmacy intern who is acting on behalf of a patient and who is making a request for this information as specified in Subsection (12) of this section.

(6) Prescriptions for terminal patients in licensed hospices, home health agencies or nursing homes may be partially filled if the patient has a medical diagnosis documenting a terminal illness and may not need the full prescription amount.

(7) Refills may be dispensed only in accordance with the prescriber's authorization as indicated on the original prescription drug order;

(8) If there are no refill instructions on the original prescription drug order, or if all refills authorized on the original prescription drug order have been dispensed, authorization from the prescribing practitioner shall be obtained prior to dispensing any refills.

(9) Refills of prescription drug orders for legend drugs may not be refilled after one year from the date of issuance of the original prescription drug order without obtaining authorization from the prescribing practitioner prior to dispensing any additional quantities of the drug.

(10) Refills of prescription drug orders for controlled substances shall be done in accordance with Subsection 58-37-6(7)(f).

(11) A pharmacist may exercise his professional judgment in refilling a prescription drug order for a drug, other than a controlled substance listed in Schedule II, without the authorization of the prescribing practitioner, provided:

(a) failure to refill the prescription might result in an interruption of a therapeutic regimen or create patient suffering;

(b) either:

(i) a natural or manmade disaster has occurred which prohibits the pharmacist from being able to contact the practitioner; or

(ii) the pharmacist is unable to contact the practitioner after a reasonable effort, the effort should be documented and said documentation should be available to the Division;

(c) the quantity of prescription drug dispensed does not exceed a 72-hour supply, unless the packaging is in a greater quantity;

(d) the pharmacist informs the patient or the patient's agent at the time of dispensing that the refill is being provided without such authorization and that authorization of the practitioner is required for future refills;

(e) the pharmacist informs the practitioner of the emergency refill at the earliest reasonable time;

(f) the pharmacist maintains a record of the emergency refill containing the information required to be maintained on a prescription as specified in this subsection; and

(g) the pharmacist affixes a label to the dispensing container as specified in Section 58-17b-602.

(12) If the prescription was originally filled at another pharmacy, the pharmacist may exercise his professional judgment in refilling the prescription provided:

(a) the patient has the prescription container label, receipt or other documentation from the other pharmacy which contains the essential information;

(b) after a reasonable effort, the pharmacist is unable to contact the other pharmacy to transfer the remaining prescription refills or there are no refills remaining on the prescription;

(c) the pharmacist, in his professional judgment, determines that such a request for an emergency refill is appropriate and meets the requirements of (a) and (b) of this subsection; and

(d) the pharmacist complies with the requirements of Subsections (11)(c) through (g) of this section.

(13) The address specified in Subsection 58-17b-602(1)(b) shall be a physical address, not a post office box.

(14) In accordance with Subsection 58-37-6(7)(e), a prescription may not be written, issued, filled, or dispensed for a Schedule I controlled substance unless:

(a) the person who writes the prescription is licensed to prescribe Schedule I controlled substances; and

(b) the prescribed controlled substance is to be used in research.

(15) Effective November 30, 2014, prescription container labels shall comply with standards established in USP-NF Chapter 17.

R156-17b-613. Operating Standards - Issuing Prescription Orders by Electronic Means.

In accordance with Subsections 58-17b-102([~~28~~]27) through ([~~29~~]28), 58-17b-602(1), R156-82, and R156-1, prescription orders may be issued by electronic means of communication according to the following standards:

(1) Prescription orders for Schedule II - V controlled substances received by electronic means of communication shall be handled according to Part 1304.04 of Section 21 of the CFR.

(2) Prescription orders for non-controlled substances received by electronic means of communication may be dispensed by a pharmacist or pharmacy intern only if all of the following conditions are satisfied:

(a) all electronically transmitted prescription orders shall include the following:

(i) all information that is required to be contained in a prescription order pursuant to Section 58-17b-602;

(ii) the time and date of the transmission, and if a facsimile transmission, the electronically encoded date, time and fax number of the sender; and

(iii) the name of the pharmacy intended to receive the transmission;

(b) the prescription order shall be transmitted under the direct supervision of the prescribing practitioner or his designated agent;

(c) the pharmacist shall exercise professional judgment regarding the accuracy and authenticity of the transmitted prescription. Practitioners or their agents transmitting medication orders using electronic equipment are to provide voice verification when requested by the pharmacist receiving the medication order. The pharmacist is responsible for assuring that each electronically transferred prescription order is valid and shall authenticate a prescription order issued by a prescribing practitioner which has been transmitted to the dispensing pharmacy before filling it, whenever there is a question;

(d) a practitioner may authorize an agent to electronically transmit a prescription provided that the identifying information of the transmitting agent is included on the transmission. The practitioner's electronic signature, or other secure method of validation, shall be provided with the electronic prescription; and

(e) an electronically transmitted prescription order that meets the requirements above shall be deemed to be the original prescription.

(3) This section does not apply to the use of electronic equipment to transmit prescription orders within inpatient medical facilities.

(4) No agreement between a prescribing practitioner and a pharmacy shall require that prescription orders be transmitted by electronic means from the prescribing practitioner to that pharmacy only.

(5) The pharmacist shall retain a printed copy of an electronic prescription, or a record of an electronic prescription that is readily retrievable and printable, for a minimum of five years. The printed copy shall be of non-fading legibility.

(6) Wholesalers, distributors, manufacturers, pharmacists and pharmacies shall not supply electronic equipment to any prescriber for transmitting prescription orders.

(7) An electronically transmitted prescription order shall be transmitted to the pharmacy of the patient's choice.

(8) Prescription orders electronically transmitted to the pharmacy by the patient shall not be filled or dispensed.

(9) A prescription order for a legend drug or controlled substance in Schedule III through V may be transferred up to the maximum refills permitted by law or by the prescriber by electronic transmission providing the pharmacies share a real-time, on-line database provided that:

(a) the information required to be on the transferred prescription has the same information as described in Subsection R156-17b-612(5)(a) through (f); and

(b) pharmacists, pharmacy interns or pharmacy technicians electronically accessing the same prescription drug order records may electronically transfer prescription information if the data processing system has a mechanism to send a message to the transferring pharmacy containing the following information:

(i) the fact that the prescription drug order was transferred;

(ii) the unique identification number of the prescription drug order transferred;

(iii) the name of the pharmacy to which it was transferred; and

(iv) the date and time of the transfer.

R156-17b-614a. Operating Standards - General Operating Standards, Class A and B Pharmacy.

(1) In accordance with Subsection 58-17b-601(1), the following operating standards [~~for the operations for a~~]apply to all Class A and Class B [~~pharmacy include~~]pharmacies, which may be supplemented by additional standards defined in this rule applicable to specific types of Class A and B pharmacies. The general operating standards include:

(a) shall be well lighted, well ventilated, clean and sanitary;

(b) the dispensing area, if any, shall have a sink with hot and cold culinary water separate and apart from any restroom facilities. This does not apply to clean rooms where sterile products are prepared. Clean rooms should not have sinks or floor drains that expose the area to an open sewer. All required equipment shall be clean and in good operating condition;

(c) be equipped to permit the orderly storage of prescription drugs and durable medical equipment in a manner to permit clear identification, separation and easy retrieval of products and an environment necessary to maintain the integrity of the product inventory;

(d) be equipped to permit practice within the standards and ethics of the profession as dictated by the usual and ordinary scope of practice to be conducted within that facility;

(e) be stocked with the quality and quantity of product necessary for the facility to meet its scope of practice in a manner consistent with the public health, safety and welfare; and

(f) be equipped with a security system to permit detection of entry at all times when the facility is closed.

(2) The temperature of the pharmacy shall be maintained within a range compatible with the proper storage of drugs. The temperature of the refrigerator and freezer shall be maintained within a range compatible with the proper storage of drugs requiring refrigeration or freezing.

(3) Facilities engaged in moderate or complex non-sterile or any level of sterile compounding activities shall be required to maintain proper records and procedure manuals and establish quality control measures to ensure stability, equivalency where applicable and sterility. The following requirements shall be met:

(a) shall follow USP-NF Chapter 795, compounding of non-sterile preparations, and USP-NF Chapter 797 if compounding sterile preparations;

(b) may compound in anticipation of receiving prescriptions in limited amounts;

(c) bulk active ingredients shall:

(i) be procured from a facility registered with the federal Food and Drug Administration; and

(ii) not be listed on the federal Food and Drug Administration list of drug products withdrawn or removed from the market for reasons of safety or effectiveness;

(d) a master worksheet sheet shall be developed and approved by a pharmacist for each batch of sterile or non-sterile pharmaceuticals to be prepared. Once approved, a duplicate of the master worksheet sheet shall be used as the preparation worksheet sheet from which each batch is prepared and on which all documentation for that batch occurs. The master worksheet sheet shall contain at a minimum:

(i) the formula;

(ii) the components;

(iii) the compounding directions;

(iv) a sample label;

(v) evaluation and testing requirements;

(vi) sterilization methods, if applicable;

(vii) specific equipment used during preparation such as specific compounding device; and

(viii) storage requirements;

(e) a preparation worksheet sheet for each batch of sterile or non-sterile pharmaceuticals shall document the following:

(i) identity of all solutions and ingredients and their corresponding amounts, concentrations, or volumes;

(ii) manufacturer lot number for each component;

(iii) component manufacturer or suitable identifying number;

(iv) container specifications (e.g. syringe, pump cassette);

(v) unique lot or control number assigned to batch;

(vi) [~~expiration~~]beyond use date of batch prepared products;

(vii) date of preparation;

(viii) name, initials or electronic signature of the person or persons involved in the preparation;

(ix) names, initials or electronic signature of the responsible pharmacist;

(x) end-product evaluation and testing specifications, if applicable; and

(xi) comparison of actual yield to anticipated yield, when appropriate;

(f) the label of each batch prepared of sterile or non-sterile pharmaceuticals shall bear at a minimum:

(i) the unique lot number assigned to the batch;

(ii) all solution and ingredient names, amounts, strengths and concentrations, when applicable;

(iii) quantity;

(iv) [~~expiration~~]beyond use date and time, when applicable;

(v) appropriate ancillary instructions, such as storage instructions or cautionary statements, including cytotoxic warning labels where appropriate; and

(vi) device-specific instructions, where appropriate;

(g) the [~~expiration~~]beyond use date assigned shall be based on currently available drug stability information and sterility considerations or appropriate in-house or contract service stability testing;

(i) sources of drug stability information shall include the following:

(A) references can be found in Trissel's "Handbook on Injectable Drugs", 17th Edition, October 31, 2012;

(B) manufacturer recommendations; and

(C) reliable, published research;

(ii) when interpreting published drug stability information, the pharmacist shall consider all aspects of the final sterile product being prepared such as drug reservoir, drug concentration and storage conditions; and

(iii) methods for establishing [~~expiration~~]beyond use dates shall be documented; and

(h) there shall be a documented, ongoing quality control program that monitors and evaluates personnel performance, equipment and facilities that follows the USP-NF Chapters 795 and 797 standards.

(4) The facility shall have current and retrievable editions of the following reference publications in print or electronic format and readily available and retrievable to facility personnel:

(a) Title 58, Chapter 1, Division of Occupational and Professional Licensing Act'

(b) R156-1, General Rule of the Division of Occupational and Professional Licensing;

(c) Title 58, Chapter 17b, Pharmacy Practice Act;

(d) R156-17b, Utah Pharmacy Practice Act Rule;

(e) Title 58, Chapter 37, Utah Controlled Substances Act;

(f) R156-37, Utah Controlled Substances Act Rule;

(g) Title 58, Chapter 37f, Controlled Substance Database Act;

(h) R156-37f, Controlled Substance Database Act Rule;

(i) Code of Federal Regulations (CFR) 21, Food and Drugs, Part 1300 to end or equivalent such as the USP DI Drug Reference Guides;

(j) current FDA Approved Drug Products (orange book); and

(k) any other general drug references necessary to permit practice dictated by the usual and ordinary scope of practice to be conducted within that facility.

(5) The facility shall post the license of the facility and the license or a copy of the license of each pharmacist, pharmacy intern and pharmacy technician who is employed in the facility, but may not post the license of any pharmacist, pharmacy intern or pharmacy technician not actually employed in the facility.

(6) Facilities shall have a counseling area to allow for confidential patient counseling, where applicable.

(7) If the pharmacy is located within a larger facility such as a grocery or department store, and a licensed Utah pharmacist is not immediately available in the facility, the pharmacy shall not remain open to pharmacy patients and shall be locked in such a way as to bar entry to the public or any non-pharmacy personnel. All pharmacies located within a larger facility shall be locked and enclosed in such a way as to bar entry by the public or any non-pharmacy personnel when the pharmacy is closed.

(8) Only a licensed Utah pharmacist or authorized pharmacy personnel shall have access to the pharmacy when the pharmacy is closed.

(9) The facility or parent company shall maintain a permanent log of the initials or identification codes which identify each dispensing pharmacist by name. The initials or identification code shall be unique to ensure that each pharmacist can be identified; therefore identical initials or identification codes shall not be used.

(10) The pharmacy facility shall maintain copy 3 of DEA order form (Form 222) which has been properly dated, initialed and filed and all copies of each unaccepted or defective order form and any attached statements or other documents.

(11) If applicable, a hard copy of the power of attorney authorizing a pharmacist to sign DEA order forms (Form 222) shall be available to the Division whenever necessary.

(12) Pharmacists or other responsible individuals shall verify that [~~the suppliers' invoices of legend drugs, including~~] controlled substances[~~,~~] are listed on the suppliers' invoices and were actually received by clearly recording their initials and the actual date of receipt of the controlled substances.

(13) The pharmacy facility shall maintain a record of suppliers' credit memos for controlled substances[~~and legend drugs~~].

(14) A copy of inventories required under Section R156-17b-605 shall be made available to the Division when requested.

(15) The pharmacy facility shall maintain hard copy reports of surrender or destruction of controlled substances and legend drugs submitted to appropriate state or federal agencies.

(16) If the pharmacy includes a drop/false ceiling, the pharmacy's perimeter walls shall extend to the hard deck, or other measures shall be taken to prevent unauthorized entry into the pharmacy.

R156-17b-615. Operating Standards - Class C Pharmacy - Pharmaceutical Wholesaler/Distributor and Pharmaceutical Manufacturer in Utah.

In accordance with Subsections 58-17b-102([~~46~~]44) and 58-17b-601(1), the operating standards for Class C pharmacies designated as pharmaceutical wholesaler/distributor and pharmaceutical manufacturer licensees includes the following:

(1) Every pharmaceutical wholesaler or manufacturer that engages in the wholesale distribution and manufacturing of drugs or medical devices located in this state shall be licensed by the Division. A separate license shall be obtained for each separate location engaged in the distribution or manufacturing of prescription drugs. Business names cannot be identical to the name used by another unrelated wholesaler licensed to purchase drugs and devices in Utah.

(2) Manufacturers distributing only their own FDA-approved prescription drugs or co-licensed product shall satisfy this requirement by registering their establishment with the Federal Food and Drug Administration pursuant to 21 CFR Part 207 and submitting the information required by 21 CFR Part 205, including any amendments thereto, to the Division.

(3) An applicant for licensure as a pharmaceutical wholesale distributor shall provide the following minimum information:

(a) All trade or business names used by the licensee (including "doing business as" and "formerly known as");

(b) Name of the owner and operator of the license as follows:

(i) if a person, the name, business address, social security number and date of birth;

(ii) if a partnership, the name, business address, and social security number and date of birth of each partner, and the partnership's federal employer identification number;

(iii) if a corporation, the name, business address, social security number and date of birth, and title of each corporate officer and director, the corporate names, the name of the state of incorporation, federal employer identification number, and the name of the parent company, if any, but if a publicly traded corporation, the social security number and date of birth for each corporate officer shall not be required;

(iv) if a sole proprietorship, the full name, business address, social security number and date of birth of the sole proprietor and the name and federal employer identification number of the business entity;

(v) if a limited liability company, the name of each member, social security number of each member, the name of each manager, the name of the limited liability company and federal employer identification number, and the name of the state in which the limited liability company was organized; and

(c) any other relevant information required by the Division.

(4) The licensed facility need not be under the supervision of a licensed pharmacist, but shall be under the supervision of a designated representative who meets the following criteria:

(a) is at least 21 years of age;

(b) has been employed full time for at least three years in a pharmacy or with a pharmaceutical wholesaler in a capacity related to the dispensing and distribution of, and recordkeeping related to prescription drugs;

(c) is employed by the applicant full time in a managerial level position;

(d) is actively involved in and aware of the actual daily operation of the pharmaceutical wholesale distribution;

(e) is physically present at the facility during regular business hours, except when the absence of the designated representative is authorized, including but not limited to, sick leave and vacation leave; and

(f) is serving in the capacity of a designated representative for only one licensee at a time.

(5) The licensee shall provide the name, business address, and telephone number of a person to serve as the designated representative for each facility of the pharmaceutical wholesaler that engages in the distribution of drugs or devices.

(6) Each facility that engages in pharmaceutical wholesale distribution and manufacturing facilities shall undergo an inspection by the Division for the purposes of inspecting the pharmaceutical wholesale distribution or manufacturing operation prior to initial licensure and periodically thereafter with a schedule to be determined by the Division.

(7) All pharmaceutical wholesalers and manufacturer shall publicly display or have readily available all licenses and the most recent inspection report administered by the Division.

(8) All Class C pharmacies shall:

(a) be of suitable size and construction to facilitate cleaning, maintenance and proper operations;

(b) have storage areas designed to provide adequate lighting, ventilation, sanitation, space, equipment and security conditions;

(c) have the ability to control temperature and humidity within tolerances required by all prescription drugs and prescription drug precursors handled or used in the distribution or manufacturing activities of the applicant or licensee;

(d) provide for a quarantine area for storage of prescription drugs and prescription drug precursors that are outdated, damaged, deteriorated, misbranded, adulterated, opened or unsealed containers that have once been appropriately sealed or closed or in any other way unsuitable for use or entry into distribution or manufacturing;

(e) be maintained in a clean and orderly condition; and

(f) be free from infestation by insects, rodents, birds or vermin of any kind.

(9) Each facility used for wholesale drug distribution or manufacturing of prescription drugs shall:

(a) be secure from unauthorized entry;

(b) limit access from the outside to a minimum in conformance with local building codes, life and safety codes and control access to persons to ensure unauthorized entry is not made;

(c) limit entry into areas where prescription drugs, prescription drug precursors, or prescription drug devices are held to authorized persons who have a need to be in those areas;

(d) be well lighted on the outside perimeter;

(e) be equipped with an alarm system to permit detection of entry and notification of appropriate authorities at all times when the facility is not occupied for the purpose of engaging in distribution or manufacturing of prescription drugs; and

(f) be equipped with security measures, systems and procedures necessary to provide reasonable security against theft and diversion of prescription drugs or alteration or tampering with computers and records pertaining to prescription drugs or prescription drug precursors.

(10) Each facility shall provide the storage of prescription drugs, prescription drug precursors, and prescription drug devices in accordance with the following:

(a) all prescription drugs and prescription drug precursors shall be stored at appropriate temperature, humidity and other conditions in accordance with labeling of such prescription drugs or prescription drug precursors or with requirements in the USP-NF;

(b) if no storage requirements are established for a specific prescription drug, prescription drug precursor, or prescription drug devices, the products shall be held in a condition of controlled temperature and humidity as defined in the USP-NF to ensure that its identity, strength, quality and purity are not adversely affected; and

(c) there shall be established a system of manual, electromechanical or electronic recording of temperature and humidity in the areas in which prescription drugs, prescription drug precursors, and prescription drug devices are held to permit review of the record and ensure that the products have not been subjected to conditions which are outside of established limits.

(11) Each person who is engaged in pharmaceutical wholesale distribution of prescription drugs for human use that leave, or have ever left, the normal distribution channel shall, before each pharmaceutical wholesale distribution of such drug, provide a pedigree to the person who receives such drug. A retail pharmacy or pharmacy warehouse shall comply with the requirements of this section only if the pharmacy engages in pharmaceutical wholesale distribution of prescription drugs. The pedigree shall:

(a) include all necessary identifying information concerning each sale in the chain of distribution of the product from the manufacturer, through acquisition and sale by any pharmaceutical wholesaler, until sale to a pharmacy or other person dispensing or administering the prescription drug. At a minimum, the necessary chain of distribution information shall include:

(i) name, address, telephone number, and if available, the email address of each owner of the prescription drug, and each pharmaceutical wholesaler of the prescription drug;

(ii) name and address of each location from which the product was shipped, if different from the owner's;

(iii) transaction dates;

(iv) name of the prescription drug;

(v) dosage form and strength of the prescription drug;

(vi) size of the container;

(vii) number of containers;

(viii) lot number of the prescription drug;

(ix) name of the manufacturer of the finished dose form; and

(x) National Drug Code (NDC) number.

(b) be maintained by the purchaser and the pharmaceutical wholesaler for five years from the date of sale or transfer and be available for inspection or use upon a request of an authorized officer of the law.

(12) Each facility shall comply with the following requirements:

(a) in general, each person who is engaged in pharmaceutical wholesale distribution of prescription drugs shall establish and maintain inventories and records of all transactions regarding the receipt and distribution or other disposition of the prescription drugs. These records shall include pedigrees for all prescription drugs that leave the normal distribution channel;

(b) upon receipt, each outside shipping container containing prescription drugs, prescription drug precursors, or prescription drug devices shall be visibly examined for identity and to prevent the acceptance of prescription drugs, prescription drug precursors, or prescription drug devices that are contaminated, reveal damage to the containers or are otherwise unfit for distribution:

(i) prescription drugs, prescription drug precursors, or prescription drug devices that are outdated, damaged, deteriorated, misbranded, adulterated or in any other way unfit for distribution or use in manufacturing shall be quarantined and physically separated from other prescription drugs, prescription drug precursors or prescription drug devices until they are appropriately destroyed or returned to their supplier; and

(ii) any prescription drug or prescription drug precursor whose immediate sealed or outer secondary sealed container has been opened or in any other way breached shall be identified as such and shall be quarantined and physically separated from other prescription drugs and prescription drug precursors until they are appropriately destroyed or returned to their supplier;

(c) each outgoing shipment shall be carefully inspected for identity of the prescription drug products or devices and to ensure that there is no delivery of prescription drugs or devices that have been damaged in storage or held under improper conditions:

(i) if the conditions or circumstances surrounding the return of any prescription drug or prescription drug precursor cast any doubt on the product's safety, identity, strength, quality or purity, then the drug shall be appropriately destroyed or returned to the supplier, unless examination, testing or other investigation proves that the product meets appropriate and applicable standards related to the product's safety, identity, strength, quality and purity;

(ii) returns of expired, damaged, recalled, or otherwise non-saleable prescription drugs shall be distributed by the receiving pharmaceutical wholesale distributor only to the original manufacturer or a third party returns processor that is licensed as a pharmaceutical wholesale distributor under this chapter;

(iii) returns or exchanges of prescription drugs (saleable or otherwise), including any redistribution by a receiving pharmaceutical wholesaler, shall not be subject to the pedigree requirements, so long as they are exempt from the pedigree requirement under the FDA's Prescription Drug Marketing Act guidance or regulations; and

(d) licensee under this Act and pharmacies or other persons authorized by law to dispense or administer prescription drugs for use by a patient shall be accountable for administering their returns process and ensuring that all aspects of their operation are secure and do not permit the entry of adulterated and counterfeit prescription drugs.

(13) A manufacturer or pharmaceutical wholesaler shall furnish prescription drugs only to a person licensed by the Division or to another appropriate state licensing authority to possess, dispense or administer such drugs for use by a patient.

(14) Prescription drugs furnished by a manufacturer or pharmaceutical wholesaler shall be delivered only to the business address of a person described in Subsections R156-17b-102(14)(c) and R156-17b-615(13), or to the premises listed on the license, or to an authorized person or agent of the licensee at the premises of the manufacturer or pharmaceutical wholesaler if the identity and authority of the authorized agent is properly established.

(15) Each facility shall establish and maintain records of all transactions regarding the receipt and distribution or other disposition of prescription drugs and prescription drug precursors and shall make inventories of prescription drugs and prescription drug precursors and required records available for inspection by authorized representatives of the federal, state and local law enforcement agencies in accordance with the following:

(a) there shall be a record of the source of the prescription drugs or prescription drug precursors to include the name and principal address of the seller or transferor and the address of the location from which the drugs were shipped;

(b) there shall be a record of the identity and quantity of the prescription drug or prescription drug precursor received, manufactured, distributed or shipped or otherwise disposed of by specific product and strength;

(c) there shall be a record of the dates of receipt and distribution or other disposal of any product;

(d) there shall be a record of the identity of persons to whom distribution is made to include name and principal address of the receiver and the address of the location to which the products were shipped;

(e) inventories of prescription drugs and prescription drug precursors shall be made available during regular business hours to authorized representatives of federal, state and local law enforcement authorities;

(f) required records shall be made available for inspection during regular business hours to authorized representatives of federal, state and local law enforcement authorities and such records shall be maintained for a period of two years following disposition of the products; and

(g) records that are maintained on site or immediately retrievable from computer or other electronic means shall be made readily available for authorized inspection during the retention period; or if records are stored at another location, they shall be made available within two working days after request by an authorized law enforcement authority during the two year period of retention.

(16) Each facility shall establish, maintain and adhere to written policies and procedures which shall be followed for the receipt, security, storage, inventory, manufacturing, distribution or other disposal of prescription drugs or prescription drug precursors, including policies and procedures for identifying, recording and reporting losses or thefts, and for correcting all errors and inaccuracies in inventories. In addition, the policies shall include the following:

(a) a procedure whereby the oldest approved stock of a prescription drug or precursor product is distributed or used first with a provision for deviation from the requirement if such deviation is temporary and appropriate;

(b) a procedure to be followed for handling recalls and withdrawals of prescription drugs adequate to deal with recalls and withdrawals due to:

(i) any action initiated at the request of the FDA or other federal, state or local law enforcement or other authorized administrative or regulatory agency;

(ii) any voluntary action to remove defective or potentially defective drugs from the market; or

(iii) any action undertaken to promote public health, safety or welfare by replacement of existing product with an improved product or new package design;

(c) a procedure to prepare for, protect against or handle any crisis that affects security or operation of any facility in the event of strike, fire, flood or other natural disaster or other situations of local, state or national emergency;

(d) a procedure to ensure that any outdated prescription drugs or prescription drug precursors shall be segregated from other drugs or precursors and either returned to the manufacturer, other appropriate party or appropriately destroyed;

(e) a procedure for providing for documentation of the disposition of outdated, adulterated or otherwise unsafe prescription drugs or prescription drug precursors and the maintenance of that documentation available for inspection by authorized federal, state or local authorities for a period of five years after disposition of the product;

(f) a procedure for identifying, investigating and reporting significant drug inventory discrepancies (involving counterfeit drugs suspected of being counterfeit, contraband, or suspect of being contraband) and reporting of such discrepancies within three (3) business days to the Division and/or appropriate federal or state agency upon discovery of such discrepancies; and

(g) a procedure for reporting criminal or suspected criminal activities involving the inventory of drugs and devices to the Division, FDA and if applicable, Drug Enforcement Administration (DEA), within three (3) business days.

(17) Each facility shall establish, maintain and make available for inspection by authorized federal, state and local law enforcement authorities, lists of all officers, directors, managers and other persons in charge which lists shall include a description of their duties and a summary of their background and qualifications.

(18) Each facility shall comply with laws including:

(a) operating within applicable federal, state and local laws and regulations;

(b) permitting the state licensing authority and authorized federal, state and local law enforcement officials, upon presentation of proper credentials, to enter and inspect their premises and delivery vehicles and to audit their records and written operating policies and procedures, at reasonable times and in a reasonable manner, to the extent authorized by law; and

(c) obtaining a controlled substance license from the Division and registering with the Drug Enforcement Administration (DEA) if they engage in distribution or manufacturing of controlled substances and shall comply with all federal, state and local regulations applicable to the distribution or manufacturing of controlled substances.

(19) Each facility shall be subject to and shall abide by applicable federal, state and local laws that relate to the salvaging or reprocessing of prescription drug products.

(20) A person who is engaged in the wholesale distribution or manufacturing of prescription drugs but does not have a facility located within Utah in which prescription drugs are located, stored, distributed or manufactured is exempt from Utah licensure as a Class C pharmacy, if said person is currently licensed and in good standing in each state of the United States in which that person has a facility engaged in distribution or manufacturing of prescription drugs entered into interstate commerce.

(21) No facility located at the same address shall be dually licensed as both a Class C pharmacy and any other classification of Class A or B pharmacy. Nothing within this section prevents a facility from obtaining licensure for a secondary address which operates separate and apart from any other facility upon obtaining proper licensure.

R156-17b-616. Operating Standards - Class D Pharmacy - Out of State Mail Order Pharmacies.

(1) In accordance with Subsections 58-1-301(3) and 58-17b-306(2), an application for licensure as a Class D pharmacy shall include:

(a) a pharmacy care protocol that includes the operating standards established in Subsections R156-17b-610(1) and (8) and R156-17b-[~~614~~]612(1) through (4);

(b) a copy of the pharmacist's license for the PIC; and

(c) a copy of the most recent state inspection showing the status of compliance with the laws and regulations for physical facility, records and operations.

(2) An out of state mail order pharmacy that compounds must follow the USP-NF Chapter 795 Compounding of non-sterile preparations and Chapter 797 Compounding of sterile preparations.

R156-17b-617e. Class E Pharmacy Operating Standards - Human Clinical Investigational Drug Research Facility.

(1) In accordance with Section 58-17b-302 and Subsection 58-17b-601(1), a human clinical investigational drug research facility licensed as a Class E Pharmacy shall, in addition to the requirements contained in Subsection R156-17b-617a, conduct operations in accordance with the operating standards set forth in 21 CFR Part 312, April 1, 2012 edition, which are hereby incorporated by reference.

(2) In accordance with Subsections 58-37-6(2)(b) and (3)(a)[~~.~~](i), persons licensed to conduct research with controlled substances in Schedules I-V within this state may possess, manufacture, produce, distribute, prescribe, dispense, administer, conduct research with, or perform laboratory analysis upon those substances to the extent authorized by their license.

(3) In accordance with Subsection 58-37-6(2), the following persons are not required to obtain a license and may lawfully possess controlled substances included in Schedules II-V:

(a) an agent or employee acting in the usual course of the person's business or employment, and

(b) an ultimate user, or any person who possesses any controlled substance pursuant to a lawful order of a practitioner.

(4) A separate license is required at each principal place of business or professional practice where the applicant manufactures, produces, distributes, dispenses, conducts research with, or performs laboratory analysis upon controlled substances.

KEY: pharmacists, licensing, pharmacies
Date of Enactment or Last Substantive Amendment: [~~August 8,~~]2013
Notice of Continuation: February 23, 2010
Authorizing, and Implemented or Interpreted Law: 58-17b-101; 58-17b-601(1); 58-37-1; 58-1-106(1)(a); 58-1-202(1)(a)

Commerce, Occupational and Professional Licensing
R156-49
Dietitian Certification Act Rule

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38074
FILED: 10/29/2013

RULE ANALYSIS
PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Division and the Dietitian Board are proposing amendments to the rule to implement required changes to the name of the credentialing association and registration examination because the national organization changed its name and the name of the examination. Amendments also delete Section R156-49-304 which deals with temporary certification. Temporary certification was originally offered because the examination was only available twice a year. The Division has not issued a temporary certification since 1999.

SUMMARY OF THE RULE OR CHANGE: The statute and rule citations are updated throughout the rule. In Section R156-49-102, amendments are made to update the names of the national association and required competency examination and to delete a reference to "temporary certificate holder". Section R156-49-304 is deleted in its entirety.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 58-49-1 and Subsection 58-1-106(1)(a) and Subsection 58-1-202(1)(a)

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: The Division will incur minimal costs of approximately $50 to print and distribute the rule once the proposed amendments are made effective. Any costs incurred will be absorbed in the Division's current budget.
♦ LOCAL GOVERNMENTS: The proposed amendments only apply to certified dietitians and applicants for licensure in that classification. As a result, the proposed amendments do not apply to local governments.
♦ SMALL BUSINESSES: The proposed amendments only apply to certified dietitians and applicants for licensure in that classification. Licensees and applicants for licensure may work in a small business; however, the proposed amendments would not directly affect the business. The Division anticipates it is unlikely the proposed amendments will result in any costs or savings primarily because the certification examination is now offered anytime by appointment and given the fact that no one has applied for temporary certification with the Division since 1999.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: The proposed amendments only apply to certified dietitians and applicants for licensure in that classification. The Division anticipates it is unlikely the proposed amendments will result in any costs or savings primarily because the certification examination is now offered anytime by appointment and given the fact that no one has applied for temporary certification with the Division since 1999.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The proposed amendments only apply to certified dietitians and applicants for licensure in that classification. The Division anticipates it is unlikely the proposed amendments will result in any costs or savings primarily because the certification examination is now offered anytime by appointment and given the fact that no one has applied for temporary certification with the Division since 1999.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule filing updates an existing definition to include a credentialing agency's changed name and deletes a section that has become unnecessary due to increased availability of the licensing examination. No fiscal impact to businesses is anticipated.

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:
♦ Sally Stewart by phone at 801-530-6179, by FAX at 801-530-6511, or by Internet E-mail at sstewart@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 12/23/2013

AUTHORIZED BY: Mark Steinagel, Director

R156. Commerce, Occupational and Professional Licensing.
R156-49. Dietitian Certification Act Rule.
R156-49-102. Definitions.

In addition to the definitions in Title 58, Chapters 1 and 49, as used in Title 58, Chapters 1 and 49 or this rule:

(1) "CDR" means the Commission on Dietetic Registration which is the credentialing agency for the Academy of Nutrition and Dietetics (formerly the American Dietetic Association).

(2) "Competency examination", as used in Subsection 58-49-4(4), means the Registration Examination for Dietitians or Dietitian Nutritionists established by the CDR.

(3) "Internship or pre-planned professional baccalaureate or post-baccalaureate experience", as used in Subsection 58-49-4(3), means completion of the supervised practice requirements established by the CDR.

(4) "Under the supervision of a certified dietitian", as used in Subsection [~~R156-49-304(1)(d)~~]58-49-4(3), means that the supervising certified dietitian is responsible for the dietetic activities performed by the [~~temporary certificate holder~~]student or intern.

R156-49-103. Authority - Purpose.

This rule is adopted by the [~~d~~]Division under the authority of Subsection 58-1-106(1)(a) to enable the [~~d~~]Division to administer Title 58, Chapter 49.

R156-49-302. Qualification for Licensure - CDR Registered Dietitian.

In accordance with Section 58-49-4, CDR registration as a Registered Dietitian is documentation that an individual has completed the requirements of Subsections 58-49-4(2), (3) and (4).

R156-49-303. Renewal Cycle - Procedures.

(1) In accordance with Subsection 58-1-308(1)(a), the renewal date for the two-year renewal cycle applicable to licensees under Title 58, Chapter 49 is established by rule in Section R156-1-308a.

(2) Renewal procedures shall be in accordance with Section R156-1-308c.[

~~**R156-49-304. Temporary Dietitian Certificate - Supervision Required.**~~

~~(1) In accordance with Section 58-1-303, an applicant for temporary dietitian certification shall:~~

~~(a) submit an application for temporary dietitian certification in the form prescribed by the division;~~

~~(b) pay a fee determined by the department under Section 63J-1-504;~~

~~(c) meet all the requirements for certification, except passing the CDR Registration Examination; and~~

~~(d) practice dietetics only under the supervision of a certified dietitian.~~

~~(2) The temporary certificate will not be issued for a period greater than 10 months.~~

~~(3) The temporary certificate will not be renewed or extended for any purpose.~~]

KEY: licensing, dietitians
Date of Enactment or Last Substantive Amendment: [~~October 19, 1998~~]2013
Notice of Continuation: February 7, 2013
Authorizing, and Implemented or Interpreted Law: 58-49-1; 58-1-106(1)(a); 58-1-202(1)(a)

Commerce, Occupational and Professional Licensing
R156-60b
Marriage and Family Therapist Licensing Act Rule

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38068
FILED: 10/17/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: During the 2013 General Legislative Session, H.B. 56 was passed which amended provisions of the Marriage and Family Therapist Licensing Act. As a result, the Division and the Marriage and Family Therapist Licensing Board are now proposing amendments to this rule to comply with the provisions of H.B. 56. Additional amendments are also being proposed as requested by the Marriage and Family Therapist Licensing Board.

SUMMARY OF THE RULE OR CHANGE: In Subsection R156-60b-102(2), the term "directly related to marriage and family therapy" is defined. During the last renewal cycle, the Division received several questions from therapists about what constituted a course that was "directly related to marriage and family therapy". As a result, the Board recommended that the Division further define the term. Adding this subsection required renumbering of the remaining subsections. In Section R156-60b-302b, H.B. 56 removed the phrase "face to face" from Subsection 58-60-305(1)(f) where the license requirement to complete not less than 100 hours of supervision is established. As a result, this filing removes the phrase "face to face" from the rule. Subsection R156-60b-302b(1)(e) is amended to clarify the intent of the experience requirement. In Subsection R156-60b-304(5)(c), the maximum number of contact hours of continuing education recognized for clinical readings, internet, or distance learning courses is increased from 10 to 15. The Board recommended this amendment upon review of requests from licensees practicing in rural Utah. In Subsection R156-60b-502(16) the incorporation of the July 1, 2012, edition of the Code of Ethics of the American

Association for Marriage and Family Therapy (AAMFT) replaces the incorporation of the July 2001 version. The 2012 version adds two paragraphs: Subprinciple 1.14, which addresses online therapy, and Subprinciple 2.7, which addresses the protection of electronic information.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 58-60-301 and Subsection 58-1-106(1)(a) and Subsection 58-1-202(1)(a)

MATERIALS INCORPORATED BY REFERENCES:

♦ Updates Code of Ethics of the American Association for Marriage and Family Therapy, published by American Association for Marriage and Family Therapy, July 1, 2012

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: The Division will incur minimal costs of approximately $100 to reprint and distribute the rule once the proposed amendments are made effective. Any costs incurred will be absorbed in the Division's current budget.
♦ LOCAL GOVERNMENTS: The proposed amendments only apply to licensed marriage and family therapists and applicants for licensure as a marriage and family therapist. As a result, the proposed amendments do not apply to local governments.
♦ SMALL BUSINESSES: The proposed amendments only apply to licensed marriage and family therapists and applicants for licensure in that classification. Licensees and applicants for licensure may work in a small business; however, the proposed amendments would not directly affect the business.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: The proposed amendments only apply to licensed marriage and family therapists and applicants for licensure in that classification. Increasing the maximum number of contact hours of continuing education recognized for clinical readings, internet, or distance learning courses from 10 to 15 is likely to result in a cost savings to licensees that complete continuing education via distance methods. Licensees practicing in rural Utah are likely to benefit the most from this amendment because they travel longer distances to attend live courses. Due to a wide range of circumstances, the Division cannot quantify anticipated savings to licensees.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The proposed amendments only apply to licensed marriage and family therapists and applicants for licensure in that classification. Increasing the maximum number of contact hours of continuing education recognized for clinical readings, internet, or distance learning courses from 10 to 15 is likely to result in a cost savings to licensees that complete continuing education via distance methods. Licensees practicing in rural Utah are likely to benefit the most from this amendment because they travel longer distances to attend live courses. Due to a wide range of circumstances, the Division cannot quantify anticipated savings to licensees.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule filing provides a definition regarding continuing education courses and clarifies and updates other existing provisions. While licensees may experience savings from being allowed to complete continuing education courses online, no fiscal impact to businesses is anticipated.

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

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

INTERESTED PERSONS MAY ATTEND A PUBLIC HEARING REGARDING THIS RULE:
♦ 12/13/2013 09:00 AM, Heber Wells Bldg, 160 E 300 S, Conference Room 474, Salt Lake City, UT

THIS RULE MAY BECOME EFFECTIVE ON: 12/23/2013

AUTHORIZED BY: Mark Steinagel, Director

R156. Commerce, Occupational and Professional Licensing.
R156-60b. Marriage and Family Therapist Licensing Act Rule.
R156-60b-102. Definitions.

In addition to the definitions in Title 58, Chapters 1 and 60, as used in Title 58, Chapters 1 and 60, or this rule:

(1) "AAMFT" means the American Association for Marriage and Family Therapy.

(2) "Directly related to marriage and family therapy", as used in R156-60b-304(2)(a), means that the continuing education course meets at least one of the following criteria:

(a) approved by an international, national, or state marriage and family therapy association, national or state marriage and family therapy regulatory board, or a COAMFTE accredited program; or

(b) title, objective, or official description of the course indicates instruction on relationships, couples, or families.

([~~2~~]3) "Face to face supervision" as described in Subsection R156-60b-302a(1)(b)(ii)(G) includes both individual and group supervision.

([~~3~~]4) "Group supervision" means supervision between the supervisor and no more than three supervisees, unless preapproved by the Board.

([~~4~~]5) "Individual supervision" means supervision between the supervisor and one or two supervisees.

([~~5~~]6) "Practicum", as used in R156-60b-302a(1)(b)(ii)(G) means a clinical program of training at an accredited school under general supervision in a setting other than a student's private practice.

([~~6~~]7) "Unprofessional conduct" as defined in Title 58, Chapters 1 and 60, is further defined, in accordance with Subsection 58-1-203(1)(e), in Section R156-60b-502.

R156-60b-302b. Qualifications for Licensure - Experience Requirements.

(1) Pursuant to Subsections 58-60-305(1)(e) and (f), an applicant shall complete marriage and family therapy and mental health therapy training consisting of a minimum of 4,000 hours of supervised training which shall:

(a) be completed in not less than two years;

(b) be completed while the applicant is an employee of a public or private agency engaged in mental health therapy;

(c) be completed under the supervision of a marriage and family therapist supervisor meeting the requirements under Section 58-60-307;

(d) include at least 100 hours of [~~clinical face to face~~]direct supervision spread uniformly throughout the training period;

(e) in accordance with Subsection 58-60-305(1)(f), include a minimum of 1,000 hours of mental health therapy of which at least 500 hours are in couple or family therapy with two or more clients participating and at least one physically present; and

(f) hours completed in a group therapy session may count only if the supervisee functions as the primary therapist.

(2) An applicant for licensure as a marriage and family therapist, who is not seeking licensure by endorsement based upon licensure in another jurisdiction, who has completed all or part of the marriage and family therapy training requirements outside the state, may receive credit for that training completed outside of the state if it is demonstrated by the applicant that the training completed outside the state is equivalent to and in all respects meets the requirements for training under Subsections 58-60-305(1)(e) and (f), and Subsection R156-60b-302b(1). The applicant shall have the burden of demonstrating by evidence satisfactory to the Division and Board that the training completed outside the state is equivalent to and in all respects meets the requirements under this subsection.

R156-60b-304. Continuing Education.

(1) In accordance with Section 58-60-105, there is hereby established a continuing education requirement for all individuals licensed under Title 58, Chapter 60, Part 3, as a marriage and family therapist.

(2) During each two year period commencing October 1st of each even numbered year, a marriage and family therapist shall be required to complete not fewer than 40 hours of continuing education directly related to the licensee's professional practice of which:

(a) at least 15 hours must be directly related to marriage and family therapy; and

(b) at least six hours must be in ethics/law, of which at least three hours must be directly related to marriage and family therapy.

(3) The required number of hours of continuing education for an individual who first becomes licensed during the two year period shall be decreased in a pro-rata amount equal to any part of that two year period preceding the date on which that individual first became licensed.

(4) Continuing education under this section shall:

(a) be relevant to the licensee's professional practice;

(b) be prepared and presented by individuals who are qualified by education, training, and experience to provide continuing education relevant to the practice of a mental health therapist; and

(c) have a method of verification of attendance and completion.

(5) Credit for continuing education shall be recognized in accordance with the following:

(a) unlimited hours shall be recognized for continuing education completed in blocks of time of not less than one hour in formally established classroom courses, seminars, or conferences which meet the criteria listed in Subsection (4) above, and which are approved by, conducted by, or under the sponsorship of universities, colleges or professional associations, societies and organizations representing a licensed profession whose program objectives relate to the practice of mental health therapy;

(b) a maximum of 14 hours per two year period may be recognized for:

(i) teaching courses under Subsection (5)(a); or

(ii) supervision of an individual completing the experience requirement for licensure as a mental health therapist;

(c) a maximum of [~~ten~~]15 hours per two year period may be recognized for clinical readings, internet or distance learning courses directly related to practice as a mental health therapist; and

(d) a maximum of two hours per two year period may be for continuing education from the Division of Occupational and Professional Licensing.

(6) A licensee shall be responsible for maintaining competent records of completed continuing education for a period of four years.

(7) A licensee requesting a waiver of the continuing education requirement must comply with requirements as established by rule in R156-1-308d.

(8) If a licensee completes more than the required number of hours of continuing education during a two year renewal cycle specified in Subsection (2), up to ten hours of the excess over the required number may be carried over to the next two year renewal cycle. No education received prior to a license being granted may be carried forward to apply towards the continuing education required after the license is granted.

R156-60b-502. Unprofessional Conduct.

"Unprofessional conduct" includes:

(1) acting as a supervisor or accepting supervision of a supervisor without complying with or ensuring the compliance with the requirements of Sections R156-60b-302d and R156-60b-302e;

(2) engaging in the supervised practice of mental health therapy when not in compliance with Subsections R156-60b-302b;

(3) engaging in and aiding or abetting conduct or practices which are dishonest, deceptive or fraudulent;

(4) engaging in or aiding or abetting deceptive or fraudulent billing practices;

(5) failing to maintain professional boundaries with a client within two years after the formal termination of therapy or last professional contact, with or without client consent, including engaging in any of the following:

(a) dual or multiple relationships; or

(b) romantic, intimate or sexual relationship;

(6) if engaging in any activity or relationship referenced in Subsection (5) with a client after two years following the formal termination of therapy or last professional contact, failing to demonstrate that there has been no exploitation or injury to the client or to the client's immediate family;

(7) engaging in sexual activities or sexual contact with client's relatives or other individuals with whom the client maintains a relationship when that individual is especially vulnerable or susceptible to being disadvantaged because of the personal history, current mental status, or any condition which could reasonably be expected to place that individual at a disadvantage recognizing the power imbalance which exists or may exist between the marriage and family therapist and that individual;

(8) physical contact with a client when there is a risk of exploitation or potential harm to the client resulting from the contact;

(9) engaging in or aiding or abetting sexual harassment or any conduct which is exploitive or abusive with respect to a student, trainee, employee, or colleague with whom the licensee has supervisory or management responsibility;

(10) failing to render impartial, objective, and informed services, recommendations or opinions with respect to custodial or parental rights, divorce, domestic relationships, adoptions, sanity, competency, mental health or any other determination concerning an individual's civil or legal rights;

(11) exploiting a client for personal gain;

(12) use of a professional client relationship to exploit a person that is known to have a personal relationship with a client for personal gain;

(13) failing to maintain appropriate client records for a period of not less than ten years from the documented termination of services to the client;

(14) failing to obtain informed consent from the client or legal guardian before taping, recording or permitting third party observations of client care or records;

(15) failure to cooperate with the Division during an investigation; and

(16) failure to abide by provisions 1 to 8.8 of the Code of Ethics of the American Association for Marriage and Family Therapy (AAMFT) as adopted by the AAMFT effective July 1, [~~2001~~]2012, which is adopted and incorporated by reference.

KEY: licensing, therapists, marriage and family therapist
Date of Enactment or Last Substantive Amendment: [~~August 22, 2011~~]2013
Notice of Continuation: August 31, 2009
Authorizing, and Implemented or Interpreted Law: 58-1-106(1)(a); 58-1-202(1)(a); 58-60-301

Environmental Quality, Radiation Control
R313-14
Violations and Escalated Enforcement

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38076
FILED: 10/30/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: H.B. 124 (2013 General Legislative Session) changed the maximum civil penalty from $5,000 to $10,000 per violation in the Radiation Control Act at Section 19-3-109. The proposed change to Rule R313-14 is to change the rule so it is consistent with the Act.

SUMMARY OF THE RULE OR CHANGE: The proposed changes to Rule R313-14 would: 1) double the potential penalty for each violation severity level. See Subsection R313-14-15(2)(b); 2) eliminate a provision that limited the Director's ability to require a response under oath to civil penalties and orders, since it was unclear how the requirement could be broader than that. See Subsection R313-14-15(1)(b); 3) prescribe a specific time, 90 days, rather than relying on the ambiguous term "reasonable time" for correcting a violation in order to avoid a penalty for self-reported problem. See Subsection R313-14-15(1)(c)(iv); 4) add "Rule", "Section", and "Subsection", as appropriate, in front of rule citations in accordance with the "Rulewriting Manual for Utah"; and 5) make minor language clarifications and corrections.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 19-3-103.5(1)(A) and Subsection 19-3-109(1)

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: The general fund of the state budget may be affected by the proposed rule change. A Notice of Violation issued to the licensees, permittees and registrants by the Director of the Utah Division of Radiation Control sometimes includes monetary penalties. The monetary penalties collected by the Utah Division of Radiation Control are placed into the state general fund, as required by Subsection 19-3-109(6). With the proposed increase in monetary penalties, it is expected that additional monies will be collected and placed in the state general fund. However, the additional amount is unknown, as it is not possible to predict issues of non-compliance and the associated enforcement actions with a monetary penalty.

♦ LOCAL GOVERNMENTS: It is expected that local governments may be affected by this amendment. There are some local governments in the State of Utah that have a Radioactive Material License. If they are issued a Notice of Violation with a civil penalty, they may be assessed a larger penalty under the proposed rule and in accordance with Subsection 19-3-109(1).
♦ SMALL BUSINESSES: It is expected that small businesses may be affected by this amendment. The majority of the Utah Division of Radiation Control licensees are small businesses. If they are issued a Notice of Violation with a civil penalty, they may be assessed a larger penalty under the proposed rule and in accordance with Subsection 19-3-109(1).
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: It is expected that some individuals and/or corporations may be affected by this amendment. If they are issued a Notice of Violation with a civil penalty, they may be assessed a larger penalty under the proposed rule and in accordance with Subsection 19-3-109(1).

COMPLIANCE COSTS FOR AFFECTED PERSONS: Licensees, permittees, and registrants regulated by the Utah Division of Radiation Control may be fined more when issued civil penalties as a result of the proposed rule and in accordance with Subsection 19-3-109(1).

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: If the proposed rule is promulgated, entities that possess a Radioactive Material License, X-ray Registration, or Generator Site Access Permit may be affected financially if they fail to follow the requirement outlined in their permit, license, registration, and state or federal law; as the penalty they would have received may be greater than previous penalties.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ENVIRONMENTAL QUALITY
RADIATION CONTROL
THIRD FLOOR
195 N 1950 W
SALT LAKE CITY, UT 84116-3085
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Craig Jones by phone at 801-536-4264, by FAX at 801-533-4097, or by Internet E-mail at cwjones@utah.gov
♦ Spencer Wickham by phone at 801-536-0082, by FAX at 801-533-4097, or by Internet E-mail at swickham@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 01/21/2014

AUTHORIZED BY: Rusty Lundberg, Director

R313. Environmental Quality, Radiation Control.
R313-14. Violations and Escalated Enforcement.
R313-14-1. Introduction, Purpose, and Authority.

(1) The purpose of the radiation control inspection and compliance program is to assure the radiological safety of the public, radiation workers, and the environment by:

(a) ensuring compliance with Utah Radiation Control rules or license conditions;

(b) obtaining prompt correction of violations;

(c) deterring future violations; and

(d) encouraging improvement of licensee, permittee, or registrant performance, including the prompt identification, reporting, and correction of potential safety problems.

(2) Consistent with the purpose of the radiation control inspection and compliance program, prompt and vigorous enforcement action shall be taken when dealing with licensees, permittees, or registrants who fail to demonstrate adherence to these rules. Enforcement action is dependent on the circumstances of the case and may require that discretion be exercised after consideration of these standards. Sanctions have been designed to ensure that a licensee, permittee, or registrant does not deliberately profit from violations of the Utah Radiation Control rules.

(3) The rules set forth herein are adopted pursuant to the provisions of Subsections 19-3-103.5(1)(d), 19-3-104(4) and 19-3-104(8), 19-3-108, 19-3-109, and 19-3-111.

R313-14-3. Definitions.

As used in Rule R313-14, the following definitions apply:

(1) "Material False Statement" means a statement that is false by omission or commission and is relevant to the regulatory process.

(2) "Requirement" means a legally binding [~~requirement~~]mandate such as a statute, rule, license condition, permit, registration, technical specification, or order.

(3) "Similar" means those violations which could have been reasonably expected to have been prevented by the licensee's, permittee's, or registrant's corrective action for a previous violation.

(4) "Willfulness" means the deliberate intent to violate or falsify, and includes careless disregard for requirements. Acts which do not rise to the level of careless disregard are not included in this definition.

R313-14-10. Severity of Violations.

(1) Violations are placed in one of two major categories. These categories are:

(a) electronically produced radiation operations; or

(b) radioactive materials operations.

(2) Regulatory requirements vary in public health and environmental safety significance. Therefore, it is essential that the relative importance of violations be identified as the first step in the enforcement process. Based upon their relative hazard, violations are assigned to one of five levels of severity.

(3) Severity Level I is assigned to violations that are the most significant and Severity Level V violations are the least

significant. In general, violations that are included in Severity Levels I and II involve actual or high potential impact on the public. Severity Level III violations are cause for significant concern. Severity Level IV violations are less serious but are of more than minor concern, however, if left uncorrected, they could lead to a more serious concern. Severity Level V violations are of minor safety or environmental concern.

(4) The severity of a violation shall be characterized at the level best suited to the significance of the particular violation. A severity level may be increased if [~~the~~]circumstances surrounding the violation involve careless disregard of requirements, deception, or other indications of willfulness. In determining the specific severity level of a violation involving willfulness, relevant factors will be considered, including[~~consideration will be given to factors like~~] the position of the person involved in the violation, the significance of an underlying violation, the intent of the violator and the economic advantage gained by the violation. The relative weight given to these factors in arriving at the appropriate severity level is dependent on the circumstances of the violation.

(5) The severity level assigned to material false statements may be Severity Level I, II, or III, depending on the circumstances surrounding the statement. In determining the specific severity level of a violation involving material false statements or falsification of records, consideration is given to factors like the position of the person involved in the violation, for example, a first line supervisor as opposed to a senior manager, the significance of the information involved, and the intent of the violator. Negligence not amounting to careless disregard would be weighted differently than careless disregard or deliberateness. The relative weight given to these factors in arriving at the appropriate severity level is dependent on the circumstances of the violation.

R313-14-15. Enforcement Actions.

This Section describes the enforcement sanctions available to the Director and specifies the conditions under which they are to be used.

(1) Notice of Violation

(a) A Notice of Violation is a written notice setting forth one or more violations of a legally binding requirement. The [~~notice normally requires the~~]licensee, permittee, or registrant may be required to provide a written statement describing:

(i) corrective steps which have been taken by the licensee, permittee or registrant and the results achieved;

(ii) corrective steps which shall be taken to prevent recurrence; and

(iii) the date when full compliance will be achieved.

(b) The Director may require responses to Notices of Violation to be under oath.[~~Normally, responses under oath may be required only in connection with civil penalties and orders.~~]

(c) A Notice of Violation is used by the Director as [~~the~~]a method for formalizing the existence of a violation. The Notice may be the only enforcement action taken or it may be used as a basis for other enforcement actions. Licensee, permittee, or registrant initiative for self-identification and correction of problems is encouraged. The Director shall not generally issue Notices of Violation for a violation that meets the five following tests:

(i) it was identified by the licensee, permittee, or registrant;

(ii) it fits in Severity Level IV or V;

(iii) it was reported, in writing, to the Director;

(iv) it was or will be corrected, including measures to prevent recurrence, within [~~a reasonable time~~]90 days; and

(v) it was not a violation that could reasonably be expected to have been prevented by the licensee's, permittee's, or registrant's corrective action for a previous violation.

(d) Licensees, permittees, or registrants are not ordinarily cited for violations resulting from matters outside of their control, like equipment failures that were not avoidable by reasonable quality assurance measures or management controls. [~~Generally h~~]However, licensees, permittees, and registrants are held responsible for [~~the~~]acts of their employees. Accordingly, the rules should not be construed to excuse personal errors.

(2) Civil Penalty.

(a) A civil penalty is a monetary penalty that may be imposed for violation of Utah Radiation Control Rules or lawful orders issued by the Director. Civil penalties are designed to emphasize the need for lasting remedial action and to deter future violations. Generally, civil penalties are imposed for Severity Level I and Severity Level II violations. [~~, are imposed for Severity Level II violations, i~~]In the absence of mitigating circumstances, civil penalties are considered for Severity Level III violations.[~~, and may be imposed~~] Penalties are not ordinarily imposed for Severity Level IV and V violations unless those violations[~~that~~] are similar to previous violations for which the licensee, permittee, or registrant failed to take effective corrective action.

(b) The level of a civil penalty [~~is established so that a penalty does~~]may not exceed $[~~5~~]10,000 per violation. Except as modified by provision of the next paragraphs, the base civil penalties are as follows:

TABLE

Severity Level I Violations	$[~~5~~]10,000
Severity Level II Violations	$[4]8,000
Severity Level III Violations	$[~~2,5~~]5,000
Severity Level IV Violations	$[~~7~~]1,500
Severity Level V Violations	$[~~2~~]500

(i) Comprehensive licensee, permittee, or registrant programs for detection, correction and reporting of problems that may constitute, or lead to, violation of regulatory requirements are important and consideration may be given for effective internal audit programs. When licensees, permittees, or registrants find, report, and correct a violation expeditiously and effectively, the Director may apply adjustment factors to reduce or eliminate a civil penalty.

(ii) Ineffective licensee, permittee, or registrant programs for problem identification or correction are unacceptable. In cases involving willfulness, flagrant violations, repeated poor performance in an area of concern, or serious breakdown in management controls, the Director may apply the full enforcement authority.

(iii) The Director may review the proposed civil penalty case on its own merits and adjust the civil penalty upward or downward appropriately. After considering the relevant circumstances, adjustments to these values may be made for the factors identified below:

(A) Reduction of the civil penalty may be given when a licensee, permittee, or registrant identifies the violation and promptly reports, in writing, the violation to the Director. No consideration will be given to this factor if the licensee, permittee, or registrant does not take immediate action to correct the problem upon discovery.

(B) Recognizing that corrective action is always required to meet regulatory requirements, the promptness and extent to which the licensee, permittee, or registrant takes corrective action, including actions to prevent recurrence, may be considered in modifying the civil penalty to be assessed.

(C) Reduction of the civil penalty may be given for prior good performance in the general area of concern.

(D) The civil penalty may be increased as much as 50%, up to the $10,000 maximum, for cases where the licensee, permittee, or registrant had prior knowledge of a problem as a result of an internal audit, or specific Director or industry notification, and had failed to take effective preventive steps.

(E) The civil penalty may be increased as much as 50%, up to the $10,000 maximum, where multiple examples of a particular violation are identified during the inspection period.

(c) A violation of a continuing nature shall, for the purposes of calculating the proposed civil penalty, be considered a separate violation for each day of its continuance. A continuing violation is not considered a repeat violation. In the event a violation is repeated within five years, the scheduled amount of the civil penalty may be increased [~~2~~]50%, up to the $10,000 maximum; and for repeat violations of Severity Levels II and III, the penalty [~~may~~]will not be avoided by compliance. Other rights and procedures are not affected by the repeat violation.

(d) Payment of civil penalties shall be made within 30 working days of receipt of a Notice of Violation and Notice of Proposed Imposition of a Civil Penalty. An extension may be given when extenuating circumstances are shown to exist. Payment shall be made by check, payable to the Division of Radiation Control and mailed to the Division at the address shown with the Notice of Violation.

(3) Orders.

(a) An Order is a written directive to modify, suspend, or revoke a license, permit, or registration; to cease and desist from a given practice or activity; to issue a civil penalty; or to take other action that may be necessary.

(b) Modification Orders are issued when some change in licensee, permittee, or registrant equipment, procedures, or management control is necessary.

(c) Suspension Orders may be used:

(i) to remove a threat to the public health and safety or the environment;

(ii) when the licensee, permittee, or registrant has not responded adequately to other enforcement action;

(iii) when the licensee, permittee, or registrant interferes with the conduct of an inspection; or

(iv) for a reason not mentioned above for which license, permit, or registration revocation is authorized.

(v) Suspensions may apply to all or part of the regulated activity. Ordinarily, an activity is not suspended, nor is a suspension prolonged for failure to comply with requirements when the failure is not willful or when adequate corrective actions have been taken.

(d) Revocation Orders may be used:

(i) when a licensee, permittee, or registrant is unable or unwilling to comply with these rules;

(ii) when a licensee, permittee, or registrant refuses to correct a violation;

(iii) when a licensee, permittee, or registrant does not respond to a Notice of Violation;

(iv) when a licensee, permittee, or registrant does not pay a fee required by the Department; or

(v) for any other reason for which revocation is authorized.

(e) Cease and Desist Orders are used to stop unauthorized activity that has continued despite notification by the Director that the activity is unauthorized.

(f) Orders may be made effective immediately, without prior opportunity for hearing, whenever it is determined that the public health, interest, or safety so requires, or when the Order is responding to a violation involving willfulness. Otherwise, a prior opportunity for a hearing is afforded. For cases in which a basis could reasonably exist for not taking the action as proposed, the licensee, permittee, or registrant shall be afforded an opportunity to show cause why the Order should not be issued in the proposed manner.

(4) Escalation of Enforcement Sanctions.

(a) In accordance with the provisions of Section 19-3-111 the radioactive material of a person may be impounded. Administrative procedures will be conducted as provided by Section R313-14-20, prior to disposal of impounded radioactive materials.

(b) Violations of Severity Levels I, II, or III are considered to be very serious. If repetitive very serious violations occur, the Director may issue Orders in conjunction with other enforcement actions to achieve immediate corrective actions and to deter their recurrence. In accordance with the criteria contained in this section, the Director shall carefully consider the circumstances of cases when selecting and applying the appropriate sanctions.

(c) The progression of enforcement actions for repetitive violations may be based on violations under a single license, permit, or registration. The actual progression to be used in a particular case may depend on the circumstances. When more than one facility is covered by a single license, permit, or registration, the normal progression may be based on repetitive violations under the same license, permit, or registration. It should be noted that under some circumstances, for example, where there is common control over some facet of facility operations, repetitive violations may be charged even though the second violation occurred at a different facility or under a different license, permit, or registration.

(5) Related Administrative Actions.

(a) In addition to the formal enforcement mechanisms of Notices of Violation and Orders, the Director may use administrative mechanisms, like enforcement conferences, bulletins, circulars, information notices, generic letters, and confirmatory action letters as part of the enforcement and regulatory program. Licensees, permittees, and registrants are expected to adhere to obligations and commitments resulting from these processes and the Director shall, if necessary, issue appropriate orders to make sure that expectation is realized.

(b) Enforcement Conferences are meetings held by the Director with licensee, permittee or registrant management to discuss safety, public health, or environmental problems, compliance with regulatory requirements, proposed corrective measures, including schedules for implementation, and enforcement options available to the Director.

(c) Bulletins, Circulars, Information Notices, and Generic Letters are written notifications to groups of licensees, permittees, or registrants identifying specific problems and calling for or recommending specific actions on their part. Responses to these notifications may be required.

(d) Confirmatory Action Letters are letters confirming a licensee's, permittee's, or registrant's agreement to take certain actions to remove significant concerns about health and safety, or the environment.

R313-14-25. Public Disclosure of Enforcement Actions.

Enforcement actions and responses are publicly available for inspection. In addition, press releases are generally issued for Notices of Proposed Imposition of a Civil Penalty and Orders. In the case of orders and civil penalties related to violations at Severity Level I, II, or III, press releases may be issued at the time of the Order or the Notice of Proposed Imposition of the Civil Penalty. Press releases are not normally issued for Notices of Violation.

KEY: violations, penalties, enforcement
Date of Enactment or Last Substantive Amendment: [~~March 19, 2013~~]2014
Notice of Continuation: July 7, 2011
Authorizing, and Implemented or Interpreted Law: 19-3-109; 19-3-111

Environmental Quality, Radiation Control
R313-25
License Requirements for Land Disposal of Radioactive Waste - General Provisions

NOTICE OF PROPOSED RULE

(Amendment)
DAR FILE NO.: 38082
FILED: 10/30/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule governs the licensing of radioactive waste land disposal facilities. Currently, EnergySolutions is the only such facility in Utah. H.B. 124 (2013 General Legislative Session) instructed the Radiation Control Board to make new rules governing the Division of Radiation Control's (DRC's) review times for the Division Director's approval or denial of "approval applications" for a radioactive waste disposal facility. An approval application is broadly defined as "an application by a radioactive waste facility regulated under Title 19, Chapter 3 or Chapter 5, for a permit, permit modification, license, license amendment, or other authorization".

SUMMARY OF THE RULE OR CHANGE: Preliminary proposed changes to R313-25 would: 1) add a new definition of "approval application", taken from H.B. 124 (Section R313-25-2); 2) add a new definition of "day", to clarify that the deadlines for each category are in calendar days (Section R313-25-2); 3) add a definition of "groundwater permit", since those permits will also now be addressed in the rule (Section R313-25-2); 4) add a definition of "tolling period" to clarify the provisions of the rule (and of H.B. 124) that toll DRC's deadlines for, e.g., public comment periods (Section R313-25-2); 5) add a new section that creates each category, describes which approval applications apply, specifies a deadline for DRC action, and describes tolling provisions (Section R313-25-6); 6) add a provision that allows the Director to reject a substantially deficient application. The application may be resubmitted with the required information but the review clock would be reset (Subsection R313-25-6(1)(c)); 7) add "Rule", "Section", and "Subsection", as appropriate, in front of rule citations in accordance with the "Rulewriting Manual for Utah"; and 8) renumber provisions to accommodate new Section R313-25-6 and make minor clarifications and corrections.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 19-3-104 and Section 19-3-105 and Section 19-3-108

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: State budget is not impacted. Staff resources for reviewing license and permit applications are covered by the annual flat fee as required in Subsection 19-3-106(1)(b)(ii). The required flat fee provides for reasonable and timely oversight by the department; and adequately meets the needs of industry and the department, including allowing for the department to employ qualified personnel to appropriately oversee industry regulation.
♦ LOCAL GOVERNMENTS: Tooele County collects impact fees from waste facilities located in the county, including EnergySolutions. However, the Agency's licensing and permitting actions under the proposed categories and related time frames will not directly impact local governments/Tooele County's budget.
♦ SMALL BUSINESSES: The agency does not anticipate small businesses to be affected by this amendment. These changes establish specific time frames for the agency in its review of license and permit applications for a radioactive waste disposal facility.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: By establishing specific time frames for licensing and permitting actions, the proposed rule may result in overall, unspecified cost savings for an owner/operator of a radioactive waste disposal facility. The fiscal impact this rule may have is difficult to quantify due to the unpredictability and variability of licensing and permitting actions that may be submitted for agency review.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Compliance cost will vary based on the complexity of the application submitted. The proposed changes will not add to the existing cost to prepare license or permit applications by the applicant. The proposed changes establish categories and their associated time frames to review and either approve or deny the license or permit application. The applicant may realize some undefined cost savings when the overall time to

complete the licensing actions is reduced. In contrast, the number of licensing actions could increase to where the agency would have to "outsource" some of these actions to complete them in the required time frame. The cost associated with outsourcing is passed on to the licensee. The cost savings or cost for outsourcing are difficult to quantify due to the unpredictability of the actual request and the variability of license and permitting requirements.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: If the proposed rule is promulgated, certain licensing and permitting actions taken by the agency that are associated with a low-level radioactive disposal facility will be determined within specified time frames. The fiscal impact this rule may have is difficult to quantify due to the unpredictability and variability of licensing and permitting actions that may be submitted for agency review. Overall, certain licensing and permitting actions completed within the required timeframe could result in business cost savings and program efficiency increases. Additionally, certain licensing and permitting actions may not fiscally impact the facility; however efficiencies in operations may be realized due to specific licensing or permitting actions.

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

ENVIRONMENTAL QUALITY
RADIATION CONTROL
THIRD FLOOR
195 N 1950 W
SALT LAKE CITY, UT 84116-3085
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

♦ John Hultquist by phone at 801-536-4623, by FAX at 801-536-4250, or by Internet E-mail at jhultquist@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 01/21/2014

AUTHORIZED BY: Rusty Lundberg, Director

R313. Environmental Quality, Radiation Control.
R313-25. License Requirements for Land Disposal of Radioactive Waste - General Provisions.
R313-25-1. Purpose and Authority.

(1) The purpose of this rule is to prescribe the requirements for the issuance of licenses for the land disposal of wastes received from other persons.

(2) The rules set forth herein are adopted pursuant to the provisions of Subsections 19-3-104(4), 19-3-104(8), 19-3-104(11), and 19-3-104(12).

(3) The requirements of Rule R313-25 are in addition to, and not in substitution for, other applicable requirements of these rules.

R313-25-2. Definitions.

As used in Rule R313-25, the following definitions apply:

"Active maintenance" means significant activity needed during the period of institutional control to maintain a reasonable assurance that the performance objectives in Sections[~~R313-25-19 and~~] R313-25-20 and R313-25-21 are met. Active maintenance may include the pumping and treatment of water from a disposal unit, the replacement of a disposal unit cover, or other episodic or continuous measures. Active maintenance does not include custodial activities like repair of fencing, repair or replacement of monitoring equipment, revegetation, minor additions to soil cover, minor repair of disposal unit covers, and general disposal site upkeep.

"Approval application" means an application by a radioactive waste facility regulated under Title 19, Chapter 3 or Title 19, Chapter 5, for a permit, permit modification, license, license amendment, or other authorization.

"Buffer zone" means a portion of the disposal site that is controlled by the licensee and that lies under the disposal units and between the disposal units and the boundary of the site.

"Commencement of construction" means clearing of land, excavation, or other substantial action that could adversely affect the environment of a land disposal facility. The term does not mean disposal site exploration, necessary roads for disposal site exploration, borings to determine foundation conditions, or other preconstruction monitoring or testing to establish background information related to the suitability of the disposal site or the protection of environmental values.

"Custodial agency" means an agency of the government designated to act on behalf of the government owner of the disposal site.

"Day" for purposes of this Rule means calendar days.

"Disposal" means the isolation of wastes from the biosphere by placing them in a land disposal facility.

"Disposal site" means that portion of a land disposal facility which is used for disposal of waste. It consists of disposal units and a buffer zone.

"Disposal unit" means a discrete portion of the disposal site into which waste is placed for disposal. For near-surface disposal, the disposal unit may be a trench.

"Engineered barrier" means a man-made structure or device intended to improve the land disposal facility's performance under Rule R313-25.

"Groundwater permit" means a groundwater quality discharge permit issued under the authority of Title 19, Chapter 5 and Rule R317-6.

"Hydrogeologic unit" means a soil or rock unit or zone that has a distinct influence on the storage or movement of ground water.

"Inadvertent intruder" means a person who may enter the disposal site after closure and engage in activities unrelated to post closure management, such as agriculture, dwelling construction, or other pursuits which could, by disturbing the site, expose individuals to radiation.

"Intruder barrier" means a sufficient depth of cover over the waste that inhibits contact with waste and helps to ensure that radiation exposures to an inadvertent intruder will meet the performance objectives set forth in Rule R313-25, or engineered structures that provide equivalent protection to the inadvertent intruder.

"Land disposal facility" means the land, buildings and structures, and equipment which are intended to be used for the disposal of radioactive waste.

"Monitoring" means observing and making measurements to provide data to evaluate the performance and characteristics of the disposal site.

"Near-surface disposal facility" means a land disposal facility in which waste is disposed of within approximately the upper 30 meters of the earth's surface.

"Site closure and stabilization" means those actions that are taken upon completion of operations that prepare the disposal site for custodial care, and that assure that the disposal site will remain stable and will not need ongoing active maintenance.

"Stability" means structural stability.

"Surveillance" means monitoring and observation of the disposal site to detect needs for maintenance or custodial care, to observe evidence of intrusion, and to ascertain compliance with other license and regulatory requirements.

"Tolling period," for purposes of this Rule, means a period during which days are not counted toward the deadlines specified in Subsections R313-25-6(3)(c), (4)(c)(i), (5)(b)(i), and (6)(b)(i).

"Treatment" means the stabilization or the reduction in volume of waste by a chemical or a physical process.

"Waste" means those low-level radioactive wastes containing radioactive material that are acceptable for disposal in a land disposal facility. For the purposes of this definition, low-level radioactive waste means radioactive waste not classified as high-level radioactive waste, transuranic waste, spent nuclear fuel, or byproduct material as defined in (b), (c), and (d) of the definition for byproduct material found in [~~Subsection~~]Section R313-12-3.

R313-25-3. Pre-licensing Plan Approval Criteria for Siting of Commercial Radioactive Waste Disposal Facilities.

(1) Persons proposing to construct or operate commercial radioactive waste disposal facilities, including waste incinerators, shall obtain a plan approval from the Director before applying for a license. Plans shall meet the siting criteria and plan approval requirements of Section R313-25-3.

(2) The siting criteria and plan approval requirements in Section R313-25-3 apply to prelicensing plan approval applications.

(3) Treatment and disposal facilities, including commercial radioactive waste incinerators, shall not be located:

(a) within or underlain by:

(i) national, state, and county parks, monuments, and recreation areas; designated wilderness and wilderness study areas; wild and scenic river areas;

(ii) ecologically and scientifically significant natural areas, including wildlife management areas and habitats for listed or proposed endangered species as designated by federal law;

(iii) 100 year floodplains;

(iv) areas 200 feet distant from Holocene faults;

(v) underground mines, salt domes and salt beds;

(vi) dam failure flood areas;

(vii) areas subject to landslide, mud flow, or other earth movement, unless adverse impacts can be mitigated;

(viii) farmlands classified or evaluated as "prime", "unique", or of "statewide importance" by the U.S. Department of Agricultural Soil Conservation Service under the Prime Farmland Protection Act;

(ix) areas five miles distant from existing permanent dwellings, residential areas, and other habitable structures, including schools, churches, and historic structures;

(x) areas five miles distant from surface waters including intermittent streams, perennial streams, rivers, lakes, reservoirs, and wetlands;

(xi) areas 1000 feet distant from archeological sites to which adverse impacts cannot reasonably be mitigated;

(xii) recharge zones of aquifers containing ground water which has a total dissolved solids content of less than 10,000 mg/l; or

(xiii) drinking water source protection areas designated by the Utah Drinking Water Board;

(b) in areas:

(i) above or underlain by aquifers containing ground water which has a total dissolved solids content of less than 500 mg/l and which aquifers do not exceed state ground water standards for pollutants;

(ii) above or underlain by aquifers containing ground water which has a total dissolved solids content between 3000 and 10,000 mg/l when the distance from the surface to the ground water is less than 100 ft.;

(iii) areas of extensive withdrawal of water, mineral or energy resources.

(iv) above or underlain by weak and unstable soils, including soils that lose their ability to support foundations as a result of hydrocompaction, expansion, or shrinkage;

(v) above or underlain by karst terrains.

(4) Commercial radioactive waste disposal facilities may not be located within a distance to existing drinking water wells and watersheds for public water supplies of five years ground water travel time plus 1000 feet.

(5) The plan approval siting application shall include hydraulic conductivity and other information necessary to estimate adequately the ground water travel distance.

(6) The plan approval siting application shall include the results of studies adequate to identify the presence of ground water aquifers in the area of the proposed site and to assess the quality of the ground water of all aquifers identified in the area of the proposed site.

(7) Emergency response and safety.

(a) The plan approval siting application shall demonstrate the availability and adequacy of services for on-site emergencies, including medical and fire response. The application shall provide written evidence that the applicant has coordinated on-site emergency response plans with the local emergency planning committee (LEPC).

(b) The plan approval siting application shall include a comprehensive plan for responding to emergencies at the site.

(c) The plan approval siting application shall show proposed routes for transportation of radioactive wastes within the state. The plan approval siting application shall address the transportation means and routes available to evacuate the population at risk in the event of on-site accidents, including spills and fires.

(8) The plan approval siting application shall provide evidence that if the proposed disposal site is on land not owned by state or federal government, that arrangements have been made for assumption of ownership in fee by a state or federal agency.

(9) Siting Authority. The Director recognizes that Titles 10 and 17 of the Utah Code give cities and counties authority for local use planning and zoning. Nothing in Section R313-25-3 precludes cities

and counties from establishing additional requirements as provided by applicable state and federal law.

R313-25-4. License Required.

(1) Persons shall not receive, possess, or dispose of waste at a land disposal facility unless authorized by a license issued by the Director pursuant to Rules R313-25 and R313-22.

(2) Persons shall file an application with the Director pursuant to Section R313-22-32 and obtain a license as provided in Rule R313-25 before commencement of construction of a land disposal facility. Failure to comply with this requirement may be grounds for denial of a license and other penalties established by law and rules.

R313-25-5. Content of Application.

In addition to the requirements set forth in Section R313-22-33, an application to receive from others, possess, and dispose of wastes shall consist of general information, specific technical information, institutional information, and financial information as set forth in Sections R313-25-[~~6~~]7 through R313-25-[~~10~~]11.

R313-25-6. Director Review of Application.

(1) The Director shall review each approval application to determine whether it complies with applicable statutory and regulatory requirements. Approval applications will be categorized as Category 1, 2, 3 and 4 applications, as provided in Subsections R313-25-6(2) through (5).

(2) Category 1 applications.

(a) A Category 1 application is an application that:

(i) is administrative in nature;

(ii) requires limited scrutiny by the Director; and

(iii) does not require public comment.

(b) Examples of a Category 1 application include an application to:

(i) correct typographical errors;

(ii) Change the name, address, or phone number of persons or agencies identified in the license or permit;

(iii) change the procedures or location for maintaining records; or

(iv) extend the date for compliance with a permit or license requirement by no more than 120 days.

(c) The Director shall review and approve or deny a Category 1 application within 30 days after the day on which the Director Receives the application.

(3) Category 2 applications:

(a) A Category 2 application is one that is not a Category 1, 3 or 4 application.

(b) Examples of a Category 2 application include:

(i) Increase in process, storage, or disposal capacity

(ii) Change engineering design, construction, or process controls;

(iii) Approve a proposed corrective action plan; or

(iv) Transfer direct control of a license or groundwater permit.

(c)(i) The Director shall review and approve or deny a Category 2 application within 180 days after the day on which the Director receives the application.

(ii) The period described in Subsection R313-25-6(3)(c)(i) shall be tolled as provided in Subsection R313-25-6(7).

(4) Category 3 applications.

(a) Category 3 application is an application for:

(i) a radioactive waste license renewal;

(ii) a groundwater permit renewal;

(iii) an amendment to an existing radioactive waste license or groundwater permit to allow a new disposal cell;

(iv) an amendment to an existing radioactive waste license or groundwater permit that would allow the facility to eliminate groundwater monitoring; or

(v) approval of a radioactive waste disposal facility closure plan.

(b)(i) The Director shall review and approve or deny a Category 3 application within 365 days after the day on which the Director receives the application.

(ii) The period described in Subsection R313-25-6(4)(b)(i) shall be tolled as provided in Subsection R313-25-6(7).

(5) Category 4 applications.

(a) A Category 4 application is an application for:

(i) a new radioactive waste license; or

(ii) a new groundwater permit.

(b)(i) The Director shall review and approve or deny a Category 4 application within 540 days after the day on which the Director receives the application.

(ii) The period described in Subsection R313-25-6(5)(b)(i) shall be tolled as provided in Subsection R313-25-6(7).

(6)(a) Within 60 days after the day on which the Director receives a Category 2, 3 or 4 approval application, the Director shall determine whether the application is complete and contains all the information necessary to process it for approval and make a finding by issuance of a written:

(i) notice of completeness to the applicant; or

(ii) notice of deficiency to the applicant, including a list of the additional information necessary to complete the application.

(b) The Director shall review written information submitted in response to a notice of deficiency within 30 days after the day on which the Director receives the supplemental information and shall again follow the procedures specified in Subsection R313-25-6(1)(a).

(c) If a document that is submitted as an application is substantially deficient, the Director may determine that it does not qualify as an application. Any such determination shall be made within 45 days of the document's submission and will include the Director's written findings.

(7) Tolling Periods. The periods specified for the Director's review and approval or denial under Subsections R313-25-6(3)(c)(i), (4)(b)(i), and (5)(b)(i) shall be tolled:

(a) while an owner or operator of a facility responds to the Director's request for information;

(b) during a public comment period; and

(c) while the federal government reviews the application.

(8) The Director shall prepare a detailed written explanation of the technical and regulatory basis for the Director's approval or denial of an approval application.

R313-25-[6]7. General Information.

The general information shall include the following:

(1) identity of the applicant including:

(a) the full name, address, telephone number, and description of the business or occupation of the applicant;

(b) if the applicant is a partnership, the names and addresses of the partners and the principal location where the partnership does business;

(c) if the applicant is a corporation or an unincorporated association;

(i) the state where it is incorporated or organized and the principal location where it does business; and

(ii) the names and addresses of its directors and principal officers; and

(d) if the applicant is acting as an agent or representative of another person in filing the application, the applicant shall provide, with respect to the other person, information required under Subsection R313-25-[~~6~~]7(1).

(2) Qualifications of the applicant shall include the following;

(a) the organizational structure of the applicant, both offsite and onsite, including a description of lines of authority and assignments of responsibilities, whether in the form of administrative directives, contract provisions, or otherwise;

(b) the technical qualifications, including training and experience of the applicant and members of the applicant's staff, to engage in the proposed activities. Minimum training and experience requirements for personnel filling key positions described in Subsection R313-25-[~~6~~]7(2)(a) shall be provided;

(c) a description of the applicant's personnel training program; and

(d) the plan to maintain an adequate complement of trained personnel to carry out waste receipt, handling, and disposal operations in a safe manner.

(3) A description of:

(a) the location of the proposed disposal site;

(b) the general character of the proposed activities;

(c) the types and quantities of waste to be received, possessed, and disposed of;

(d) plans for use of the land disposal facility for purposes other than disposal of wastes; and

(e) the proposed facilities and equipment; and

(4) proposed schedules for construction, receipt of waste, and first emplacement of waste at the proposed land disposal facility.

R313-25-[~~7~~]8. Specific Technical Information.

The application shall include certain technical information. The following information is needed to determine whether or not the applicant can meet the performance objectives and the applicable technical requirements of Rule R313-25:

(1) A description of the natural and demographic disposal site characteristics shall be based on and determined by disposal site selection and characterization activities. The description shall include geologic, geochemical, geotechnical, hydrologic, ecologic, archaeologic, meteorologic, climatologic, and biotic features of the disposal site and vicinity.

(2) Descriptions of the design features of the land disposal facility and of the disposal units for near-surface disposal shall include those design features related to infiltration of water; integrity of covers for disposal units; structural stability of backfill, wastes, and covers; contact of wastes with standing water; disposal site drainage; disposal site closure and stabilization; elimination to the extent practicable of long-term disposal site maintenance; inadvertent intrusion; occupational exposures; disposal site monitoring; and adequacy of the size of the buffer zone for monitoring and potential mitigative measures.

(3) Descriptions of the principal design criteria and their relationship to the performance objectives.

(4) Descriptions of the natural events or phenomena on which the design is based and their relationship to the principal design criteria.

(5) Descriptions of codes and standards which the applicant has applied to the design, and will apply to construction of the land disposal facilities.

(6) Descriptions of the construction and operation of the land disposal facility. The description shall include as a minimum the methods of construction of disposal units; waste emplacement; the procedures for and areas of waste segregation; types of intruder barriers; onsite traffic and drainage systems; survey control program; methods and areas of waste storage; and methods to control surface water and ground water access to the wastes. The description shall also include a description of the methods to be employed in the handling and disposal of wastes containing chelating agents or other non-radiological substances which might affect meeting the performance objectives of Rule R313-25

(7) A description of the disposal site closure plan, including those design features which are intended to facilitate disposal site closures and to eliminate the need for active maintenance after closure.

(8) Identification of the known natural resources at the disposal site whose exploitation could result in inadvertent intrusion into the wastes after removal of active institutional control.

(9) Descriptions of the kind, amount, classification and specifications of the radioactive material proposed to be received, possessed, and disposed of at the land disposal facility.

(10) Descriptions of quality assurance programs, tailored to low-level waste disposal, including audit and managerial controls, for the determination of natural disposal site characteristics and for quality control during the design, construction, operation, and closure of the land disposal facility and the receipt, handling, and emplacement of waste.

(11) A description of the radiation safety program for control and monitoring of radioactive effluents to ensure compliance with the performance objective in Section R313-25-[~~19~~]20 and monitoring of occupational radiation exposure to ensure compliance with the requirements of Rule R313-15 and to control contamination of personnel, vehicles, equipment, buildings, and the disposal site. The applicant shall describe procedures, instrumentation, facilities, and equipment appropriate to both routine and emergency operations.

(12) A description of the environmental monitoring program to provide data and to evaluate potential health and environmental impacts and the plan for taking corrective measures if migration is indicated.

(13) Descriptions of the administrative procedures that the applicant will apply to control activities at the land disposal facility.

(14) A description of the facility electronic recordkeeping system as required in Section R313-25-33.

R313-25-[8]9. Technical Analyses.

(1) The licensee or applicant shall conduct a site-specific performance assessment and receive Director approval prior to accepting any radioactive waste if:

(a) the waste was not considered in the development of the limits on Class A waste and not included in the analyses of the Draft

Environmental Impact Statement on 10 CFR Part 61 "Licensing Requirements for Land Disposal of Radioactive Waste," NUREG-0782. U.S. Nuclear Regulatory Commission. September 1981, or

(b) the waste is likely to result in greater than 10 percent of the dose limits in Section R313-25-19 during the time period at which peak dose would occur, or

(c) the waste will result in greater than 10 percent of the total site source term over the operational life of the facility, or

(d) the disposal of the waste would result in an unanalyzed condition not considered in Rule R313-25.

(2) A licensee that has a previously-approved site-specific performance assessment that addressed a radioactive waste for which a site-specific performance assessment would otherwise be required under Subsection R313-25-[~~8~~]9(1) shall notify the Director of the applicability of the previously-approved site-specific performance assessment at least 60 days prior to the anticipated acceptance of the radioactive waste.

(3) The licensee shall not accept radioactive waste until the Director has approved the information submitted pursuant to Subsections R313-25-[~~8~~]9(1) or (2).

(4) The licensee or applicant shall also include in the specific technical information the following analyses needed to demonstrate that the performance objectives of Rule R313-25 will be met:

(a) Analyses demonstrating that the general population will be protected from releases of radioactivity shall consider the pathways of air, soil, ground water, surface water, plant uptake, and exhumation by burrowing animals. The analyses shall clearly identify and differentiate between the roles performed by the natural disposal site characteristics and design features in isolating and segregating the wastes. The analyses shall clearly demonstrate a reasonable assurance that the exposures to humans from the release of radioactivity will not exceed the limits set forth in Section R313-25-[~~19~~]20.

(b) Analyses of the protection of inadvertent intruders shall demonstrate a reasonable assurance that the waste classification and segregation requirements will be met and that adequate barriers to inadvertent intrusion will be provided.

(c) Analysis of the protection of individuals during operations shall include assessments of expected exposures due to routine operations and likely accidents during handling, storage, and disposal of waste. The analysis shall provide reasonable assurance that exposures will be controlled to meet the requirements of Rule R313-15.

(d) Analyses of the long-term stability of the disposal site shall be based upon analyses of active natural processes including erosion, mass wasting, slope failure, settlement of wastes and backfill, infiltration through covers over disposal areas and adjacent soils, surface drainage of the disposal site, and the effects of changing lake levels. The analyses shall provide reasonable assurance that there will not be a need for ongoing active maintenance of the disposal site following closure.

(5)(a) Notwithstanding Subsection R313-25-[~~8~~]9(1), any facility that proposes to land dispose of significant quantities of concentrated depleted uranium (more than one metric ton in total accumulation) after June 1, 2010, shall submit for the Director's review and approval a performance assessment that demonstrates that the performance standards specified in 10 CFR Part 61 and corresponding provisions of Utah rules will be met for the total quantities of concentrated depleted uranium and other wastes, including wastes already disposed of and the quantities of concentrated depleted uranium the facility now proposes to dispose. Any such performance assessment shall be revised as needed to reflect ongoing guidance and rulemaking from NRC. For purposes of this performance assessment, the compliance period shall be a minimum of 10,000 years. Additional simulations shall be performed for the period where peak dose occurs and the results shall be analyzed qualitatively.

(b) No facility may dispose of significant quantities of concentrated depleted uranium prior to the approval by the Director of the performance assessment required in Subsection R313-25-[~~8~~]9(5)(a).

(c) For purposes of this Subsection R313-25-[~~8~~]9(5) only, "concentrated depleted uranium" means waste with depleted uranium concentrations greater than 5 percent by weight.

R313-25-[~~9~~]10. Institutional Information.

The institutional information submitted by the applicant shall include:

(1) A certification by the federal or state agency which owns the disposal site that the agency is prepared to accept transfer of the license when the provisions of Section R313-25-[~~16~~]17 are met and will assume responsibility for institutional control after site closure and for post-closure observation and maintenance.

(2) Evidence, if the proposed disposal site is on land not owned by the federal or a state government, that arrangements have been made for assumption of ownership in fee by the federal or a state agency.

R313-25-[~~10~~]11. Financial Information.

This information shall demonstrate that the applicant is financially qualified to carry out the activities for which the license is sought. The information shall meet other financial assurance requirements of Rule R313-25.

R313-25-[~~11~~]12. Requirements for Issuance of a License.

A license for the receipt, possession, and disposal of waste containing radioactive material will be issued by the Director upon finding that:

(1) the issuance of the license will not constitute an unreasonable risk to the health and safety of the public;

(2) the applicant is qualified by reason of training and experience to carry out the described disposal operations in a manner that protects health and minimizes danger to life or property;

(3) the applicant's proposed disposal site, disposal design, land disposal facility operations, including equipment, facilities, and procedures, disposal site closure, and post-closure institutional control, are adequate to protect the public health and safety as specified in the performance objectives of Section R313-25-[~~19~~]20;

(4) the applicant's proposed disposal site, disposal site design, land disposal facility operations, including equipment, facilities, and procedures, disposal site closure, and post-closure institutional control are adequate to protect the public health and safety in accordance with the performance objectives of Section R313-25-[~~20~~]21;

(5) the applicant's proposed land disposal facility operations, including equipment, facilities, and procedures, are adequate to protect the public health and safety in accordance with Rule R313-15;

(6) the applicant's proposed disposal site, disposal site design, land disposal facility operations, disposal site closure, and post-closure institutional control plans are adequate to protect the public health and safety in that they will provide reasonable assurance of the long-term stability of the disposed waste and the disposal site and will eliminate to the extent practicable the need for continued maintenance of the disposal site following closure;

(7) the applicant's demonstration provides reasonable assurance that the requirements of Rule R313-25 will be met;

(8) the applicant's proposal for institutional control provides reasonable assurance that control will be provided for the length of time found necessary to ensure the findings in Subsections R313-25-[~~11~~]12(3) through (6) and that the institutional control meets the requirements of Section R313-25-[~~28~~]29.

(9) the financial or surety arrangements meet the requirements of Rule R313-25.

R313-25-12. Conditions of Licenses.

(1) A license issued under Rule R313-25, or a right thereunder, may not be transferred, assigned, or disposed of, either voluntarily or involuntarily, directly or indirectly, through transfer of control of the license to a person, unless the Director finds, after securing full information, that the transfer is in accordance with the provisions of the Radiation Control Act and Rules and gives his consent in writing in the form of a license amendment.

(2) The Director may require the licensee to submit written statements under oath.

(3) The license will be terminated only on the full implementation of the final closure plan, including post-closure observation and maintenance, as approved by the Director.

(4) The licensee shall submit to the provisions of the Act now or hereafter in effect, and to all findings and orders of the Director. The terms and conditions of the license are subject to amendment, revision, or modification, by reason of amendments to, or by reason of rules, and orders issued in accordance with the terms of the Act and these rules.

(5) Persons licensed by the Director pursuant to Rule R313-25 shall confine possession and use of the materials to the locations and purposes authorized in the license.

(6) The licensee shall not dispose of waste until the Director has inspected the land disposal facility and has found it to conform with the description, design, and construction described in the application for a license.

(7) The Director may incorporate, by rule or order, into licenses at the time of issuance or thereafter, additional requirements and conditions with respect to the licensee's receipt, possession, and disposal of waste as the Director deems appropriate or necessary in order to:

(a) protect health or to minimize danger to life or property;

(b) require reports and the keeping of records, and to provide for inspections of licensed activities as the Director deems necessary or appropriate to effectuate the purposes of the Radiation Control Act and Rules.

(8) The authority to dispose of wastes expires on the expiration date stated in the license. An expiration date on a license applies only to the above ground activities and to the authority to dispose of waste. Failure to renew the license shall not relieve the licensee of responsibility for implementing site closure, post-closure observation, and transfer of the license to the site owner.

R313-25-[~~13~~]14. Application for Renewal or Closure.

(1) An application for renewal or an application for closure under Section R313-25-[~~14~~]15 shall be filed at least 90 days prior to license expiration.

(2) Applications for renewal of a license shall be filed in accordance with Sections R313-25-5 and R313-25-7 through 25-[~~10~~]11. Applications for closure shall be filed in accordance with Section R313-25-[~~14~~]15. Information contained in previous applications, statements, or reports filed with the Director under the license may be incorporated by reference if the references are clear and specific.

(3) If a licensee has filed an application in proper form for renewal of a license, the license shall not expire unless and until the Director has taken final action to deny application for renewal.

(4) In evaluating an application for license renewal, the Director will apply the criteria set forth in Section R313-25-[~~11~~]12.

R313-25-[~~14~~]15. Contents of Application for Site Closure and Stabilization.

(1) Prior to final closure of the disposal site, or as otherwise directed by the Director, the licensee shall submit an application to amend the license for closure. This closure application shall include a final revision and specific details of the disposal site closure plan included in the original license application submitted and approved under Section R313-25-[~~7~~]8(7). The plan shall include the following:

(a) additional geologic, hydrologic, or other data pertinent to the long-term containment of emplaced wastes obtained during the operational period;

(b) the results of tests, experiments, or other analyses relating to backfill of excavated areas, closure and sealing, waste migration and interaction with emplacement media, or other tests, experiments, or analyses pertinent to the long-term containment of emplaced waste within the disposal site;

(c) proposed revision of plans for:

(i) decontamination or dismantlement of surface facilities;

(ii) backfilling of excavated areas; or

(iii) stabilization of the disposal site for post-closure care.

(d) Significant new information regarding the environmental impact of closure activities and long-term performance of the disposal site.

(2) Upon review and consideration of an application to amend the license for closure submitted in accordance with Subsection R313-25-[~~14~~]15(1), the Director shall issue an amendment authorizing closure if there is reasonable assurance that the long-term performance objectives of Rule R313-25 will be met.

R313-25-[~~15~~]16. Post-Closure Observation and Maintenance.

The licensee shall observe, monitor, and carry out necessary maintenance and repairs at the disposal site until the site closure is complete and the license is transferred by the Director in accordance with Section R313-25-[~~16~~]17. The licensee shall remain responsible for the disposal site for an additional five years. The Director may approve closure plans that provide for shorter or longer time periods of post-closure observation and maintenance, if sufficient rationale is developed for the variance.

R313-25-[~~16~~]17. Transfer of License.

Following closure and the period of post-closure observation and maintenance, the licensee may apply for an amendment to transfer

the license to the disposal site owner. The license shall be transferred when the Director finds:

(1) that the disposal site was closed according to the licensee's approved disposal site closure plan;

(2) that the licensee has provided reasonable assurance that the performance objectives of Rule R313-25 have been met;

(3) that funds for care and records required by Subsections R313-25-33(4) and (5) have been transferred to the disposal site owner;

(4) that the post-closure monitoring program is operational and can be implemented by the disposal site owner; and

(5) that the Federal or State agency which will assume responsibility for institutional control of the disposal site is prepared to assume responsibility and ensure that the institutional requirements found necessary under Subsection R313-25-[~~11~~]12(8) will be met.

R313-25-[~~17~~]18. Termination of License.

(1) Following the period of institutional control needed to meet the requirements of Section R313-25-[~~11~~]12, the licensee may apply for an amendment to terminate the license.

(2) This application will be reviewed in accordance with the provisions of Section R313-22-32.

(3) A license shall be terminated only when the Director finds:

(a) that the institutional control requirements of Subsection R313-25-[~~11~~]12(8) have been met;

(b) that additional requirements resulting from new information developed during the institutional control period have been met;

(c) that permanent monuments or markers warning against intrusion have been installed; and

(d) that records required by Subsections R313-25-33(4) and (5) have been sent to the party responsible for institutional control of the disposal site and a copy has been sent to the Director immediately prior to license termination.

R313-25-[~~18~~]19. General Requirement.

Land disposal facilities shall be sited, designed, operated, closed, and controlled after closure so that reasonable assurance exists that exposures to individuals do not exceed the limits stated in Sections R313-25-[~~19~~]20 and 25-[~~22~~]23.

R313-25-[~~19~~]20. Protection of the General Population from Releases of Radioactivity.

Concentrations of radioactive material which may be released to the general environment in ground water, surface water, air, soil, plants or animals shall not result in an annual dose exceeding an equivalent of 0.25 mSv (0.025 rem) to the whole body, 0.75 mSv (0.075 rem) to the thyroid, and 0.25 mSv (0.025 rem) to any other organ of any member of the public. No greater than 0.04 mSv (0.004 rem)committed effective dose equivalent or total effective dose equivalent to any member of the public shall come from groundwater. Reasonable efforts should be made to maintain releases of radioactivity in effluents to the general environment as low as is reasonably achievable.

R313-25-[~~20~~]21. Protection of Individuals from Inadvertent Intrusion.

Design, operation, and closure of the land disposal facility shall ensure protection of any individuals inadvertently intruding into the disposal site and occupying the site or contacting the waste after active institutional controls over the disposal site are removed.

R313-25-[~~21~~]22. Protection of Individuals During Operations.

Operations at the land disposal facility shall be conducted in compliance with the standards for radiation protection set out in Rule R313-15 of these rules, except for release of radioactivity in effluents from the land disposal facility, which shall be governed by Section R313-25-[~~19~~]20. Every reasonable effort should be made to maintain radiation exposures as low as is reasonably achievable, ALARA.

R313-25-[~~22~~]23. Stability of the Disposal Site After Closure.

The disposal facility shall be sited, designed, used, operated, and closed to achieve long-term stability of the disposal site and to eliminate, to the extent practicable, the need for ongoing active maintenance of the disposal site following closure so that only surveillance, monitoring, or minor custodial care are required.

R313-25-[~~23~~]24. Disposal Site Suitability Requirements for Land Disposal - Near-Surface Disposal.

(1) The primary emphasis in disposal site suitability is given to isolation of wastes and to disposal site features that ensure that the long-term performance objectives are met.

(2) The disposal site shall be capable of being characterized, modeled, analyzed and monitored.

(3) Within the region where the facility is to be located, a disposal site should be selected so that projected population growth and future developments are not likely to affect the ability of the disposal facility to meet the performance objectives of Rule R313-25.

(4) Areas shall be avoided having known natural resources which, if exploited, would result in failure to meet the performance objectives of Rule R313-25.

(5) The disposal site shall be [~~generally~~]well drained and free of areas of flooding or [~~frequent~~]ponding. Waste disposal shall not take place in a 100-year flood plain, coastal high-hazard area or wetland, as defined in Executive Order 11988, "Floodplain Management Guidelines."

(6) Upstream drainage areas shall be minimized to decrease the amount of runoff which could erode or inundate waste disposal units.

(7) The disposal site shall provide sufficient depth to the water table that ground water intrusion, perennial or otherwise, into the waste will not occur. The Director will consider an exception to this requirement to allow disposal below the water table if it can be conclusively shown that disposal site characteristics will result in molecular diffusion being the predominant means of radionuclide movement and the rate of movement will result in the performance objectives being met. In no case will waste disposal be permitted in the zone of fluctuation of the water table.

(8) The hydrogeologic unit used for disposal shall not discharge ground water to the surface within the disposal site.

(9) Areas shall be avoided where tectonic processes such as faulting, folding, seismic activity, vulcanism, or similar phenomena may occur with such frequency and extent to significantly affect the ability of the disposal site to meet the performance objectives of Rule R313-25 or may preclude defensible modeling and prediction of long-term impacts.

(10) Areas shall be avoided where surface geologic processes such as mass wasting, erosion, slumping, landsliding, or weathering occur with sufficient such frequency and extent to significantly affect the ability of the disposal site to meet the performance objectives of Rule R313-25, or may preclude defensible modeling and prediction of long-term impacts.

(11) The disposal site shall not be located where nearby facilities or activities could adversely impact the ability of the site to meet the performance objectives of Rule R313-25 or significantly mask the environmental monitoring program.

R313-25-[~~24~~]25. Disposal Site Design for Near-Surface Land Disposal.

(1) Site design features shall be directed toward long-term isolation and avoidance of the need for continuing active maintenance after site closure.

(2) The disposal site design and operation shall be compatible with the disposal site closure and stabilization plan and lead to disposal site closure that provides reasonable assurance that the performance objectives will be met.

(3) The disposal site shall be designed to complement and improve, where appropriate, the ability of the disposal site's natural characteristics to assure that the performance objectives will be met.

(4) Covers shall be designed to minimize, to the extent practicable, water infiltration, to direct percolating or surface water away from the disposed waste, and to resist degradation by surface geologic processes and biotic activity.

(5) Surface features shall direct surface water drainage away from disposal units at velocities and gradients which will not result in erosion that will require ongoing active maintenance in the future.

(6) The disposal site shall be designed to minimize to the extent practicable the contact of water with waste during storage, the contact of standing water with waste during disposal, and the contact of percolating or standing water with wastes after disposal.

R313-25-[~~25~~]26. Near Surface Land Disposal Facility Operation and Disposal Site Closure.

(1) Wastes designated as Class A pursuant to Section R313-15-1009 of these rules shall be segregated from other wastes by placing them in disposal units which are sufficiently separated from disposal units for the other waste classes so that any interaction between Class A wastes and other wastes will not result in the failure to meet the performance objectives of Rule R313-25. This segregation is not necessary for Class A wastes if they meet the stability requirements of Subsection R313-15-1009(2)(b).

(2) Wastes designated as Class C pursuant to Section R313-15-1009 shall be disposed of so that the top of the waste is a minimum of five meters below the top surface of the cover or shall be disposed of with intruder barriers that are designed to protect against an inadvertent intrusion for at least 500 years.

(3) Except as provided in Subsection R313-25-1(1), only waste classified as Class A, B, or C shall be acceptable for near-surface disposal. Wastes shall be disposed of in accordance with the requirements of Subsections R313-25-[~~25~~]26(4) through 11.

(4) Wastes shall be emplaced in a manner that maintains the package integrity during emplacement, minimizes the void spaces between packages, and permits the void spaces to be filled.

(5) Void spaces between waste packages shall be filled with earth or other material to reduce future subsidence within the fill.

(6) Waste shall be placed and covered in a manner that limits the radiation dose rate at the surface of the cover to levels that at a minimum will permit the licensee to comply with all provisions of Section R313-15-105 at the time the license is transferred pursuant to Section R313-25-[~~16~~]17.

(7) The boundaries and locations of disposal units shall be accurately located and mapped by means of a land survey. Near-surface disposal units shall be marked in such a way that the boundaries of the units can be easily defined. Three permanent survey marker control points, referenced to United States Geological Survey or National Geodetic Survey control stations, shall be established on the site to facilitate surveys. The United States Geological Survey or National Geodetic Survey control stations shall provide horizontal and vertical controls as checked against United States Geological Survey or National Geodetic Survey record files.

(8) A buffer zone of land shall be maintained between any buried waste and the disposal site boundary and beneath the disposed waste. The buffer zone shall be of adequate dimensions to carry out environmental monitoring activities specified in Subsection R313-25-[~~26~~]27(4) and take mitigative measures if needed.

(9) Closure and stabilization measures as set forth in the approved site closure plan shall be carried out as the disposal units are filled and covered.

(10) Active waste disposal operations shall not have an adverse effect on completed closure and stabilization measures.

(11) Only wastes containing or contaminated with radioactive material shall be disposed of at the disposal site.

(12) Proposals for disposal of waste that are not generally acceptable for near-surface disposal because the wastes form and disposal methods shall be different and, in general, more stringent than those specified for Class C waste, may be submitted to the Director for approval.

R313-25-[~~26~~]27. Environmental Monitoring.

(1) At the time a license application is submitted, the applicant shall have conducted a preoperational monitoring program to provide basic environmental data on the disposal site characteristics. The applicant shall obtain information about the ecology, meteorology, climate, hydrology, geology, geochemistry, and seismology of the disposal site. For those characteristics that are subject to seasonal variation, data shall cover at least a 12-month period.

(2) During the land disposal facility site construction and operation, the licensee shall maintain an environmental monitoring program. Measurements and observations shall be made and recorded to provide data to evaluate the potential health and environmental impacts during both the construction and the operation of the facility and to enable the evaluation of long-term effects and need for mitigative measures. The monitoring system shall be capable of providing early warning of releases of waste from the disposal site before they leave the site boundary.

(3) After the disposal site is closed, the licensee responsible for post-operational surveillance of the disposal site shall maintain a monitoring system based on the operating history and the closure and stabilization of the disposal site. The monitoring system shall be capable of providing early warning of releases of waste from the disposal site before they leave the site boundary.

(4) The licensee shall have plans for taking corrective measures if the environmental monitoring program detects migration of waste which would indicate that the performance objectives may not be met.

R313-25-[~~27~~]28. Alternative Requirements for Design and Operations.

The Director may, upon request or on [~~his~~]the Director's own initiative, authorize provisions other than those set forth in Sections R313-25-[~~24~~]25 and 25-[~~26~~]27 for the segregation and disposal of waste and for the design and operation of a land disposal facility on a specific basis, if it finds reasonable assurance of compliance with the performance objectives of Rule R313-25.

R313-25-[~~28~~]29. Institutional Requirements.

(1) Land Ownership. Disposal of waste received from other persons may be permitted only on land owned in fee by the Federal or a State government.

(2) Institutional Control. The land owner or custodial agency shall conduct an institutional control program to physically control access to the disposal site following transfer of control of the disposal site from the disposal site operator. The institutional control program shall also include, but not be limited to, conducting an environmental monitoring program at the disposal site, periodic surveillance, minor custodial care, and other equivalents as determined by the Director, and administration of funds to cover the costs for these activities. The period of institutional controls will be determined by the Director, but institutional controls may not be relied upon for more than 100 years following transfer of control of the disposal site to the owner.

R313-25-30. Applicant Qualifications and Assurances.

The applicant shall show that it either possesses the necessary funds, or has reasonable assurance of obtaining the necessary funds, or by a combination of the two, to cover the estimated costs of conducting all licensed activities over the planned operating life of the project, including costs of construction and disposal.

R313-25-31. Funding for Disposal Site Closure and Stabilization.

(1) The applicant shall provide assurances prior to the commencement of operations that sufficient funds will be available to carry out disposal site closure and stabilization, including:

(a) decontamination or dismantlement of land disposal facility structures, and

(b) closure and stabilization of the disposal site so that following transfer of the disposal site to the site owner, the need for ongoing active maintenance is eliminated to the extent practicable and only minor custodial care, surveillance, and monitoring are required. These assurances shall be based on Director approved cost estimates reflecting the Director approved plan for disposal site closure and stabilization. The applicant's cost estimates shall take into account total costs that would be incurred if an independent contractor were hired to perform the closure and stabilization work.

(2) In order to avoid unnecessary duplication and expense, the Director will accept financial sureties that have been consolidated with earmarked financial or surety arrangements established to meet requirements of Federal or other State agencies or local governmental bodies for decontamination, closure, and stabilization. The Director will accept these arrangements only if they are considered adequate to satisfy the requirements of Section R313-25-31 and if they clearly identify that the portion of the surety which covers the closure of the disposal site is clearly identified and committed for use in accomplishing these activities.

(3) The licensee's financial or surety arrangement shall be submitted annually for review by the Director to assure that sufficient funds will be available for completion of the closure plan.

(4) The amount of the licensee's financial or surety arrangement shall change in accordance with changes in the predicted costs of closure and stabilization. Factors affecting closure and stabilization cost estimates include inflation, increases in the amount of disturbed land, changes in engineering plans, closure and stabilization that have already been accomplished, and other conditions affecting costs. The financial or surety arrangement shall be sufficient at all times to cover the costs of closure and stabilization of the disposal units that are expected to be used before the next license renewal.

(5) The financial or surety arrangement shall be written for a specified period of time and shall be automatically renewed unless the person who issues the surety notifies the Director; the beneficiary, the site owner; and the principal, the licensee, not less than 90 days prior to the renewal date of its intention not to renew. In such a situation, the licensee shall submit a replacement surety within 30 days after notification of cancellation. If the licensee fails to provide a replacement surety acceptable to the Director, the beneficiary may collect on the original surety.

(6) Proof of forfeiture shall not be necessary to collect the surety so that, in the event that the licensee could not provide an acceptable replacement surety within the required time, the surety shall be automatically collected prior to its expiration. The conditions described above shall be clearly stated on surety instruments.

(7) Financial or surety arrangements generally acceptable to the Director include surety bonds, cash deposits, certificates of deposit, deposits of government securities, escrow accounts, irrevocable letters or lines of credit, trust funds, and combinations of the above or other types of arrangements as may be approved by the Director. Self-insurance, or an arrangement which essentially constitutes self-insurance, will not satisfy the surety requirement for private sector applicants.

(8) The licensee's financial or surety arrangement shall remain in effect until the closure and stabilization program has been completed and approved by the Director, and the license has been transferred to the site owner.

R313-25-32. Financial Assurances for Institutional Controls.

(1) Prior to the issuance of the license, the applicant shall provide for Director approval, a binding arrangement, between the applicant and the disposal site owner that ensures that sufficient funds will be available to cover the costs of monitoring and required maintenance during the institutional control period. The binding arrangement shall be reviewed annually by the Director to ensure that changes in inflation, technology, and disposal facility operations are reflected in the arrangements.

(2) Subsequent changes to the binding arrangement specified in Subsection R313-25-32(1) relevant to institutional control shall be submitted to the Director for prior approval.

R313-25-33. Maintenance of Records, Reports, and Transfers.

(1) Licensees shall maintain records and make reports in connection with the licensed activities as may be required by the conditions of the license or by the rules and orders of the Director.

(2) Records which are required by these rules or by license conditions shall be maintained for a period specified by the appropriate rules or by license condition. If a retention period is not otherwise specified, these records shall be maintained and transferred to the officials specified in Subsection R313-25-33(4) as a condition of license termination unless the Director otherwise authorizes their disposition.

(3) Records which shall be maintained pursuant to Rule R313-25 may be the original or a reproduced copy or microfilm if this reproduced copy or microfilm is capable of producing copy that is clear and legible at the end of the required retention period.

(4) Notwithstanding Subsections R313-25-33(1) through (3), copies of records of the location and the quantity of wastes contained in the disposal site shall be transferred upon license termination to the chief executive of the nearest municipality, the chief executive of the county in which the facility is located, the county zoning board or land development and planning agency, the State Governor, and other state, local, and federal governmental agencies as designated by the Director at the time of license termination.

(5) Following receipt and acceptance of a shipment of waste, the licensee shall record the date that the shipment is received at the disposal facility, the date of disposal of the waste, a traceable shipment manifest number, a description of any engineered barrier or structural overpack provided for disposal of the waste, the location of disposal at the disposal site, the condition of the waste packages as received, discrepancies between the materials listed on the manifest and those received, the volume of any pallets, bracing, or other shipping or onsite generated materials that are contaminated, and are disposed of as contaminated or suspect materials, and evidence of leakage or damaged packages or radiation or contamination levels in excess of limits specified in U.S. Department of Transportation and Director regulations or rules. The licensee shall briefly describe repackaging operations of the waste packages included in the shipment, plus other information required by the Director as a license condition.

(6) Licensees authorized to dispose of waste received from other persons shall file a copy of their financial report or a certified financial statement annually with the Director in order to update the information base for determining financial qualifications.

(7)(a) Licensees authorized to dispose of waste received from other persons, pursuant to Rule R313-25, shall submit annual reports to the Director. Reports shall be submitted by the end of the first calendar quarter of each year for the preceding year.

(b) The reports shall include:

(i) specification of the quantity of each of the principal contaminants released to unrestricted areas in liquid and in airborne effluents during the preceding year;

(ii) the results of the environmental monitoring program;

(iii) a summary of licensee disposal unit survey and maintenance activities;

(iv) a summary, by waste class, of activities and quantities of radionuclides disposed of;

(v) instances in which observed site characteristics were significantly different from those described in the application for a license; and

(vi) other information the Director may require.

(c) If the quantities of waste released during the reporting period, monitoring results, or maintenance performed are significantly different from those predicted, the report shall cover this specifically.

(8) In addition to the other requirements in Section R313-25-33, the licensee shall store, or have stored, manifest and other information pertaining to receipt and disposal of radioactive waste in an electronic recordkeeping system.

(a) The manifest information that must be electronically stored is:

(i) that required in Appendix G of 10 CFR 20.1001 to 20.2402, (2006), which is incorporated into these rules by reference, with the exception of shipper and carrier telephone numbers and shipper and consignee certifications; and

(ii) that information required in Subsection R313-25-33(5).

(b) As specified in facility license conditions, the licensee shall report the stored information, or subsets of this information, on a computer-readable medium.

R313-25-34. Tests on Land Disposal Facilities.

Licensees shall perform, or permit the Director to perform, any tests the Director deems appropriate or necessary for the administration of the rules in Rule R313-25, including, but not limited to, tests of;

(1) wastes;

(2) facilities used for the receipt, storage, treatment, handling or disposal of wastes;

(3) radiation detection and monitoring instruments; or

(4) other equipment and devices used in connection with the receipt, possession, handling, treatment, storage, or disposal of waste.

R313-25-35. Director Inspections of Land Disposal Facilities.

(1) Licensees shall afford to the Director, at reasonable times, opportunity to inspect waste not yet disposed of, and the premises, equipment, operations, and facilities in which wastes are received, possessed, handled, treated, stored, or disposed of.

(2) Licensees shall make available to the Director for inspection, upon reasonable notice, records kept by it pursuant to these rules. Authorized representatives of the Director may copy and take away copies of, for the Director's use, any records required to be kept pursuant to Rule R313-25.

KEY: radiation, radioactive waste disposal, depleted uranium
Date of Enactment or Last Substantive Amendment: [~~April 4, 2011~~]2014
Notice of Continuation: September 23, 2011
Authorizing, and Implemented or Interpreted Law: 19-3-104; 19-3-108

Health, Children's Health Insurance Program
R382-10
Eligibility

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38096
FILED: 11/01/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this change is to comply with provisions of the Patient Protection and Affordable Care Act (PPACA) through changes that relate to the treatment of applications and reviews, determining income, income budgeting, and by using Modified Adjusted Gross Income (MAGI)-based methodology.

SUMMARY OF THE RULE OR CHANGE: This amendment defines general provisions for accepting and processing applications and reviews, defines provisions for determining countable income, specifies methodologies used to determine best estimates of income, and outlines provisions to determine household composition through MAGI-based methodology. The rule also defines the new process for quarterly premiums and the sanction period for failure to pay a premium. It also updates incorporations by reference and makes other technical changes.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Pub. L. No. 111-148 and Section 26-1-5 and Title 26, Chapter 40

MATERIALS INCORPORATED BY REFERENCES:
- ♦ Updates 42 CFR 457.315, published by Government Printing Office, 10/01/2012
- ♦ Updates 42 CFR 457.320(d), published by Government Printing Office, 10/01/2012
- ♦ Updates 42 CFR 457.330, published by Government Printing Office, 10/01/2012
- ♦ Updates 42 CFR 457.340(b), published by Government Printing Office, 10/01/2012
- ♦ Updates 42 CFR 457.343, published by Government Printing Office, 10/01/2012
- ♦ Updates 42 CFR 457.348, published by Government Printing Office, 10/01/2012
- ♦ Adds 78 FR 42313, published by Government Printing Office, 07/15/2013
- ♦ Adds 78 FR 42312, published by Government Printing Office, 07/15/2013

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: The impact to the state budget is addressed in the companion rule filing for Rule R414-304. (DAR NOTE: The proposed amendment to Rule R414-304 is under DAR No. 38100 in this issue, November 15, 2013, of the Bulletin.)
♦ LOCAL GOVERNMENTS: There is no impact to local governments because they neither fund services for the Children's Health Insurance Program (CHIP) nor make CHIP eligibility determinations.
♦ SMALL BUSINESSES: This amendment does not impose any new costs or requirements because it does not affect services for CHIP recipients and small businesses do not make CHIP eligibility determinations. In addition, this amendment does not affect business revenue because the conversion process to MAGI-based methodology does not systematically increase or decrease CHIP eligibility.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Some CHIP recipients may realize savings roughly equivalent to the anticipated state costs because more individuals will become eligible for CHIP services. Nevertheless, this amendment does not affect provider revenue because the conversion process to MAGI-based methodology does not systematically increase or decrease CHIP eligibility.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs because this amendment can only result in out-of-pocket savings to a single CHIP recipient. Furthermore, this amendment does not affect provider revenue because the conversion process to MAGI-based methodology does not systematically increase or decrease CHIP eligibility.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The changes may modify individual eligibility but will have no impact on business.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HEALTH
CHILDREN'S HEALTH INSURANCE PROGRAM
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 AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 01/01/2014

AUTHORIZED BY: David Patton, PhD, Executive Director

R382. Health, Children's Health Insurance Program.
R382-10. Eligibility.
R382-10-4. Applicant and Enrollee Rights and Responsibilities.

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

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

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

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

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

(6) The parent or child, or other responsible person acting on behalf of a child must report certain changes to the eligibility agency within ten calendar days of the day the change becomes known. [~~Some examples of r~~]Reportable changes include:

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

(b) An enrollee leaves the household or dies.

(c) An enrollee or the household moves out of state.

(d) Change of address of an enrollee or the household.

(e) An enrollee enters a public institution or an institution for mental diseases.

(7) An applicant and enrollee may review the information that the eligibility agency uses to determine eligibility.

(8) An applicant and enrollee have the right to be notified about actions that the agency takes to determine their eligibility or continued eligibility, the reason the action was taken, and the right to request an agency conference or agency action as defined in Section[~~s~~] R414-301-[~~5~~]6 and Section R414-301-[~~6~~]7.

(9) An enrollee in CHIP must pay quarterly premiums, co-payments, or co-insurance amounts to providers for medical services that the enrollee receives under CHIP.

R382-10-6. Citizenship and Alienage.

(1) To be eligible to enroll in CHIP, a child must be a citizen or national of the United States (U.S.) or a qualified alien.

(2) The provisions of Section R414-302-[~~1~~]3 regarding citizenship and alien status requirements apply to applicants and enrollees of CHIP.

R382-10-7. Utah Residence.

(1) The Department adopts and incorporates by reference, 42 CFR 457.320(d), October 1, 2012 ed. A child must be a Utah resident to be eligible to enroll in the program.

(2) An American Indian or Alaska Native child in a boarding school is a resident of the state where his parents reside. A child in a school for the deaf and blind is a resident of the state where his parents reside.

(3) A child is a resident of the state if he is temporarily absent from Utah due to employment, schooling, vacation, medical treatment, or military service.

(4) The child need not reside in a home with a permanent location or fixed address.

R382-10-9. Social Security Numbers.

(1) The eligibility agency may request an applicant to provide the correct Social Security Number (SSN) or proof of application for a SSN for each household member at the time of application for the program. The eligibility agency shall use the SSN in accordance with the requirements of 42 CFR 457.340(b), October 1, 2012 ed., which is incorporated by reference.

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

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

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

R382-10-10. Creditable Health Coverage.

(1) To be eligible for enrollment in the program, a child must meet the requirements of Sections 2110(b)[~~(1)(C) and (2)(B)~~] of the Compilation of Social Security Laws.

(2) A child who is covered under a group health plan or other health insurance that provides coverage in Utah, including coverage under a parent's or legal guardian's employer, as defined in 29 CFR 2590.701-4, [~~2010~~]July 1, 2013 ed., is not eligible for CHIP assistance.

([~~3~~]a) A child who is covered under health insurance that does not provide coverage in the State of Utah is eligible for enrollment.

[~~(4) A child who is covered under a group health plan or other health coverage but reaches the lifetime maximum coverage under that plan is eligible for enrollment.~~

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

([~~6~~]3) An eligible child who has access to an employer-sponsored health plan may choose to enroll in either CHIP or the employer-sponsored health plan.

(a) If the child chooses to enroll in the employer-sponsored health plan, the child may enroll in and receive premium reimbursement through the UPP program if enrollment is not closed. The health plan must meet the following conditions:

(i) The cost of the least expensive plan equals or exceeds 5% of the [~~household's gross annual~~]countable MAGI-based income for the individual; and

(ii) The plan meets the requirements of Subsection R414-320-2(19).

(b) The cost of coverage includes a deductible if the employer plan has a deductible that must be met before the plan will pay any claims. For a dependent child, if the employee must enroll to enroll the dependent child, the cost of coverage will include the cost to enroll the employee and the dependent child.

(c) If the child enrolls in the employer-sponsored health plan or COBRA coverage and UPP, but the plan does not include dental benefits, the child may receive dental-only benefits through CHIP. If the employer-sponsored health plan includes dental, the applicant may choose to enroll the child in the dental plan and receive an additional reimbursement from UPP of up to $20 per month, or may choose not to enroll the child in the dental plan and receive dental-only benefits through CHIP.

(d) A child who chooses to enroll in the employer-sponsored health plan or COBRA coverage and UPP may discontinue the employer-sponsored health plan or COBRA coverage and switch to CHIP coverage at any time without a 90-day ineligibility period for voluntarily discontinuing health insurance. Eligibility continues through the current certification period without a new eligibility determination.

([~~7~~]4) Subject to the provisions published in 78 FR 42313, which the Department adopts and incorporates by reference, [~~T~~]the eligibility agency shall deny eligibility and impose a 90-day waiting period for enrollment under CHIP if the applicant or a custodial parent voluntarily terminates health insurance that provides coverage in Utah within the 90 days before the application date for enrollment under CHIP. In addition, the agency may not apply a 90-day waiting period in the following situations:

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

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

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

(d) a child is terminated from a custodial parent's insurance because ORS reverses the forced enrollment requirement.

([~~a~~]5) If the 90-day ineligibility period for CHIP ends in the month of application, or by the end of the month that follows, the eligibility agency shall determine the applicant's eligibility.

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

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

(6) The Department shall comply with the provisions of enrollment after the waiting period in accordance with 78 FR 42312, which the Department adopts and incorporates by reference.

([~~8~~]7) If an applicant or an applicant's parent voluntarily terminates coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) plan or under the Health Insurance Pool (HIP), or if an applicant is involuntarily terminated from an employer's plan, the applicant is eligible for CHIP without a 90-day ineligibility period.

([~~9~~]8) A child with creditable health coverage operated or financed by the Indian Health Services is not excluded from enrolling in the program.

([~~10~~]9) An applicant must report at application and review whether any of the children in the household for whom enrollment is being requested have access to or are covered by a group health plan, other health insurance coverage, or a state employee's health benefits plan.

([~~11~~]10) The eligibility agency shall deny an application or review if the enrollee fails to respond to questions about health insurance coverage for children that the household seeks to enroll or renew in the program.

([~~12~~]11) A recipient must report when a child enrolls in health insurance coverage within ten calendar days of the date of enrollment or the date that benefits are effective, whichever is later. The eligibility agency shall end eligibility effective the end of the month in which the agency sends proper notice of the closure. A child may switch to UPP in accordance with Subsection R382-10-10([~~6~~]3) if the change is reported timely. Failure to make a timely report may result in overpayment.

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

(1) [~~The following individuals who reside together must be included in the household for purposes of determining the household size, whether or not the individual is eligible to enroll in the program:~~

~~(a) At least one child who meets the CHIP age requirement and who does not have access to and is not covered by a group health plan or other health insurance;~~

~~(b) Siblings, half-siblings, adopted siblings, and step-siblings of the eligible child if they are under 19 years of age. They may also be eligible for CHIP if they meet the CHIP eligibility criteria;~~

~~(c) Parents and stepparents of any child who is included in the household size;~~

~~(d) Children of any child included in the household size;~~

~~(e) The spouse of any child who is included in the household size;~~

~~(f) Unborn children of anyone included in the household size; and~~

~~(g) Children of a former spouse when a divorce is finalized.~~]The Department adopts and incorporates by reference, 42 CFR 457.315, October 1, 2012 ed., regarding the household composition and income methodology to determine eligibility for CHIP.

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

[~~(3) Any household member described in Subsection R382-10-11 (1) who is not a citizen, a national, or a qualified alien is included in the household size. The eligibility agency counts the income of these individuals the same way that it counts the income for household members who are citizens, nationals, or qualified aliens.~~

](3) The household size includes the number of unborn children that a pregnant household member expects to deliver.

(4) The eligibility agency counts children who are 19 or 20 years old and are full-time students in the household size of individuals whose household size is determined under the non-tax filer rules found in 42 CFR 435.603(f)(3).

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

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

(7) The eligibility agency counts as income, cash support received from a tax filer who claims the individual as a tax dependent when that dependent is not the spouse or child of the tax filer, but only the amount that exceeds a minimal amount set by the Department.

(8) The eligibility agency determines eligibility by deducting an amount equal to 5% of the federal poverty guideline for the applicable household size from the MAGI-based household income determined for the individual.

[R382-10-13. Income Provisions.

(1) To be eligible to enroll in the Children's Health Insurance Program, gross household income must be equal to or less than 200% of the federal non-farm poverty guideline for a household of equal size.

(a) All gross income, earned and unearned, received by the parents and stepparents of any child who is included in the household size, counts toward household income, unless this section specifically describes a different treatment of the income.

(b) When a CHIP household is scheduled for a renewal of eligibility, the household may give consent to the eligibility agency to access the household's most recent adjusted gross income from the Utah State Tax Commission. Only CHIP eligible households can elect this option. When the household elects this option, the eligibility agency shall use the adjusted gross income from the most recent tax record as the countable income of the household to determine eligibility for CHIP.

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

(3) The Department may count any income in a trust that is available to, or is received by any of the following household members:

(a) a parent or spouse of a parent;

(b) an eligible child who is the head of the household;

(c) a spouse of an eligible child if the spouse is 19 years of age or older; or

(d) a spouse who is under 19 years old and is the head of the household.

(4) Payments received from the Family Employment Program, General Assistance, or refugee cash assistance is countable income.

(5) Rental income is countable income. The following expenses can be deducted:

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

(b) upkeep and repair costs necessary to maintain the current value of the property;

(c) utility costs only if they are paid by the owner; and

(d) interest only on a loan or mortgage secured by the rental property.

(6) Deposits to joint checking or savings accounts are countable income, even if the deposits are made by a non-household member. An applicant or enrollee who disputes household ownership of deposits to joint checking or savings accounts shall be given an opportunity to prove that the deposits do not represent income to the household. Funds that are successfully disputed are not countable income.

(7) Cash contributions made by non-household members are counted as income unless the parties have a signed written agreement for repayment of the funds.

(8) The interest earned from payments made under a sales contract or a loan agreement is countable income to the extent that these payments will continue to be received during the eligibility period.

(9) In-kind income, which is goods or services provided to the individual from a non-household member and which is not in the form of cash, for which the individual performed a service or is provided as part of the individual's wages is counted as income. In-kind income for which the individual did not perform a service or did not work to receive is not counted as income.

(10) SSI and State Supplemental Payments are countable income.

(11) Death benefits are not countable income to the extent that the funds are spent on the deceased person's burial or last illness.

(12) A bona fide loan that an individual must repay and that the individual has contracted in good faith without fraud or deceit, and genuinely endorsed in writing for repayment is not countable income.

(13) Child Care Assistance under Title XX is not countable income.

(14) Reimbursements of Medicare premiums received by an individual from Social Security Administration or the Department are not countable income.

(15) Needs-based Veteran's pensions are counted as income. The Department may only count the portion of a Veteran's Administration benefit to which the individual is legally entitled.

(16) The Department may not count the income of a child under the age of 19 if the child is not the head of a household.

(17) The Department shall count the income of the spouse of an eligible child if:

(a) the spouse is 19 years of age or older; or

(b) the spouse is under 19 years old and is the head of the household.

(18) Educational income such as educational loans, grants, scholarships, and work-study programs are not countable income. The individual must verify enrollment in an educational program.

(19) Reimbursements for expenses incurred by an individual are not countable income.

(20) Any payments made to an individual because of his status as a victim of Nazi persecution as defined in Pub. L. No. 103-286 are not countable income, including payments made by the Federal Republic of Germany, Austrian Social Insurance payments, and Netherlands WUV payments.

(21) Victim's Compensation payments as defined in Pub. L. No. 101-508 are not countable income.

(22) Disaster relief funds received if a catastrophe has been declared a major disaster by the President of the United States as defined in Pub. L. No. 103-286 are not countable income.

(23) Income of an alien's sponsor or the sponsor's spouse is not countable income.

(24) If the household expects to receive less than $500 per year in taxable interest and dividend income, then they are not countable income.

~~(25) Income paid by the U.S. Census Bureau to a temporary census taker to prepare for and conduct the census is not countable income.~~

~~(26) The additional $25 a week payment to unemployment insurance recipients provided under Section 2002 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115, which an individual may receive from March 2009 through June 2010 is not countable income.~~

~~(27) The one-time economic recovery payments received by individuals receiving social security, supplemental security income, railroad retirement, or veteran's benefits under the provisions of Section 2201 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115, and refunds received under the provisions of Section 2202 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115, for certain government retirees are not countable income.~~

~~(28) The Consolidated Omnibus Reconciliation Act (COBRA) premium subsidy provided under Section 3001 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115, is not countable income.~~

~~(29) The making work pay credit provided under Section 1001 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115, is not countable income.~~

~~(30) The eligibility agency may not count as income any payments that an individual receives pursuant to the Individual Indian Money Account Litigation Settlement under the Claims Resolution Act of 2010, Pub. L. No. 111-291, 124 Stat. 3064.~~

~~(31) The eligibility agency may not count as income any federal tax refund and refundable credit that an individual receives between January 1, 2010, and December 31, 2012, pursuant to the Tax Relief Unemployment Insurance Reauthorization and Job Creation Act of 2010, Pub. L. No. 111-312, 124, Stat 3296.~~

]

R382-10-1[4]3. Budgeting.

(1) The [~~Department~~]eligibility agency [~~shall count the gross income for parents and stepparents of any child included in the household size to determine a child's eligibility, unless the income is excluded under this rule. The Department may only deduct required expenses from the gross income to make an income available to the individual. No other deductions are allowed.~~]determines countable household income according to MAGI-based methodology as required by 42 CFR 457.315.

(2) [~~The Department shall determine monthly income by taking into account the months of pay where an individual receives a fifth paycheck when paid weekly, or a third paycheck when paid every other week. The Department shall multiply the weekly amount by 4.3 to obtain a monthly amount. The Department shall multiply income paid bi-weekly by 2.15 to obtain a monthly amount.~~

~~(3)~~]The [~~Department~~]eligibility agency shall determine a child's eligibility and cost[~~-~~] sharing requirements prospectively for the upcoming eligibility period at the time of application and at each renewal for continuing eligibility.

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

(b) The eligibility agency shall include in its estimate, reasonably predictable income changes such as seasonal income or contract income, to determine the average monthly income expected to be received during the certification period.

(c) The [~~Department~~]eligibility agency [~~shall~~]prorates income that is received less often than monthly over the eligibility period to determine an average monthly income.[~~The Department may request prior years' tax returns as well as current income information to determine a household's income.~~]

[~~(4) A household may elect upon renewal to have the Department use the most recent adjusted gross income (AGI) from the Utah State Tax Commission. The eligibility agency shall then use AGI instead of requesting verification of current income. If the use of AGI should result in an adverse decision or change, the household may provide verification of current income.~~

] ([~~5~~]3) Methods of determining the best estimate are income averaging, income anticipating, and income annualizing. The [~~Department~~]eligibility agency may use a combination of methods to obtain the most accurate best estimate. The best estimate may be a monthly amount that is expected to be received each month of the eligibility period, or an annual amount that is prorated over the eligibility period. Different methods may be used for different types of income received in the same household.

([~~6~~]4) The [~~Department~~]eligibility agency [~~shall~~] determines farm and self-employment income by using the individual's recent tax return forms or other verifications the individual can provide. If tax returns are not available, or are not reflective of the individual's current farm or self-employment income, the [~~Department~~]eligibility agency may request income information from a recent time period during which the individual had farm or self-employment income. [~~The Department shall deduct 40% of the gross income as a deduction for business expenses to determine the countable income of the individual. For individuals who have business expenses greater than 40%, the Department may exclude more than 40% if the individual can demonstrate that the actual expenses are greater than 40%.~~]The [~~Department~~]eligibility agency [~~shall~~]deducts the same expenses from gross income that the Internal Revenue Service allows as self-employment expenses to determine net self-employment income.

[~~(7) The Department may annualize income for any household and in particular for households that have self-employment income, receive income sporadically under contract or commission agreements, or receive income at irregular intervals throughout the year.~~

]

R382-10-1[5]4. Assets.

An asset test is not required for CHIP eligibility.

R382-10-1[6]5. Application and Eligibility Reviews.

(1) The Department adopts and incorporates by reference 78 FR 42312. The Department also adopts and incorporates by reference 42 CFR 457.330, 457.343, and 457.348, October 1, 2012 ed. [~~The applicant must complete and sign a written application or an on-line application to enroll in the CHIP program. The application process includes gathering information and verification to determine the child's eligibility for enrollment in the program.~~

~~(2) The eligibility agency may accept any Department-approved application form for medical assistance programs offered by the state as an application for CHIP enrollment.~~

~~(3) Individuals may apply for enrollment in person, through the mail, by fax, or online.~~]

([~~4~~]2) The provisions of Section R414-308-3 apply to applicants for CHIP, except for Subsection R414-308-3(10) and the three months of retroactive coverage.

([~~5~~]3) Individuals can apply without having an interview. The eligibility agency may interview applicants and enrollee's, the parents or spouse, and any adult who assumes responsibility for the care or supervision of the child, when necessary to resolve discrepancies or to gather information that cannot be obtained otherwise.

([~~6~~]4) According to the provisions of Section 2105(a)(4)(F) of the Social Security Act, the Department provides medical assistance during a presumptive eligibility period to a child if a Medicaid eligibility worker with the Department of Human Services has determined, based on preliminary information, that:

(a) the child meets citizenship or alien status criteria as defined in Section R414-302-[~~1~~]3;

(b) the child is not enrolled in a health insurance plan; and

(c) the child's household income exceeds the applicable income limit for Medicaid, but does not exceed 200% of the federal poverty level for the applicable household size.

([~~7~~]5) A child determined presumptively eligible is required to file an application for medical assistance with the eligibility agency in accordance with the requirements of Section 1920A of the Social Security Act.

([~~8~~]6) A child may receive medical assistance during only one presumptive eligibility period in any six month period.

([~~9~~]7) The eligibility agency shall complete a periodic review of an enrollee's eligibility for CHIP medical assistance in accordance with the requirements of 42 CFR 457.343.[~~at least once every 12 months. The periodic review is a review of eligibility factors that may be subject to change. The eligibility agency shall use available, reliable sources to gather necessary information to complete the review. The eligibility agency may conduct the review without requiring the enrollee to provide additional information.~~]

([~~10~~]8) [~~The eligibility agency may ask the enrollee to respond to a request to complete the review process.~~]If [~~the~~]an enrollee fails to respond to [~~the~~]a request for information to complete the review during the review month, the agency shall end the enrollee's eligibility effective at the end of the review month and send proper notice to the enrollee.

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

[~~(a) The eligibility agency may ask the enrollee for verification to redetermine eligibility.~~

~~(b) Upon receiving verification, the eligibility agency shall redetermine eligibility and notify the enrollee.~~

~~(i)~~](b) If the enrollee is determined eligible based on this reapplication, the new certification period begins the first day of the month [~~after the closure date~~]in which the enrollee contacts the agency to complete the review if verification is provided within the application processing period. The four day grace period may apply.[

~~(ii)~~] If the enrollee fails to return verification within the application processing period, or if the enrollee is determined ineligible, the eligibility agency shall send a denial notice to the enrollee.

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

([~~d~~]9) Except as defined in R382-10-15(8), [~~If~~] the enrollee must reapply for CHIP if the enrollee's case is closed for one or more calendar months[~~, the enrollee must reapply for CHIP~~].

[~~(11) If the enrollee responds to the review request during the review month, the eligibility agency may request verification from the enrollee.~~

~~(a) The eligibility agency shall send a written request for the necessary verification.~~

~~(b) The enrollee has at least ten calendar days to provide the requested verification to the eligibility agency.~~

~~(c) If the enrollee provides all verification by the due date in the review month, the eligibility agency shall determine eligibility and notify the enrollee of its decision.~~

] ([~~i~~]10) If the eligibility agency sends proper notice of an adverse decision during the review month, the agency shall change eligibility for the month that follows.

([~~ii~~]11) If the eligibility agency does not send proper notice of an adverse change for the month that follows, the agency shall extend eligibility to that month. The eligibility agency shall send proper notice of the effective date of an adverse decision. The enrollee does not owe a premium for the due process month.

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

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

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

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

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

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

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

R382-10-1[~~7~~]6. Eligibility Decisions.

(1) The Department adopts and incorporates by reference 78 FR 42312, regarding eligibility screening.

(2) The eligibility agency shall determine eligibility for CHIP within 30 days of the date of application. If the eligibility agency cannot make a decision in 30 days because the applicant fails to take a required action and requests additional time to complete the

application process, or if circumstances beyond the eligibility agency's control delay the eligibility decision, the eligibility agency shall document the reason for the delay in the case record.

([~~2~~]3) If a child made presumptively eligible files an application for medical assistance in accordance with the requirements of Section 1920A of the Social Security Act, presumptive eligibility continues only until the eligibility agency makes an eligibility decision based on that application. Filing additional applications does not extend the presumptive eligibility period.

([~~3~~]4) The eligibility agency may not use the time standard as a waiting period before determining eligibility, or as a reason for denying eligibility when the agency does not determine eligibility within that time.

([~~4~~]5) The eligibility agency shall complete a determination of eligibility or ineligibility for each application unless:

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

(b) the applicant died; or

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

([~~5~~]6) The eligibility agency shall redetermine eligibility [~~at least~~]every 12 months.

([~~6~~]7) At application and review, the eligibility agency shall determine if any child applying for CHIP enrollment is eligible for coverage under Medicaid.

[~~(a) The enrollee must provide any additional verification needed to determine if a child is eligible for Medicaid or the eligibility agency shall deny the application or review.~~

] ([~~b~~]a) A child who is eligible for Medicaid coverage is not eligible for CHIP.

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

[~~(d) If the use of the adjusted gross income (AGI) at a review causes the household to appear eligible for Medicaid, the eligibility agency shall request verification of current income and other factors needed to determine Medicaid eligibility. The eligibility agency cannot renew CHIP coverage if the household fails to provide requested verification.~~

~~(e) If the AGI causes the household to qualify for a more expensive CHIP plan, the household may choose to verify current income. If current income verification shows the family is eligible for a lower cost plan, the eligibility agency shall change the household's eligibility to the lower cost plan effective the month after verification is provided.~~

] ([~~7~~]8) If an enrollee asks for a new income determination during the CHIP certification period and the eligibility agency finds the child is eligible for Medicaid, the agency shall end CHIP coverage and enroll the child in Medicaid.

R382-10-1[8]7. Effective Date of Enrollment and Renewal.

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

(2) The presumptive eligibility period begins on the first day of the month in which a child is determined presumptively eligible for CHIP. Coverage cannot begin in a month that the child is otherwise eligible for medical assistance.

(3) If the eligibility agency receives an application during the first four days of a month, the agency shall allow a grace enrollment period that begins no earlier than four days before the date that the agency receives a completed and signed application. During the grace enrollment period, the individual must receive medical services, meet eligibility criteria, and have an emergency situation that prevents the individual from applying. The Department may not pay for any services that the individual receives before the effective enrollment date.

(4) If a child determined eligible for a presumptive eligibility period files an application in accordance with the requirements of Section 1920A of the Social Security Act and is determined eligible for regular CHIP based on that application, the effective date of CHIP enrollment is the first day of the month of application or the first day of the month in which the presumptive eligibility period began, if later.

(a) The four-day grace period defined in Subsection R382-10-1[~~8~~]7(3) applies if the applicant meets that criteria and the child was not eligible for any medical assistance during such time period.

(b) Any applicable CHIP premiums apply beginning with the month regular CHIP coverage begins, even if such months are the same months as the CHIP presumptive eligibility period.

(5) For a family who has a child enrolled in CHIP and who adds a newborn or adopted child, the effective date of enrollment is the date of birth or placement for adoption if the family requests the coverage within 30 days of the birth or adoption. If the family makes the request more than 30 days after the birth or adoption, enrollment in CHIP will be effective beginning the first day of the month in which the date of report occurs, subject to the limitations in Sections R414-306-6, R382-10-10 and the provisions of Subsection R382-10-1[~~8~~]7(3).

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

R382-10-1[9]8. Enrollment Period.

(1) Subject to the provisions in Subsection R382-10-1[~~9~~]8(2), a child eligible for CHIP enrollment receives 12 months of coverage that begins with the effective month of enrollment. If the eligibility agency allows a grace enrollment period that extends into the month before the application month, the days of the grace enrollment period do not count as a month in the 12-month enrollment period.

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

(a) turns 19 years of age before the end of the 12-month enrollment period;

(b) moves out of the state;

(c) becomes eligible for Medicaid;

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

(e) enters a public institution or an institution for mental diseases; or

(f) does not pay the quarterly premium.

(3) The presumptive eligibility period ends on the earlier of:

(a) the day the eligibility agency makes an eligibility decision for medical assistance based on the child's application when that application is made in accordance with the requirements of Section 1920A of the Social Security Act; or

(b) the last day of the month following the month in which a presumptive eligibility period begins if an application for medical assistance is not filed on behalf of the child by the last day of such month.

(4) [~~The month that a child turns 19 years of age is the last month that the child may be eligible for CHIP, including CHIP presumptive eligibility coverage.~~

~~(5)~~] Certain changes affect an enrollee's eligibility during the 12-month certification period.

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

(b) If income decreases, the enrollee may report the income and request a redetermination. If the change makes the enrollee eligible for Medicaid, the eligibility agency shall end CHIP eligibility and enroll the child in Medicaid.

[~~(c) If the decrease in income causes the child to be eligible for a lower premium, the change in eligibility becomes effective the month after the eligibility agency receives verification of the change.~~

] ([~~d~~]c) If income increases during the certification period, eligibility remains unchanged through the end of the certification period.

(5) The agency shall redetermine eligibility if a family reports a decrease in income and requests a redetermination during the certification period. A decrease in the premium is effective as follows:

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

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

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

(6) Failure to make a timely report of a reportable change may result in an overpayment of benefits.

R382-10-[~~20~~]19. Quarterly Premiums.

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

(a) A family whose countable income is equal to or less than 100% of the federal poverty level or who are American Indian or Alaska Native pays no premium.

(b) A family with countable income greater than 100% and up to 150% of the federal poverty level must pay a quarterly premium of $30.

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

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

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

(3) The agency may reinstate coverage [~~when any of the following events occur:~~

~~(a) The~~]if the family pays the premium and the late fee by the last day of the month immediately following the termination[~~;~~].

[~~(b) The family's countable income decreased to below 100% of the federal poverty level prior to the first month of the quarter.~~

~~(c) The family's countable income decreases prior to the first month of the quarter and the family owes a lower premium amount. The new premium must be paid within 30 days.~~

] ([~~3~~]4) A child is ineligible for CHIP for three months if CHIP is terminated for failure to pay the quarterly premium. The child must reapply at the end of the three months. If eligible, the agency shall approve eligibility without payment of the past due premiums or late fee.[~~A family whose CHIP coverage ends and who reapplies within one year for coverage must pay any outstanding premiums and late fees before the children can be re-enrolled.~~]

([~~4~~]5) The eligibility agency may not charge the household a premium during a due process month associated with the periodic eligibility review.

([~~5~~]6) The eligibility agency shall assess premiums that are payable each quarter for each month of eligibility.

R382-10-2[~~1~~]0. Termination and Notice.

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

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

(3) Notices under Section R382-10-2[~~1~~]0 shall provide the following information:

(a) the action to be taken;

(b) the reason for the action;

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

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

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

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

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

(a) the child is deceased;

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

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

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

R382-10-2[~~2~~]1. Case Closure or Withdrawal.

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

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

KEY: children's health benefits
Date of Enactment or Last Substantive Amendment: [~~October 1,~~] 2013
Notice of Continuation: May 9, 2013
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-40

Health, Disease Control and Prevention, Health Promotion
R384-203
Prescription Drug Database Access

NOTICE OF PROPOSED RULE
(New Rule)
DAR FILE NO.: 38081
FILED: 10/30/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This proposed rule provides procedures for the Utah Department of Health (UDOH) Executive Director to allow access to the controlled substance database to designated individuals conducting scientific studies regarding the use or abuse of controlled substances.

SUMMARY OF THE RULE OR CHANGE: This rule establishes procedure and application process for UDOH Executive Director to designate and assign a person who is not an employee of the Department of Health to conduct scientific studies regarding the use or abuse of controlled substances pursuant to Subsection 58-37f-301(2)(d).

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 58-37f-301(2)(d)

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: Cost will be minimal--Likely limited to small amount of staff time required to access data.
♦ LOCAL GOVERNMENTS: No Cost--Political subdivisions cannot apply.
♦ SMALL BUSINESSES: No Cost--Small business cannot apply.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Only research facilities associated with an accredited university or college in the state can apply for access. Anticipated costs would include the time to complete the application process and obtain Internal Review Board approval.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Research facilities associated with an accredited university or college may apply and will be required to prepare an application detailing explicit information regarding the purpose of the scientific studies and the scientific studies to be conducted if: 1) the study fits within the responsibilities of the UDOH for health and welfare; and 2) the study has been reviewed and approved by an Institutional Review Board (IRB). Assurances must be provided: 1) that the studies are not conducted for profit or commercial gain; and 2) the designee protects the information on behalf of the Department of Health as a business associate or its equivalent. It is anticipated that it would take approximately five - six hours staff time to prepare their application and obtain IRB approval. Unable to determine cost because of not knowing the salary of staff that will be preparing the application.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This should have no impact on business.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HEALTH
DISEASE CONTROL AND PREVENTION,
HEALTH PROMOTION
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:
♦ Heather Borski by phone at 801-538-9998, by FAX at 801-538-9495, or by Internet E-mail at hborski@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 12/23/2013

AUTHORIZED BY: David Patton, PhD, Executive Director

R384. Health, Disease Control and Prevention; Health Promotion.
R384-203. Prescription Drug Database Access.
R384-203-1. Authority and Purpose.

This rule establishes procedures and application processes pursuant to Title 58-37f-301(2)(d) for Utah Department of Health Executive Director to allow access to the Prescription Drug database by a designated and assigned person to conduct scientific

studies regarding the use or abuse of controlled substances, who is not an employee of the Department of Health.

R384-203-2. Definitions.

The following definitions apply to this rule:

(1) "Department" means the Utah Department of Health.

(2) "Director" means the Utah Department of Health Executive Director.

(3) "Prescription Drug Database" means the Utah Controlled Substance Database.

(4) "Research facility" means a research facility associated with a university or college in the state accredited by the Northwest Commission on Colleges and Universities.

(5) "Institutional Review Board" means a board that is approved for human subject research by the United States Department of Health and Human Services.

(6) "Designee" means a person designated and assigned by the Director to have access to the Prescription Drug database in order to conduct scientific studies regarding the use or abuse of controlled substances, who is not an employee of the Department.

(7) "Business associate" means a business associate as defined under the HIPAA privacy, security, and breach notification rules in 45 CFR 164.502(a), 164.504(e), and 164.532(d) and (e).

(8) "De-identified" means information as defined in 45 CFR 164.502(d) and 164.514(a), (b), and (c).

R384-203-3. Criteria for Application to Access Prescription Drug Database.

(1) The study must fit within the responsibilities of the Department for health and welfare.

(2) De-identified prescriber, patient and pharmacy data will meet the research needs.

(3) The research facility designee must provide:

(a) written assurances that the studies are not conducted for and will not be used for profit or commercial gain;

(b) written assurances that the designee shall protect the information as a business associate of the Department of Health; and

(c) documentation of an Institutional Review Board approval.

R384-203-4. Research Application Process.

(1) The research facility designee will prepare and submit for Department approval an application as designated by the Department detailing explicit information regarding the scientific studies to be conducted including the:

(a) purpose of the study;

(b) research protocol for the project;

(c) description of the data needed from the database to conduct that research;

(d) plan that demonstrates all database information will be maintained securely, with access being strictly restricted to the designee and research study staff; and

(e) provisions for electronic data to be stored on a secure database computer system with access being strictly restricted to the designee and research study staff.

(2) Application will be reviewed by the Department's Institutional Review Board and recommendation made to the director for or against approval.

(3) Director will determine approval status of the application.

(4) Designee will sign the Department's data sharing agreement if application is approved by the Director.

R384-203-5. Data Provision and Fees.

(1) Department will obtain, de-identify and provide the data set requested in the application.

(2) Research facility and designee shall pay all relevant expenses for data transfer and manipulation.

R384-203-6. Audit Provisions.

Research facility and designee shall submit, upon request, to a Department audit of the recipients' compliance with the terms of the data sharing agreement.

KEY: prescription drug database, controlled substances, substance abuse database
Date of Enactment or Last Substantive Amendment: 2013
Authorizing, and Implemented or Interpreted Law: 58-37f-301(2)(d)

Health, Disease Control and Prevention, Environmental Services
R392-302
Design, Construction, and Operation of Public Pools

NOTICE OF PROPOSED RULE

(Amendment)
DAR FILE NO.: 38089
FILED: 11/01/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this amendment is to clarify by rule that float tank sanitation requirements are not applicable to this rule, and to make a grammatical correction.

SUMMARY OF THE RULE OR CHANGE: New language is added and a reference to float tanks is deleted to clarify that these types of devices are not regulated under this rule. Also makes a grammatical change, modifying the word "in" to the word "is" in Subsection R392-302-3(3).

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 26-15-2

ANTICIPATED COST OR SAVINGS TO:

♦ THE STATE BUDGET: There are no additional cost or savings to the state budget as rulemaking activities will be covered by existing budgets.

♦ LOCAL GOVERNMENTS: There are no additional costs or savings. There is only one known facility that could meet the

current definition and is now regulated as a hydrotherapy pool.
♦ SMALL BUSINESSES: There will be some savings as facilities who will offer float tanks in the future would not be required to be permitted under state rule.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: There are no known entities who operate float tanks in the state at this time.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no anticipated increased costs or savings for individuals in this category as they now are not required to pay a permit fee currently, and would not be required due to the proposed change.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This will have no effect on business.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HEALTH
DISEASE CONTROL AND PREVENTION,
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 AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 12/23/2013

AUTHORIZED BY: David Patton, PhD, Executive Director

R392. Health, Disease Control and Prevention, Environmental Services.
R392-302. Design, Construction and Operation of Public Pools.
R392-302-1. Authority and Purpose of Rule.

This rule is authorized under Section 26-15-2. It establishes minimum standards for the design, construction, operation and maintenance of public pools.

R392-302-2. Definitions.

The following definitions apply in this rule.

(1) "Bather Load" means the number of persons using a pool at any one time or specified period of time.

(2) "Cleansing shower" means the cleaning of the entire body surfaces with soap and water to remove any matter, including fecal matter, that may wash off into the pool while swimming.

(3) "Department" means the Utah Department of Health.

(4) "Executive Director" means the Executive Director of the Utah Department of Health, or his designated representative.

(5) "Facility" means any premises, building, pool, equipment, system, and appurtenance which appertains to the operation of a public pool.

(6) "Float Tank" means a tank containing a skin-temperature [~~salt water~~]solution of water and Epsom salts at a specific gravity high enough to allow the user to float supine while motionless and require a deliberate effort by the user to turn over and that is designed to provide for solitary use and sensory deprivation of the user[~~body floatation upon or within the water~~].

(7) "Gravity Drain System" means a pool drain system wherein the drains are connected to a surge or collector tank and rather than drawing directly from the drain, the circulation pump draws from the surge or collector tank and the surface of the water contained in the tank is maintained at atmospheric pressure.

(8) "High Bather Load" means 90% or greater of the designed maximum bather load."

(9) "Hydrotherapy Pool" means a pool designed primarily for medically prescribed therapeutic use.

(10) "Illuminance Uniformity" means the ratio between the brightest illuminance falling on a surface compared to the lowest illuminance falling on a surface within an area. The value of illuminance falling on a surface is measured in foot candles.

(11) "Interactive Water Feature" means a recirculating water feature designed, installed or used for recreational use, in which there is direct water contact from the feature with the public, and when not in operation, all water drains freely so there is no ponding.

(12) "Lamp Lumens" means the quantity of light, illuminance, produced by a lamp.

(13) "Lifeguard" means an attendant who supervises the safety of bathers.

(14) "Living Unit" means one or more rooms or spaces that are, or can be, occupied by an individual, group of individuals, or a family, temporarily or permanently for residential or overnight lodging purposes. Living units include motel and hotel rooms, condominium units, travel trailers, recreational vehicles, mobile homes, single family homes, and individual units in a multiple unit housing complex.

(15) "Local Health Officer" means the health officer of the local health department having jurisdiction, or his designated representative.

(16) "Pool" means a man-made basin, chamber, receptacle, tank, or tub which, when filled with water, creates an artificial body of water used for swimming, bathing, diving, recreational and therapeutic uses.

(17) "Pool Deck" means the area contiguous to the outside of the pool curb, diving boards, diving towers and slides.

(18) "Pool Shell" means the rigid encasing structure of a pool that confines the pool water by resisting the hydrostatic pressure of the pool water, resisting the pressure of any exterior soil, and transferring the weight of the pool water (sometimes through other supporting structures) to the soil or the building that surrounds it.

(19) "Private Residential Pool" means a swimming pool, spa pool or wading pool used only by an individual, family, or living unit members and guests, but not serving any type of multiple unit housing complex of four or more living units.

(20) "Public Pool" means a swimming pool, spa pool, wading pool, or special purpose pool facility which is not a private residential pool.

(21) "Saturation Index" means a value determined by application of the formula for calculating the saturation index in Table 5, which is based on interrelation of temperature, calcium hardness, total alkalinity and pH which indicates if the pool water is corrosive, scale forming or neutral.

(22) "Spa Pool" means a pool which uses therapy jet circulation, hot water, cold water, bubbles produced by air induction, or any combination of these, to impart a massaging effect upon a bather. Spa pools include, spas, whirlpools, hot tubs, or hot spas.

(23) "Special Purpose Pool" means a pool with design and operational features that provide patrons recreational, instructional, or therapeutic activities which are different from that associated with a pool used primarily for swimming, diving, or spa bathing.

(24) "Splash Pool" means the area of water located at the terminus of a water slide or vehicle slide.

(25) "Swimming Pool" means a pool used primarily for recreational, sporting, or instructional purposes in bathing, swimming, or diving activities.

(26) "Surge Tank" means a tank receiving the gravity flow from an overflow gutter and main drain or drains from which the circulation pump takes water which is returned to the system.

(27) "Turnover" means the circulation of a quantity of water equal to the pool volume through the filter and treatment facilities.

(28) "Vehicle Slide" means a recreational pool where bathers ride vehicles, toboggans, sleds, etc., down a slide to descend into a splash pool.

(29) "Unblockable Drain" means a drain of any size or shape such that a representation of the torso of a 99 percentile adult male cannot sufficiently block it to the extent that it creates a body suction entrapment hazard.

(30) "Wading Pool" means any pool or pool area used or designed to be used by children five years of age or younger for wading or water play activities.

(31) "Water Slide" means a recreational facility consisting of flumes upon which bathers descend into a splash pool.

R392-302-3. General Requirements.

(1) This rule does not require a construction change in any portion of a public pool facility if the facility was installed and in compliance with law in effect at the time the facility was installed, except as specifically provided otherwise in this rule. However if the Executive Director or the Local Health Officer determines that any facility is dangerous, unsafe, unsanitary, or a nuisance or menace to life, health or property, the Executive Director or the Local Health Officer may order construction changes consistent with the requirements of this rule to existing facilities.

(2) This rule does not regulate any private residential pool. A private residential pool that is used for swimming instruction purposes shall not be regulated as a public pool.

(3) This rule does not regulate any body of water larger than 30,000 square feet, 2,787.1 square meters, and for which the design purpose i[~~n~~]s not swimming, wading, bathing, diving, a water slide splash pool, or children's water play activities.

(4) This rule does not regulate float tanks.

R392-302-16. Circulation Systems.

(1) A circulation system, consisting of pumps, piping, filters, water conditioning and disinfection equipment and other related equipment must be provided. The operator shall maintain the normal water line of the pool at the overflow rim of the gutter, if an overflow gutter is used, or at the midpoint of the skimmer opening if skimmers are used whenever the pool is open for bathing. An exemption to this requirement may be granted by the department if the pool operator can demonstrate that the safety of the bathers is not compromised.

(a) The circulation system shall meet the minimum turnover time listed in Table 1.

(b) If a single pool incorporates more than one the pool types listed in Table 1, either:

(i) the entire pool shall be designed with the shortest turnover time required in Table 1 of all the turnover times for the pool types incorporated into the pool or

(ii) the pool shall be designed with pool-type zones where each zone is provided with the recirculation flow rate that meets the requirements of Table 1.

(c) The Health Officer may require the pool operator to demonstrate that a pool is performing in accordance with the approved design.

(d) The operator shall run circulation equipment continuously except for periods of routine or other necessary maintenance. Pumps with the ability to decrease flow when the pool has little or no use are allowed as long as the same number of turnovers are achieved in 24 hours that would be required using the turnover time listed in Table 1 and the water quality standards of R392-302-27 can be maintained. The circulation system must be designed to permit complete drainage of the system.

(e) Piping must be of non-toxic material, resistant to corrosion and be able to withstand operating pressures.

(f) Plumbing must be identified by a color code or labels.

(2) The water velocity in discharge piping may not exceed 10 feet, 3.05 meters, per second, except for copper pipe where the velocity for piping may not exceed 8 feet, 2.44 meters, per second.

(3) Suction velocity for all piping may not exceed 6 feet, 1.83 meters, per second.

(4) The circulation system must include a strainer to prevent hair, lint, etc., from reaching the pump.

(a) Strainers must be corrosion-resistant with openings not more than 1/8 inch, 3.18 millimeters, in size.

(b) Strainers must provide a free flow capacity of at least four times the area of the pump suction line.

(c) Strainers must be readily accessible for frequent cleaning.

(d) Strainers must be maintained in a clean and sanitary condition.

(e) Each pump strainer must be provided with necessary valves to facilitate cleaning of the system without excessive flooding.

(5) A vacuum-cleaning system must be provided.

(a) If this system is an integral part of the circulation system, connections must be located in the walls of the pool, at least

8 inches, 20.32 centimeters, below the water line. This requirement does not apply to vacuums operated from skimmers.

(b) The number of connections provided must facilitate access to all areas of the pool through hoses less than 50 feet, 15.24 meters, in length.

(6) A rate-of-flow indicator, reading in gallons per minute, must be properly installed and located according to manufacturer recommendations. The indicator must be located in a place and position where it can be easily read.

(7) Pumps must be of adequate capacity to provide the required number of turnovers of pool water as specified in Subsection R392-302-16, Table 1. The pump or pumps must be capable of providing flow adequate for the backwashing of filters. Under normal conditions, the pump or pumps must supply the circulation rate of flow at a dynamic head which includes, in addition to the usual equipment, fitting and friction losses, an additional loss of 15 feet, 4.57 meters, for rapid sand filters, vacuum precoat media filters or vacuum cartridge filters and 40 feet, 12.19 meters, for pressure precoat media filters, high rate sand filters or cartridge filters, as well as pool inlet orifice loss of 15 feet, 4.57 meters.

(8) A pool equipped with heaters must meet the requirements for boilers and pressure vessels as required by the State of Utah Boiler and Pressure Vessel Rules, R576-201, and must have a fixed thermometer mounted in the pool circulation line downstream from the heater outlet. The heater must be provided with a heatsink as required by manufacturer's instructions.

(9) The area housing the circulation equipment must be designed with adequate working space so that all equipment may be easily disassembled, removed, and replaced for proper maintenance.

(10) All circulation lines to and from the pool must be regulated with valves in order to control the circulation flow.

(a) All valves must be located where they will be readily and easily accessible for maintenance and removal.

(b) Multiport valves must comply with National Sanitation Foundation NSF/ANSI 50-2007, which is incorporated and adopted by reference.

(11) Written operational instructions must be immediately available at the facility at all times.

TABLE 1
Circulation

Pool Type	Min. Number of Wall Inlets	Min. Number of Skimmers per 3,500 square ft. or less	Min. Turnover Time
1. Swim	1 per 10 ft., 3.05 m.	1 per 500 sq. ft., 46.45 sq. m.	8 hrs.
2. Swim, high bather load	1 per 10 ft., 3.05 m.	1 per 500 sq. ft., 46.45 sq. m.	6 hrs.
3. Wading pool	1 per 20 ft., 6.10 m. min. of 2 equally spaced	1 per 500 sq. ft. 46.45 sq. m.	1 hr.
4. Spa	1 per 20 ft., 6.10 m.	1 per 100 sq. ft., 9.29 sq. m.	0.5 hr.
5. Wave	1 per 10 ft., 3.05 m.	1 per 500 sq. ft., 46.45 sq. m.	6 hrs.
6. Slide	1 per 10 ft., 3.05 m.	1 per 500 sq. ft., 46.45 sq. m.	1 hr.
7. Vehicle slide	1 per 10 ft., 3.05 m.	1 per 500 sq. ft., 46.45 sq. m.[	1 hr.
~~8. Float tank~~	~~1~~	~~1~~	~~15 min. with 2 turnovers between patrons~~]
[~~9~~]8. Special Purpose Pool	1 per 10 ft., 3.05 m.	1 per 500 sq. ft., 46.45 sq. m.	1 hr.

(12) Each air induction system installed must comply with the following requirements:

(a) An air induction system must be designed and maintained to prevent any possibility of water back-up that could cause electrical shock hazards.

(b) An air intake may not introduce contaminants such as noxious chemicals, fumes, deck water, dirt, etc. into the pool.

(13) The circulation lines of jet systems and other forms of water agitation must be independent and separate from the circulation-filtration and heating systems.

R392-302-31. Special Purpose Pools.

(1) Special purpose pools must meet all applicable requirements of all Sections of R392-302 in addition to those of this Section as they apply to special design features and uses of special purpose pools.

(a) Special purpose pool projects require consultation with the local health department having jurisdiction in order that consideration can be given to areas where potential problems may exist and before deviations from some of the requirements are approved.

(b) The local health officer shall require such measures as deemed necessary to assure the health and safety of special purpose pool patrons.

(2) Spa Pools.

(a) This subsection supercedes R392-302-6(5). A spa pool shell may be a color other than white or light pastel.

(b) Spa pools shall meet the bather load requirement of R392-302-7(1)(a).

(c) A spa pool may not exceed a maximum water depth of 4 feet, 1.22 meters. The department may grant exceptions to the maximum depth requirement for a spa pool designed for special purposes, such as instruction, treatment, or therapy.

(d) This subsection supercedes R392-302-12(1)(f). A spa pool may be equipped with a single entry/exit. A spa pool must be equipped with at least one handrail for each 50 feet, 15.24 meters, of perimeter, or portion thereof, to designate the point of entry and

exit. Points of entry and exit must be evenly spaced around the perimeter of the spa pool and afford unobstructed entry and egress.

(e) This subsection supercedes R392-302-12(3)(c). In a spa pool where the bottom step serves as a bench or seat, the bottom riser may be a maximum of 14 inches, 35.56 centimeters.

(f) This subsection supercedes R392-302-13(1). A spa pool must have a continuous, unobstructed deck at least 3 feet, 91.44 centimeters, wide around 25 percent or more of the spa.

(g) This subsection supercedes R392-302-13(5). The department may allow spa decks or steps made of sealed, clear-heart redwood.

(h) A pool deck may be included as part of the spa deck if the pools are separated by a minimum of 5 feet, 1.52 meters. The department may grant an exception to deck and pool separation requirements if a spa pool and another pool are constructed adjacent to each other and share a common pool sidewall which separates the two pools. The common pool side wall may not exceed 12 inches, 30.48 centimeters, in width.

(i) This subsection supersedes R392-302-15. The local health officer may exempt a spa pool from depth marking requirements if the spa pool owner can successfully demonstrate to the local health officer that bather safety is not compromised by the elimination of the markings.

(j) A spa pool must have a minimum of one turnover every 30 minutes.

(k) Spa pool air induction systems shall meet the requirements of R392-302-16(12)(a) through (b). Jet or water agitation systems shall meet the requirements of R392-302-16(13).

(l) Spa pool filtration system inlets shall be wall-type inlets and the number of inlets shall be based on a minimum of one for each 20 feet, 6.10 meters, or fraction thereof, of pool perimeter.

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

(i) Multiple spa outlets shall be spaced at least three feet apart from each other as measured from the centers of the drain covers or grates or a third drain shall be provided and the separation distance between individual outlets shall be at the maximum possible spacing.

(ii) 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.

(n) 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.

(o) A spa pool must be equipped with an oxidation reduction potential controller which monitors chemical demands, including pH and disinfectant demands, and regulates the amount of chemicals fed into the pool circulation system. A spa pool constructed and approved prior to September 16, 1996 is exempt from this requirement if it is able to meet bacteriological quality as required in Subsection R392-302-27(5)(e).

(p) A spa pool is exempt from the Section R392-302-22, except for Section R392-302-22(3).

(q) The maximum water temperature for a spa pool is 104 degrees Fahrenheit, 40 degrees Celsius.

(r) A spa pool shall meet the total alkalinity requirements of R392-302-27(3)(d).

(s) A spa pool must have an easily readable caution sign mounted adjacent to the entrance to the spa or hot tub which contains the following information:

(i) The word "caution" centered at the top of the sign in large, bold letters at least two inches in height.

(ii) Elderly persons and those suffering from heart disease, diabetes or high blood pressure should consult a physician before using the spa pool.

(iii) Persons suffering from a communicable disease transmissible via water may not use the spa pool. Persons using prescription medications should consult a physician before using the spa.

(iv) Individuals under the influence of alcohol or other impairing chemical substances should not use the spa pool.

(v) Bathers should not use the spa pool alone.

(vi) Pregnant women should not use the spa pool without consulting their physicians.

(vii) Persons should not spend more than 15 minutes in the spa in any one session.

(viii) Children under the age of 14 must be accompanied and supervised by at least one responsible adult over the age of 18 years, when lifeguards are not on duty.

(ix) Children under the age of five years are prohibited from bathing in a spa or hot tub.

(x) Running or engaging in unsafe activities or horseplay in or around the spa pool is prohibited.

(t) Water jets and air induction ports on spa pools must be controlled by an automatic timer which limits the duration of their use to 15 minutes per each cycle of operation. The operator shall mount the timer switch in a location which requires the bather to exit the spa before the timer can be reset for another 15 minute cycle or part thereof.

(3) Wading Pools.

(a) Wading pools shall be separated from other pools. Wading pools may not share common circulation, filtration, or chemical treatment systems, or walls.

(b) A wading pool may not exceed a maximum water depth of 2 feet, 60.96 centimeters.

(c) The deck of a wading pool may be included as part of adjacent pool decks.

(d) A wading pool must have a minimum of one turnover per hour and have a separate circulation system.

(e) A wading pool that utilizes wall inlets shall have a minimum of two equally spaced inlets around its perimeter at a minimum of one in each 20 feet, 6.10 meters, or fraction thereof.

(f) 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.

(4) Hydrotherapy Pools.

(a) A hydrotherapy pool shall at all times comply with R392-302-27 Disinfection and Quality of Water, R392-302-28 Cleaning of Pools and R392-302-29 Supervision of Pools unless it is drained cleaned, and sanitized after each individual use.

(b) A hydrotherapy pool is exempt from all other requirements of R392-302, only if use of the hydrotherapy pool is restricted to therapeutic uses and is under the continuous and direct supervision of licensed medical or physiotherapy personnel.

(c) Local health departments may enter and examine the use of hydrotherapy pools to respond to complaints, to assure that use of the pool is being properly supervised, to examine records of testing and sampling, and to take samples to assure that water quality and cleanliness are maintained.

(d) A local health officer may grant an exception to section R392-302-31(4)(a) if the operator of the hydrotherapy pool can demonstrate that the exception will not compromise pool sanitation or the health or safety of users.[

~~(5) Float Tanks.~~

~~(a) Float tank circulation systems, consisting of pumps, piping, filters, and disinfection equipment must be provided which will clarify and disinfect the tank's volume of water in 15 minutes or less.~~

~~(b) The total volume of water within a float tank must be turned over at least twice between uses by patrons.~~]

([~~6~~]5) Water Slides.

(a) Slide Flumes.

(i) The flumes within enclosed slides must be designed to prevent accumulation of hazardous concentrations of toxic chemical fumes.

(ii) All curves, turns, and tunnels within the path of a slide flume must be designed so that body contact with the flume or tunnel does not present an injury hazard. The slide flume must be banked to keep the slider's body safely inside the flume.

(iii) The flume must be free of hazards including joints and mechanical attachments separations, splinters, holes, cracks, or abrasive characteristics.

(iv) Wall thickness of flumes must be thick enough so that the continuous and combined action of hydrostatic, dynamic, and static loads and normal environmental deterioration will not cause structural failures which could result in injury. The facility operator or owner shall insure that repairs or patchwork maintains original designed levels of safety and structural integrity. The facility operator or owner shall insure that repairs or patchwork is performed in accordance with manufacturer's guidelines.

(v) Multiple-flume slides must have parallel exits or be constructed, so that the projected path of their centerlines do not intersect within a distance of less than 8 feet, 2.44 meters, beyond the point of forward momentum of the heaviest bather permitted by the engineered design.

(vi) A slide flume exit must provide safe entry into the splash pool. Design features for safe entry include a water backup, and a deceleration distance adequate to reduce the slider's exit velocity to a safe speed. Other methods may be acceptable if safe exiting from the slide flume is demonstrated to the department.

(b) Flume Clearance Distances.

(i) A distance of at least 4 feet, 1.22 meters, must be provided between the side of a slide flume exit and a splash pool side wall.

(ii) The distance between nearest sides of adjacent slide flume exits must be at least 6 feet, 1.83 meters.

(iii) A distance between a slide flume exit and the opposite end of the splash pool, excluding steps, must be at least 20 feet, 6.10 meters.

(iv) The distance between the side of the vehicle flume exit and the pool side wall must be at least 6 feet, 1.83 meters.

(v) The distance between nearest sides of adjacent vehicle slide flume exits must be at least 8 feet, 2.44 meters.

(vi) The distance between a vehicle slide flume exit and the opposite end of the splash pool, excluding steps, must be long enough to provide clear, unobstructed travel for at least 8 feet, 2.44 meters, beyond the point of forward momentum of the heaviest bather permitted by the engineered design.

(c) Splash Pool Dimensions.

(i) The depth of a water slide splash pool at the end of a horizontally oriented slide flume exit must be at least 3 feet, 9.14 centimeters, but may be required to be deeper if the pool design incorporates special features that may increase risks to bathers as determined by the department.

(ii) The depth must be maintained in front of the flume for a distance of at least 20 feet, 6.10 meters, from which point the splash pool floor may have a constant slope upward. Slopes may not be designed or constructed steeper than a 1 to 10 ratio.

(iii) The operating water depth of a vehicle slide splash pool, at the flume exit, must be a minimum of 3 feet 6 inches, 1.07 meters. This depth must be maintained to the point at which forward travel of the vehicle ends. From the point at which forward travel ends, the floor may have a constant upward slope to the pool exit at a ratio not to exceed 1 to 10.

(iv) The department may waive minimum depth and distance requirements for a splash pool and approve a special exit system if the designer can demonstrate to the department that safe exit from the flume into the splash pool can be assured.

(v) A travel path with a minimum width of 4 feet, 1.22 meters, must be provided between the splash pool deck and the top of the flume.

(d) General Water Slide Requirements.

(i) Stairways serving a slide may not retain standing water. Stairways must have non-slip surfaces and shall conform to the requirements of applicable building codes.

(ii) Vehicles, including toboggans, sleds, inflatable tubes, and mats must be designed and manufactured of materials which will safeguard the safety of riders.

(iii) Water slides shall meet the bather load requirements of R392-302-7(1)(d).

(e) Water Slide Circulation Systems.

(i) Splash pool overflow reservoirs must have sufficient volume to contain at least two minutes of flow from the splash pool overflow. Splash pool overflow reservoirs must have enough water to insure that the splash pool will maintain a constant water depth.

(ii) The circulation and filtration equipment of a special purpose pool must be sized to turn over the entire system's water at least once every hour.

(iii) Splash pool overflow reservoirs must circulate water through the water treatment system and return when flume supply service pumps are turned off.

(iv) Flume pumps and motors must be sized, as specified by the flume manufacturer, and must meet all National Sanitation Foundation, NSF/ANSI 50-2007, Section 6. Centrifugal Pumps, standards for pool pumps.

(v) Flume supply service pumps must have check valves on all suction lines.

(vi) The splash pool and the splash pool overflow reservoir must be designed to prohibit bather entrapment as water flows from the splash pool to the overflow reservoir.

(vii) Perimeter overflow gutter systems must meet the requirements of Section R392-302-19, except that gutters are not

required directly under slide flumes or along the weirs which separate splash pools and splash pool overflow reservoirs.

(viii) Pump reservoir areas must be accessible for cleaning and maintenance.

(f) Caution Signs.

(i) A caution sign must be mounted adjacent to the entrance to a water slide that states at least the following warnings:

(A) The word caution centered at the top of the sign in large bold letters at least two inches in height.

(B) No running, standing, kneeling, tumbling, or stopping on flumes or in tunnels.

(C) No head first sliding at any time.

(D) The use of a slide while under the influence of alcohol or impairing drugs is prohibited.

(E) Only one person at a time may travel the slide.

(F) Obey instructions of lifeguards and other staff at all times.

(G) Keep all parts of the body within the flume.

(H) Leave the splash pool promptly after exiting from the slide.

([~~7~~]6) Interactive Water Feature Requirements.

(a) All parts of the interactive water feature shall be designed, constructed, maintained, and operated so there are no slip, fall, or other safety hazards, and shall meet the standards of the construction code adopted by the Utah Legislature under Section 58-56-4. A copy of the construction code is available at the office of the local building inspector.

(b) Interactive water feature nozzles that spray from the ground level shall be flush with the ground, with openings no greater than one-half inch in diameter. Spray devices that extend above ground level shall be clearly visible.

(c) Areas adjacent to the water feature collection zones shall be sloped away at a minimum of two percent from the interactive water feature to deck drains or other approved surface water disposal systems. A continuous deck at least 3 feet, 0.91 meters, wide as measured from the edge of the collection zones must extend completely around the interactive water feature.

(d) Water discharged from all interactive water feature fountain or spray features shall freely drain by gravity flow through a main drain fitting to a below grade sump or collection system which discharges to a collector tank.

(e) All interactive water feature foggers and misters that produce finely atomized mists shall be supplied directly from a potable water source and not from the underground reservoir.

(f) The interactive water feature shall have an automated oxidation reduction potential (ORP) and pH controller installed and in operation whenever the feature is open for use. The controller shall be capable of maintaining disinfection and pH levels within the requirements for special purpose pools listed in Table 6. In addition, an approved secondary disinfection system the meets the requirements of in R392-302-33 (4)(c) through (4)(f)(iii) shall be installed and in operation whenever the feature is open for use.

(g) A sign shall be posted in the immediate vicinity of interactive water feature stating that pets are prohibited.

(h) If the interactive water feature is operated at night, five foot-candles of light shall be provided in the all areas of the water feature. Lighting shall be installed in accordance with manufacturer's specifications and approved for such use by UL or NSF.

(i) Hydraulics.

(i) The interactive water feature filter system shall be capable of filtering and treating the entire water volume of the water feature within 30 minutes.

(ii) The interactive water feature filter system shall draft from the collector tank and return filtered and treated water to the tank via a minimum of 4 equally spaced inlet fittings. Inlet spacing shall also meet the requirements of section R392-302-17.

(iii) The interactive water feature circulation system shall be on a separate loop and not directly interconnected with the interactive water feature pump.

(iv) The suction intake of the interactive water feature pump in the underground reservoir shall be located adjacent to the circulation return line and shall be located to maximize uniform circulation of the tank.

(v) An automated water level controller shall be provided for the interactive water feature, and the drinking water line that supplies the feature shall be protected from any back flow by an air gap.

(vi) The water velocity through the feature nozzles of the interactive water features shall meet manufacturer's specifications and shall not exceed 20 feet per second.

(vii) The minimum size of the interactive water feature sump or collector tank shall be equal to the volume of 3 minutes of the combined flow of all feature pumps and the filter pump. Access lids or doors shall be provided to the sump and collector tank. The lids or doors shall be sized to allow easy maintenance and shall provide security from unauthorized access. Stairs or a ladder shall be provided as needed to ensure safe entry into the tank for cleaning and inspection.

(viii) The suction intake from the interactive water feature circulation pump shall be located in the lowest portion of the underground reservoir.

(ix) A means of vacuuming and completely draining the interactive water feature tank shall be provided.

(j) An interactive water feature is exempt from:

(i) The wall requirement of section R392-302-10;

(ii) The ladder, recessed step, stair, and handrail requirements of section R392-302-12;

(iii) The fencing and access barrier requirements of section R392-302-14;

(iv) The outlet requirements of section R392-302-18;

(v) The overflow gutter and skimming device requirements of section R392-302-19;

(vi) The safety and lifesaving requirements of section R392-302-22, except that an interactive water feature shall be equipped with a first aid kit as required by subsection R392-302-22(3);

(vii) The dressing room requirements of section R392-302-24 as long toilets, lavatories and changing tables are available within 150 feet; and

(viii) The pool water clarity and temperature requirements of subsection R392-302-27(4).

KEY: pools, spas, water slides
Date of Enactment or Last Substantive Amendment: [~~February 28,~~]2013
Notice of Continuation: January 20, 2012
Authorizing, and Implemented or Interpreted Law: 26-15-2

Health, Health Care Financing, Coverage and Reimbursement Policy
R414-303
Coverage Groups

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38099
FILED: 11/01/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this change is to comply with provisions of the Patient Protection and Affordable Care Act (PPACA) that relate to Modified Adjusted Gross Income (MAGI) and non-MAGI coverage groups, and to include coverage for former foster care youth.

SUMMARY OF THE RULE OR CHANGE: This amendment defines the categorical requirements for MAGI-based and non-MAGI-based coverage groups. It also includes coverage for former foster care youth and defines the requirements for hospitals that choose to determine presumptive eligibility. It further updates incorporations by reference and makes other technical changes.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Pub. L. No. 111-148 and Section 26-1-5 and Section 26-18-3

MATERIALS INCORPORATED BY REFERENCES:

- ♦ Updates Portions of Comp. Soc. Sec. Laws, Section 1902, published by Social Security Administration, 01/01/2013
- ♦ Updates Portions of 20 CFR 416, published by Government Printing Office, April 1, 2012 ed.
- ♦ Updates Portions of 42 CFR 435, published by Government Printing Office, October 1, 2012 ed.
- ♦ Adds 78 FR 42303, published by Government Printing Office, July 15, 2013
- ♦ Updates Portions of Comp. Soc. Sec. Laws, Section 1634, published by Social Security Administration, 01/01/2013
- ♦ Updates Portions of 45 CFR 400, published by Government Printing Office, October 1, 2012 ed.
- ♦ Adds Comp. Soc. Sec. Laws, Section 1925, published by Social Security Administration, 01/01/2013
- ♦ Updates Portions of Comp. Soc. Sec. Laws, Section 1931, published by Social Security Administration, 01/01/2013

ANTICIPATED COST OR SAVINGS TO:

♦ THE STATE BUDGET: The impact to the state budget is addressed in the companion rule filing for Rule R414-304. (DAR NOTE: The proposed amendment to Rule R414-304 is under DAR No. 38100 in this issue, November 15, 2013, of the Bulletin.)

♦ LOCAL GOVERNMENTS: There is no impact to local governments because they neither fund Medicaid services nor make eligibility determinations for the Medicaid program.

♦ SMALL BUSINESSES: This amendment does not impose any new costs or requirements because it does not affect services for Medicaid recipients and small businesses do not make eligibility determinations for the Medicaid program. In addition, this amendment does not affect business revenue because the conversion process to MAGI-based methodology does not systematically increase or decrease Medicaid eligibility.

♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Some Medicaid recipients may realize savings roughly equivalent to the anticipated state costs because more individuals will become eligible for Medicaid services. Nevertheless, this amendment does not affect provider revenue because the conversion process to MAGI-based methodology does not systematically increase or decrease Medicaid eligibility.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs because this amendment can only result in out-of-pocket savings to a single Medicaid recipient. Furthermore, this amendment does not affect provider revenue because the conversion process to MAGI-based methodology does not systematically increase or decrease Medicaid eligibility.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The changes may modify individual eligibility but will have no 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 AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 01/01/2014

AUTHORIZED BY: David Patton, PhD, Executive Director

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

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

R414-303-2. Definitions.

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

(a) "Caretaker relative;"

(b) "Family size;"

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

(d) "Pregnant woman."

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

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

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

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

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

(1) The Department provides Medicaid coverage to individuals as described in 42 CFR 435.120, 435.122, 435.130 through 435.135, 435.137, 435.138, 435.139, 435.211, 435.232, 435.236, 435.301, 435.320, 435.322, 435.324, 435.340, and 435.350, [~~2011~~]October 1, 2012 ed., which are adopted and incorporated by reference. The Department provides coverage to individuals as required by 1634(b), (c) and (d), 1902(a)(10)(A)(i)(II), 1902(a)(10)(A)(ii)(X), and 1902(a)(10)(E)(i) through (iv) of Title XIX of the Social Security Act in effect [~~November 19, 2012~~]January 1, 2013, which are adopted and incorporated by reference. The Department provides coverage to individuals described in Section 1902(a)(10)(A)(ii)(XIII) of Title XIX of the Social Security Act in effect [~~April 2, 2012~~]January 1, 2013, which is adopted and incorporated by reference. Coverage under Section 1902(a)(10)(A)(ii)(XIII) is known as the Medicaid Work Incentive Program.

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

(3) An individual can request a disability determination from the State Medicaid Disability Office. The Department adopts and incorporates by reference the disability determination requirements described in 42 CFR 435.541, [~~2011~~]October 1, 2012 ed., and Social Security's disability requirements for the Supplemental Security Income program as described in 20 CFR 416.901 through 416.998, [~~2011~~]April 1, 2012 ed., [~~which are incorporated by reference,~~]to decide if an individual is disabled. The Department notifies the eligibility agency of its disability decision, [~~who~~]which then sends a disability decision notice to the client.

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

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

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

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

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

(4) If an individual who is denied disability status by the State Medicaid Disability [~~Review~~]Office requests a fair hearing, the individual may request a reconsideration[~~Disability Review Office may reconsider its determination~~] as part of the fair hearing process. The individual must request the hearing within the time limit defined in Section R414-301-[~~6~~]7.

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

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

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

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

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

(ii) If disability status is denied pursuant to the reconsideration, the fair hearing process will proceed unless the individual chooses to abandon the fair hearing.[~~ The eligibility agency notifies the individual of the reconsideration decision. Thereafter, the individual may choose to pursue or abandon the fair hearing.~~]

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

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

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

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

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

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

(7) For children described in Section 1902(a)(10)(A)(i)(II) of the Social Security Act in effect [~~April 4, 2012~~]January 1, 2013, the eligibility agency shall conduct periodic redeterminations to assure that the child continues to meet the SSI eligibility criteria as required by such section.

(8) Coverage for qualifying individuals described in Section 1902(a)(10)(E)(iv) of Title XIX of the Social Security Act in effect [~~November 19, 2012~~]January 1, 2013, is limited to the amount of funds allocated under Section 1933 of Title XIX of the Social Security Act in effect [~~November 19, 2012~~]January 1, 2013, for a given year, or as subsequently authorized by Congress under the American Taxpayer Relief Act, Pub. L. No. 112 240, signed into law on January 2, 2013. The eligibility agency shall deny coverage to applicants when the uncommitted allocated funds are insufficient to provide such coverage.

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

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

R414-303-4. Medicaid for Parents and Caretaker Relatives, Pregnant Women and Children Using MAGI Methodology.

(1) The Department provides Medicaid coverage to individuals who are eligible as described in 42 CFR 435.110, 435.116, 435.118, and 435.139, October 1, 2012 ed., which are adopted and incorporated by reference.

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

(3) The Department provides Medicaid coverage to parents and other caretaker relatives, whose countable income determined using the MAGI methodology does not exceed the applicable income standard for the individual's family size. The income standards are as follows:

TABLE

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

(4) For a family that exceeds 16 persons, add $62 to the income standard for each additional family member.

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

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

(7) The Department provides Medicaid coverage to pregnant women as required in 42 CFR 435.116. The Department elects the income limit of 139% of the FPL to determine a pregnant woman's eligibility for Medicaid.

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

R414-303-[4]5. Medicaid for [~~Low-Income Families and Children for~~]Parents and Caretaker Relatives, Pregnant Women, and Children Under Non-MAGI-Based Community and Institutional Coverage Groups.

(1) The Department provides Medicaid coverage to individuals who are eligible as described in 42 CFR 435.117, 435.139, 435.170[~~435.110, 435.113 through 435.117, 435.119, 435.210 for groups defined under 201(a)(5) and (6), 435.211, 435.217, 435.223,~~] and 435.30[~~0~~]1 through 435.310, October 1, 201[~~1~~]2 ed. and Title XIX of the Social Security Act Sections 1902(e)(1), (4), (5), (6), (7)[~~, and 1931(a), (b), and (g)~~] in effect [~~April 4, 2012~~]January 1, 2013, which are adopted and incorporated by reference.

[~~(2) For unemployed two-parent households, the eligibility agency does not require the primary wage earner to have an employment history.~~

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

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

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

[~~(3) A specified relative, as that term is used in the provisions incorporated into this section, other than the child's parents, may apply for assistance for a child. In addition to other requirements for Low-Income Family and Child Medicaid (LIFC), all the following applies to an application by a specified relative:~~

~~(a) The child must be currently deprived of support because both parents are absent from the home where the child lives.~~

~~(b) The child must be currently living with, not just visiting, the specified relative.~~

] ([~~e~~]3) The income and resources of the [~~specified~~]non-parent caretaker relative are not counted to determine medically needy eligibility for the dependent child.[~~unless the specified relative is also included in the Medicaid coverage group.~~]

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

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

[~~(d) If the specified relative is currently included in an LIFC household, the child must be included in the LIFC eligibility determination for the specified relative.~~

~~(e) The specified relative may choose to be excluded from the Medicaid coverage group. If the specified relative chooses to be excluded from the Medicaid coverage group, the ineligible children of the specified relative must be excluded and the specified relative is not included in the income standard calculation.~~

~~(f) The specified relative may choose to exclude any child from the Medicaid coverage group. If a child is excluded from coverage, that child's income and resources are not used to determine eligibility or spenddown.~~

] ([~~g~~]6) [~~If the specified relative is not the parent of a dependent child who meets deprivation of support criteria and elects to be included in the Medicaid coverage group, the following income provisions apply:~~]The eligibility agency shall determine the countable income of the non-parent caretaker relative and spouse in accordance with Section R414-304-6 and Section R414-304-8.

[~~(i) The monthly gross earned income of the specified relative and spouse is counted.~~

~~(ii) $90 will be deducted from the monthly gross earned income for each employed person.~~

~~(iii) The $30 and 1/3 disregard is allowed from earned income for each employed person, as described in R414-304-6(4).~~

~~(iv) Child care expenses and the cost of providing care for an incapacitated spouse necessary for employment are deducted for only the specified relative's children, spouse, or both. The maximum allowable deduction will be $200.00 per child under age two, and $175.00 per child age two and older or incapacitated spouse each month for full-time employment. For part-time employment, the maximum deduction is $160.00 per child under age two, and $140.00 per child age two and older or incapacitated spouse each month.~~

~~(v) Unearned income of the specified relative and the excluded spouse that is not excluded income is counted.~~

] ([~~vi~~]a) [~~Total e~~]Countable earned and unearned income of the non-parent caretaker relative and spouse is divided by the number of family members living in the [~~specified relative's~~]household.

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

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

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

([~~4~~]7) An American Indian child in a boarding school and a child in a school for the deaf and blind are considered temporarily absent from the household.

[~~(5) Temporary absence from the home for purposes of schooling, vacation, medical treatment, military service, or other temporary purpose shall not constitute non-resident status. The following situations do not meet the definition of absence for purposes of determining deprivation of support:~~

~~(a) parental absences caused solely by reason of employment, schooling, military service, or training;~~

~~(b) an absent parent who will return home to live within 30 days from the date of application;~~

~~(c) an absent parent is the primary child care provider for the children, and the child care is frequent enough that the children are not deprived of parental support, care, or guidance.~~

~~(6) Joint custody situations are evaluated based on the actual circumstances that exist for a dependent child. The same policy is applied in joint custody cases as is applied in other absent parent cases.~~

~~(7) The eligibility agency imposes no suitable home requirement.~~

~~(8) Medicaid assistance is not continued for a temporary period if deprivation of support no longer exists. If deprivation of support ends due to increased hours of employment of the primary wage earner, the household may qualify for Transitional Medicaid described in R414-303-5.~~

~~(9) Full-time employment nullifies a person's claim to incapacity. To claim an incapacity, a parent must meet one of the following criteria:~~

~~(a) receive SSI;~~

~~(b) be recognized as 100% disabled by the Veteran's Administration, or be determined disabled by the Medicaid Disability Review Office or the Social Security Administration;~~

~~(c) provide, either on a Department-approved form or in another written document, completed by one of the following licensed medical professionals: medical doctor; doctor of Osteopathy; Advanced Practice Registered Nurse; Physician's Assistant; or a mental health therapist, which includes a psychologist, Licensed Clinical Social Worker, Certified Social Worker, Marriage and Family Therapist, Professional Counselor, or MD, DO or APRN engaged in the practice of mental health therapy, that states the incapacity is expected to last at least 30 days. The medical report must also state that the incapacity will substantially reduce the parent's ability to work or care for the child.~~

]

R414-303-[5]6. 12-Month Transitional[~~Family~~] Medicaid.

(1) The Department [~~provides~~]adopts and incorporates by reference [~~transitional Medicaid coverage in accordance with the provisions of~~]Title XIX of the Social Security Act Section 1925 in

effect January 1, 2013, to provide 12 months of extended medical assistance[~~for households that~~] when the parent or caretaker relative is eligible and enrolled in Medicaid as defined in 42 CFR 435.110, and loses eligibility as described in Section 1931(c)(2) of the Social Security Act.[~~for 1931 Family Medicaid as described in Section 1931(c)(2)~~].

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

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

R414-303-[6]7. Four-Month Transitional[~~Family~~] Medicaid.

(1) The Department adopts and incorporates by reference 42 CFR 435.112 and 435.115(f), (g) and (h), [~~2011~~]October 1, 2012 ed., and Title XIX of the Social Security Act, Section 1931(c)(1) and Section 1931(c)(2) in effect [~~November 19, 2012~~]January 1, 2013, [~~which are incorporated by reference.~~]to provide four months of extended medical assistance to a household when the parent or caretaker relative is eligible and enrolled in Medicaid as defined in 42 CFR 435.110, and loses eligibility for the reasons defined in 42 CFR 435.112 and 435.115.

(a) A pregnant woman who is eligible and enrolled in Medicaid as defined in 42 CFR 435.116, and who meets the income limit defined in 42 CFR 435.110 for three of the prior six months, is eligible to receive Four-Month Transitional Medicaid for the reasons defined in 42 CFR 435.112 and 435.115.

(b) Children who live with the parent are eligible to receive Four-Month Transitional Medicaid.

(2) Changes in household composition do not affect eligibility for the four-month extension period.[~~New household members may be added to the case only if they meet the AFDC or AFDC two-parent criteria for being included in the household if they were applying in the current month.~~] Newborn babies are considered household members even if they [~~were~~]are not [~~un~~]born the month the household became ineligible for [~~Family~~]Medicaid[~~ under Section 1931 of the Social Security Act~~]. New members added to the case will lose eligibility when the household loses eligibility. Assistance shall be terminated for household members who leave the household.

R414-303-[7]8. Foster Care, Former Foster Care Youth and Independent Foster Care Adolescents.

(1) The Department adopts and incorporates by reference 42 CFR 435.115(e)(2), [~~2001~~]October 1, 2012 ed., and Section 1902(a)(10)(A)(i)(IX) of the Social Security Act, effective January 1, 2013. [~~which is incorporated by reference.~~]

(2) Eligibility for foster children who meet the definition of a dependent child under the State Plan for Aid to Families with Dependent Children in effect on July 16, 1996, is not governed by this rule. The Department of Human Services determines eligibility for foster care Medicaid.

(3) The Department covers individuals who age out of foster care. This coverage is called the Former Foster Care Youth. These individuals must be enrolled in Medicaid at the time they age out of foster care.

(a) Coverage is available through the month in which the individual turns 26 years of age.

(b) There is no income or asset test for eligibility under this group.

([~~3~~]4) The Department elects to cover[~~s~~] individuals who age out of foster care, are not eligible under the Former Foster Care Youth coverage group, and who are 18 years old but not yet 21 years old as described in 1902(a)(10)(A)(ii)(XVII) of the Social Security Act. This coverage is the Independent Foster Care Adolescents program. The Department determines eligibility according to the following requirements.

(a) At the time the individual turns 18 years of age, the individual must be in the custody of the Division of Child and Family Services, or the Department of Human Services if the Division of Child and Family Services [~~was~~]is the primary case manager, or a federally recognized Indian tribe, but not in the custody of the Division of Youth Corrections.

(b) Income and assets of the child are not counted to determine eligibility under the Independent Foster Care Adolescents program.

[~~(c) Medicaid eligibility under this coverage group is not available for any month before July 1, 2006.~~

] ([~~d~~]c) When funds are available, an eligible independent foster care adolescent [~~can~~]may receive Medicaid under this coverage group until he or she reaches 21 years of age, and through the end of that month.

R414-303-[8]9. Subsidized Adoptions.

(1) The Department adopts and incorporates by reference 42 CFR 435.115(e)(1), [~~2001~~]October 1, 2012 ed.[~~, which is incorporated by reference.~~]

(2) Eligibility for subsidized adoptions is not governed by this rule. The Department of Human Services determines eligibility for subsidized adoption Medicaid.

[R414-303-9. Child Medicaid.

~~(1) The Department adopts 42 CFR 435.222 and 435.301 through 435.308, 2001 ed., which are incorporated by reference.~~

~~(2) The Department elects to cover all individuals under age 18 who would be eligible for AFDC but do not qualify as dependent children. Individuals who are 18 years old may be covered if they would be eligible for AFDC except for not living with a specified relative or not being deprived of support.~~

~~(3) If a child receiving SSI elects to receive Child Medicaid or receives benefits under the Home and Community Based Services Waiver, the child's SSI income shall be counted with other household income.~~

]**R414-303-10. Refugee Medicaid.**

(1) The Department adopts and incorporates by reference[~~provides medical assistance to refugees in accordance with the provisions of~~] 45 CFR 400.90 through 400.107 and 45 CFR, Part 401, October 1, 2012 ed., relating to refugee medical assistance.

(2) [~~Specified relative rules do not apply.~~

~~(3)~~]Child support enforcement rules do not apply.

([~~4~~]3) The sponsor's income and resources are not counted. In-kind service or shelter provided by the sponsor is not counted.

([~~5~~]4) [~~Initial settlement~~]Cash assistance payments [~~made to~~]received by a refugee from a resettlement agency are not counted.

([~~6~~]5) Refugees may qualify for medical assistance for eight months after entry into the United States.

[~~(7) The Department provides medical assistance to Iraqi and Afghan Special Immigrants in the same manner as medical assistance provided to other refugees.~~

]

R414-303-11. [~~Poverty-Level~~]Presumptive Pregnant Woman and [~~Poverty-level~~]Child Medicaid.

(1) The Department adopts and incorporates by reference 42 CFR 435.1102, October 1, 2012 ed., and also adopts and incorporates by reference 78 FR 42303, in relation to presumptive eligibility for pregnant women and children under 19 years of age.[~~incorporates by reference Title XIX of the Social Security Act, Sections 1902(a)(10)(A)(i)(IV), (VI), (VII), 1902(a)(47) for pregnant women and children under age 19, 1902(e)(4) and (5) and 1902(l), in effect January 1, 2011 which are incorporated by reference.~~]

(2) The following definitions apply to this section:

(a) "covered provider" means a provider that the Department has determined is qualified to make a determination of presumptive eligibility for a pregnant woman and that meets the criteria defined in Section 1920(b)(2) of the Social Security Act;

(b) "presumptive eligibility" means a period of eligibility for medical services [~~for a pregnant woman, or a child under age 19, ~~] based on self-declaration that the [~~pregnant woman, or the child under age 19, ~~]individual meets the eligibility criteria.

(3) The Department provides coverage to a pregnant woman during a period of presumptive eligibility if a covered provider[~~ has verified that she is pregnant and~~] determines, based on preliminary information, that the woman states she:

(a) is pregnant;

(b) meets citizenship or alien status criteria as defined in Section R414-302-[~~1~~]3;

([~~b~~]c) has [~~a declared ~~]household income that does not exceed 13[~~3~~]9% of the federal poverty guideline applicable to her declared household size; and

([~~e~~]d) [~~the woman ~~]is not already covered by Medicaid or CHIP.

(4) [~~No resource test applies to determine presumptive eligibility of a pregnant woman.~~

~~(5) ~~]A pregnant woman may only receive medical assistance during [~~only ~~]one presumptive eligibility period for any single term of pregnancy.

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

(6) The Department provides medical assistance[~~ in accordance with Section 1920A of the Social Security Act~~] to children under the age of 19 during a period of presumptive eligibility if a Medicaid eligibility worker with the Department of Human Services has determined, based on preliminary information, that:

(a) the child meets citizenship or alien status criteria as defined in Section R414-302-[~~1~~]3;

(b) for a child under age 6, the declared household income does not exceed 13[~~3~~]9% of the federal poverty guideline applicable to the declared household size;

(c) for a child [~~age 6~~]six through 18 years of age, the declared household income does not exceed 1[~~00~~]33% of the federal poverty guideline applicable to the declared household size; and

(d) the child is not already covered [~~on~~]under Medicaid or CHIP.

(7) [~~No resource test applies to determine presumptive eligibility of a child.~~

~~(8) ~~]A child may receive medical assistance during only one period of presumptive eligibility in any six-month period.

[~~(9) The Department elects to impose a resource standard on poverty-level child Medicaid coverage for children age six to the month in which they turn age 19. The resource standard is the same as other Family Medicaid Categories.~~

~~(10) The Department elects to provide Medicaid coverage to pregnant women whose countable income is equal to or below 133% of poverty.~~

~~(11) At the initial determination of eligibility for Poverty-level Pregnant Woman Medicaid, the eligibility agency determines the applicant's countable resources using SSI resource methodologies. Applicants for Poverty-level Pregnant Woman Medicaid whose countable resources exceed $5,000 must pay four percent of countable resources to the agency to receive Poverty-level Pregnant Woman Medicaid. The maximum payment amount is $3,367. The payment must be met with cash. The applicant cannot use any medical bills to meet this payment.~~

~~(a) In subsequent months, through the 60 day postpartum period, the Department disregards all excess resources.~~

~~(b) This resource payment applies only to pregnant women covered under Sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Social Security Act in effect January 1, 2011.~~

~~(c) No resource payment will be required when the Department makes a determination based on information received from a medical professional that social, medical, or other reasons place the pregnant woman in a high risk category. To obtain this waiver of the resource payment, the woman must provide this information to the eligibility agency before the woman pays the resource payment so the agency can determine if she is in a high risk category.~~

~~(12) A child born to a woman who is only presumptively eligible at the time of the infant's birth is not eligible for the one year of continued coverage defined in Section 1902(e)(4) of the Social Security Act. The mother can apply for Medicaid after the birth and if determined eligible back to the date of the infant's birth, the infant is then eligible for the one year of continued coverage under Section 1902(e)(4) of the Social Security Act. If the mother is not eligible, the Department determines if the infant is eligible under other Medicaid programs.~~

~~(13) The Department provides Medicaid coverage to an infant until the infant turns one-year old when born to a woman eligible for Utah Medicaid on the date of the delivery of the infant, in compliance with Sec. 113(b)(1), Children's Health Insurance Program Reauthorization Act, Pub. L. No. 111-3. The infant does not have to remain in the birth mother's home and the birth mother does not have to continue to be eligible for Medicaid. The infant must continue to be a Utah resident to receive coverage.~~

] ([~~14~~]8) [~~Children who meet the criteria under the Social Security Act, Section 1902(l)(1)(D) may qualify for the poverty-level child program through the month in which they turn 19.~~]A child determined presumptively eligible may receive presumptive eligibility only through the applicable period or until the end of the month in which the child turns 19, whichever occurs first.[~~The eligibility agency deems the parent's income and resources to the 18-year-old to determine eligibility when the 18-year-old lives in the parent's home. An 18-year-old who does not live with a parent may apply on his own, in which case the agency does not deem income or resources from the parent.~~]

(9) The Department adopts and incorporates by reference 78 FR 42303, which relates to a hospital electing to be a qualified entity to make presumptive eligibility decisions.

(a) The Department shall limit the coverage groups for which a hospital may make a presumptive eligibility decision to the groups defined in Section 1920 (pregnant women, former foster care children, parents or caretaker relatives), Section 1920A (children under 19 years of age) and 1920 B (breast and cervical cancer patients but only Centers for Disease Control provider hospitals can do presumptive eligibility for this group) of the Social Security Act, January 1, 2013.

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

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

[~~R414-303-12. Pregnant Women Medicaid.~~

~~(1) The Department adopts 42 CFR 435.116 (a), 435.301 (a) and (b)(1)(i) and (iv), 2001 ed. and Title XIX of the Social Security Act, Section 1902(a)(10)(A)(i)(III) in effect January 1, 2001, which are incorporated by reference.~~

]**R414-303-1[~~3~~]2. Medicaid Cancer Program.**

(1) The Department shall provide coverage to individuals described in Section 1902(a)(10)(A)(ii)(XVIII) of the Social Security Act in effect [~~April 4, 2012~~]January 1, 2013, which the Department adopts and incorporates[~~is incorporated~~] by reference. This coverage shall be referred to as the Medicaid Cancer Program.

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

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

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

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

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

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

KEY: [~~income~~]MAGI-based, coverage groups, former foster care youth, [~~independent foster care adolescent~~]presumptive eligibility
Date of Enactment or Last Substantive Amendment: [~~April 17, 2013~~]2014
Notice of Continuation: January 23, 2013
Authorizing, and Implemented or Interpreted Law: 26-18-3; 26-1-5

Health, Health Care Financing, Coverage and Reimbursement Policy
R414-304
Income and Budgeting

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38100
FILED: 11/01/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this change is to comply with provisions of the Patient Protection and Affordable Care Act (PPACA) that relate to determining income, income budgeting, and using Modified Adjusted Gross Income (MAGI)-based methodology.

SUMMARY OF THE RULE OR CHANGE: This amendment defines provisions for determining countable income, specifies methodologies used to determine best estimates of income, and specifies MAGI-based methodology and non-MAGI-based coverage groups. It also updates incorporations by reference and makes other technical changes.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Pub. L. No. 111-148 and Section 26-1-5 and Section 26-18-3

MATERIALS INCORPORATED BY REFERENCES:

♦ Updates Subsections 404(h)(4), 1612(b)(24), 1612(b)(25), 1902(a)(10)(E), 1902(l), 1902(m), 1903(f), and 1905(p) of the Compilation of the Social Security Laws, published by Social Security Administration, 01/01/2013

♦ Updates Portions of 20 CFR 416, published by Government Printing Office, 04/01/2012

♦ Updates Portions of 42 CFR 435, published by Government Printing Office, 10/01/2012

♦ Updates Subsections 1902(r)(1) and 1924(d) of the Compilation of the Social Security Laws, published by Social Security Administration, 01/01/2013

♦ Updates Portions of 45 CFR 233, published by Government Printing Office, 10/01/2012

♦ Updates Portions of 45 CFR 206, published by Government Printing Office, 10/01/2012

ANTICIPATED COST OR SAVINGS TO:

♦ THE STATE BUDGET: The Department estimates an annual cost to the General Fund of about $1,988,400 and about $4,675,300 in federal funds through PPACA implementation.

♦ LOCAL GOVERNMENTS: There is no impact to local governments because they neither fund Medicaid services nor make eligibility determinations for the Medicaid program.

♦ SMALL BUSINESSES: This amendment does not impose any new costs or requirements because it does not affect services for Medicaid recipients and small businesses do not make eligibility determinations for the Medicaid program. In addition, this amendment does not affect business revenue because the conversion process to MAGI-based methodology does not systematically increase or decrease Medicaid eligibility.

♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Some Medicaid recipients may realize savings roughly equivalent to the anticipated state costs because more individuals will become eligible for Medicaid services. Nevertheless, this amendment does not affect provider revenue because the conversion process to MAGI-based methodology does not systematically increase or decrease Medicaid eligibility.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs because this amendment can only result in out-of-pocket savings to a single Medicaid recipient. Furthermore, this amendment does not affect provider revenue because the conversion process to MAGI-based methodology does not systematically increase or decrease Medicaid eligibility.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The changes may modify individual eligibility but will have no 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 AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 01/01/2014

AUTHORIZED BY: David Patton, PhD, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-304. Income and Budgeting.
R414-304-2. Definitions.

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

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

(b) "Allocation for a spouse" means an amount of income that is the difference between the Social Security Income (SSI) federal benefit rate for a couple minus the federal benefit rate for an individual.

[~~(c) "Arrearages" means payments that the Department did not collect for past months or years.~~

] ([~~d~~]c) "Basic maintenance standard" or "BMS" means the income level for eligibility for [~~Family~~]Medicaid coverage [~~under Section 1931 of the Social Security Act, and for coverage~~]of the medically needy based on the number of family members who are counted in the household size.

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

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

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

[~~(h) "Department" means the Utah Department of Health.~~

~~(i) "Dependent" means earning less than $2,000 a year, not being claimed as a dependent by any other individual, and receiving more than half of one's annual support from the client or the client's spouse.~~

~~(j) "Eligibility agency" means the Department of Workforce Services that determines eligibility for Medicaid under contract with the Department.~~

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

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

([~~m~~]i) "Family Medicaid" means medical assistance for families caring for dependent children[~~. It may be~~] and is a general term used to refer to [~~family~~]Medicaid coverage for [~~the~~]medically needy [~~or family Medicaid for Low-Income Family and Child Medicaid~~]parents, caretaker relatives, pregnant women, and children.

([~~n~~]j) "Family member" means a son, daughter, parent, or sibling of the client or the client's spouse, the spouse of the client, and the parents of a dependent child[~~ who lives with the spouse~~].

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

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

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

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

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

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

[~~(u) "Low-Income Family and Child Medicaid" is Medicaid coverage required by Subsection 1931(a), (b), and (g) of the Compilation of Social Security Laws. It may be referred to as Low-Income Family and Child Medicaid or LIFC Medicaid.~~

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

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

([~~x~~]s) "Presumed maximum value" means the allowed maximum amount an individual is charged for the receipt of food and shelter. This amount will not exceed [~~1/3~~]one-third of the SSI federal benefit rate plus $20.

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

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

(1) The Department adopts and incorporates by reference 42 CFR 435.811 and 435.831, [~~2010 ed.,~~]October 1, 2012 ed., and 20 CFR 416.1102, 416.1103, 416.1120 through 416.1124, 416.1140 through 416.1148, 416.1150, 416.1151, 416.1157, 416.1163 through 416.1166, and Appendix to Subpart K of 416, April 1, 2012[~~2010~~] ed. The Department also adopts and incorporates by reference Subsections 404(h)(4) and 1612(b)(24) and (25) of the Compilation of the Social Security Laws in effect January 1, 2013[~~2011~~], to determine income and income deductions for Medicaid eligibility. The Department may not count as income any payments from sources that federal laws specifically prohibit from being counted as income to determine eligibility for federally-funded medical assistance programs.

(2) The following definitions apply to this section:

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

(4) The eligibility agency may only count as income the portion of a VA check to which the client is legally entitled. If the payment includes an amount for a dependent family member as determined by the VA, that amount counts as income for the dependent. If the dependent does not live with the veteran or surviving spouse, the portion for the dependent counts as the dependent's income unless the dependent applies to VA to receive the payment directly, VA denies that request, and the dependent does not receive the payment. In that case, the eligibility agency shall also count the amount for a dependent as income of the veteran or surviving spouse who receives the payment.

(5) The eligibility agency may not count as income Social Security Administration (SSA) reimbursements [~~as income~~]of Medicare premiums.

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

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

(8) The eligibility agency shall count as income of the child, child support payments [~~that~~]received from a parent or guardian [~~owes~~]for past months or years.

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

([~~9~~]10) For aged, blind and disabled Institutional Medicaid, court-ordered child support payments collected by the Office of Recovery Services (ORS) for a child who resides out-of-home in a Medicaid 24-hour care facility are not counted as income to the child. If ORS allows the parent to retain up to the amount of the personal needs allowance for the child's personal needs, that amount is counted

as income for the child. All other current child support payments received by the child or guardian that are not subject to collection by ORS count as unearned income to the child.

(11[0]) The eligibility agency shall count as unearned income the interest earned from a sales contract on either or both the lump sum and installment payments when the interest is received or made available to the client.

(12[1]) If the client, or the client and spouse do not live with an in-kind support donor, in-kind support and maintenance is the lesser of the value or the presumed maximum value of food or shelter received. If the client, or the client and spouse live with an in-kind support donor and do not pay a prorated share of household operating expenses, in-kind support and maintenance is the difference between the prorated share of household operating expenses and the amount the client, or the client and spouse actually pay, or the presumed maximum value, whichever is less.

(13[2]) Payments under a contract that provide for payments at set intervals or after completion of the contract period are not lump sum payments. The payments are subject to regular income counting rules. Retroactive payments from SSI and SSA reimbursements of Medicare premiums are not lump sum payments.

(14[3]) The eligibility agency may not count as income educational loans, grants, and scholarships received from Title IV programs of the Higher Education Act or from Bureau of Indian Affairs educational programs, and may not count any other grants, scholarships, fellowships, or gifts that a client uses to pay for education. The eligibility agency shall count as income, in the month that the client receives them, any amount of grants, scholarships, fellowships, or gifts that the client uses to pay for non-educational expenses. Allowable educational expenses include:

(a) tuition;

(b) fees;

(c) books;

(d) equipment;

(e) special clothing needed for classes;

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

(g) child care necessary for school attendance.

(15[4]) Except for an individual eligible for the Medicaid Work Incentive (MWI) program, the following provisions apply to non-institutional medical assistance:

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

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

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

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

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

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

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

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

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

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

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

(II) If the non-covered spouse does not have income to deem to the covered spouse, the eligibility agency may only compare the covered spouse's income, after allowable deductions, to a one-person BMS to calculate the spenddown.

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

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

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

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

them as a couple, they must meet the spenddown to receive coverage for both of them.

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

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

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

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

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

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

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

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

(16[5]) For Institutional Medicaid[~~that includes home and community-based waiver programs~~], the eligibility agency may only count the client in the household size. Only the client's [~~and~~]income and deemed income from an alien client's sponsor is counted to determine the cost of care contribution. The provisions in Rule R414-307 govern who to include in the household size and whose income is counted to determine eligibility for home and community-based waiver services and the cost-of-care contribution.

(17[6]) The eligibility agency shall deem any unearned and earned income from an alien's sponsor and the sponsor's spouse when the sponsor signs an Affidavit of Support pursuant to Section 213A of the Immigration and Nationality Act after December 18, 1997.

([~~17~~]a) The eligibility agency shall end sponsor deeming when the alien becomes a naturalized United States (U.S.) citizen, or has worked 40 qualifying quarters as defined under Title II of the Social Security Act, or can be credited with 40 qualifying work quarters. After December 31, 1996, a creditable qualifying work quarter is one during which the alien did not receive any federal means-tested public benefit.

([~~18~~]b) The eligibility agency may not apply sponsor deeming to applicants who are eligible for Medicaid for emergency services only.

(18[9]) If retirement income has been divided between divorced spouses by the divorce decree pursuant to a Qualified Domestic Relations Order, the eligibility agency may only count as income the amount that is paid to the individual.

[~~(20) The eligibility agency may not count as unearned income the additional $25 a week payment to a recipient of unemployment insurance provided under Section 2002 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115. The recipient may only receive this weekly payment from March 2009 through June 2010.~~

~~(21) The eligibility agency may not count as unearned income the one-time economic recovery payments that an individual receives under Social Security, Supplemental Security Income, Railroad Retirement, or Veteran's benefits under the provisions of Section 2201 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115. It further may not count refunds that a government retiree receives pursuant to the provisions of Section 2202 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115.~~

~~(22) The eligibility agency may not count as unearned income the Consolidated Omnibus Budget Reconciliation Act (COBRA) premium subsidy provided under Section 3001 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115.~~

] ([~~23~~]19) The eligibility agency may not count as income any payments that an individual receives pursuant to the Individual Indian Money Account Litigation Settlement under the Claims [~~Resolution~~]Resettlement Act of 2010, Pub. L. No. 111 291, 124 Stat. 3064.

(20[4]) The eligibility agency may not count as income any federal tax refund and refundable credit that an individual receives in accordance with the requirements of Sec. 6409, Pub. L. 112 240[~~between January 1, 2010, and December 31, 2012, pursuant to the Tax Relief Unemployment Insurance Reauthorization and Job Creation Act of 2010, Pub. L. No. 111-312, 124, Stat 3296~~].

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

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

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

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

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

(1) The Department adopts and incorporates by reference 20 CFR 416.1102, 416.1103, 416.1120 through 416.1124, 416.1140 through 416.1148, 416.1150, 416.1151, 416.1157, and Appendix to

Subpart K of 416, [~~2010~~]October 1, 2012 ed. The Department also adopts and incorporates by reference Subsections 404(h)(4) and 1612(b)(24) and (25) of the Compilation of the Social Security Laws, effective January 1, 2013. The [~~Department~~]eligibility agency may not count as income any payments from sources that federal laws specifically prohibit from being counted as income to determine eligibility for federally-funded medical assistance programs.

(2) The eligibility agency shall allow the provisions found in Subsection R414-304-3(3) through (14[~~3~~]), and (17[~~6~~]) through (21[~~4~~]).

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

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

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

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

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

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

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

(1) The Department adopts and incorporates by reference 42 CFR 435.603, October 1, 2012 ed., which applies to the methodology of determining household composition and income using the Modified Adjusted Gross Income (MAGI)-based methodology.

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

(b) The eligibility agency shall count children who are under 19 years of age and are full-time students in the household size of individuals whose household size is determined under the non-tax filer rules found in 42 CFR 435.603(f)(3).

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

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

(4) The eligibility agency shall count as income, cash support received from a tax filer who claims the individual as a tax dependent when that dependent is not the spouse or child of the tax filer, but only the amount that exceeds a minimal amount set by the Department.

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

R414-304-[5]6. [~~Family Non-Institutional Medicaid and Institutional Family Medicaid~~]Unearned Income Provisions for Medically Needy Family, Child and Pregnant Woman Non-Institutional and Institutional Medicaid.

(1) The Department adopts and incorporates by reference 42 CFR 435.811 and 435.831,[~~-2010~~]October 1, 2012 ed., [~~and~~]45 CFR 233.20(a)(1), 233.20(a)(3)(iv), 233.20(a)(3)(vi)(A),[~~-and~~] 233.20(a)(4)(ii), October 1, 2012[~~2010~~] ed., and[~~—The Department also incorporates by reference~~] Subsection 404(h)(4) of the Compilation of the Social Security Laws, in effect January 1, 2013[~~2011~~]. The [~~Department~~]eligibility agency may not count as income any payments from sources that federal laws specifically prohibit from being counted as income to determine eligibility for federally-funded medical assistance programs.

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

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

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

(5) The eligibility agency may not count income that is received too irregularly or infrequently to count as regular income, such as cash gifts, up to $30 a calendar quarter per household member. Any amount that exceeds $30 a calendar quarter per household member counts as income when received. Irregular or infrequent income may be divided equally among all members of the household.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(19) The eligibility agency may only count as income the portion of a VA check to which the client is legally entitled. If the payment includes an amount for a dependent family member as determined by the VA, that amount counts as income for the dependent. If the dependent does not live with the veteran or surviving spouse, the portion for the dependent counts as the dependent's income unless the dependent applies to VA to receive the payment directly, VA denies that request, and the dependent does not receive the payment. In that case, the eligibility agency shall also count the amount for a dependent as income of the veteran or surviving spouse who receives the payment.

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

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

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

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

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

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

([~~26~~]a) The eligibility agency shall stop deeming income from a sponsor when the alien becomes a naturalized U.S. citizen, or has worked 40 qualifying quarters as defined under Title II of the Social Security Act or can be credited with 40 qualifying work quarters. After December 31, 1996, a creditable qualifying work quarter is one during which the alien did not receive any federal means-tested public benefit.

([~~27~~]b) The eligibility agency may not apply sponsor deeming to applicants who are eligible for emergency services only.

[~~(28) The eligibility agency may not count as unearned income the additional $25 a week payment to a recipient of unemployment insurance provided under Section 2002 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115. The recipient may receive this weekly payment from March 2009 through June 2010.~~

~~(29) The eligibility agency may not count as unearned income the one-time economic recovery payments that an individual receives under Social Security, Supplemental Security Income, Railroad Retirement, or Veteran's benefits under the provisions of Section 2201 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115. It further may not count refunds that a government retiree receives pursuant to the provisions of Section 2202 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115.~~

~~(30) The eligibility agency may not count as unearned income the COBRA premium subsidy provided under Section 3001 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115.~~

] ([~~31~~]26) The eligibility agency may not count as income any payments that an individual receives pursuant to the Individual Indian Money Account Litigation Settlement under the Claims [~~Resolution~~]Resettlement Act of 2010, Pub. L. No. 111 291, 124 Stat. 3064.

([~~32~~]27) The eligibility agency may not count as income any federal tax refund and refundable credit that an individual receives in accordance with the requirements of Sec. 6409 of the American Taxpayer Relief Act of 2012, Pub. L. No. 112 240, 126, Stat. 2313. [~~between January 1, 2010, and December 31, 2012, pursuant to the Tax Relief Unemployment Insurance Reauthorization and Job Creation Act of 2010, Pub. L. No. 111 312, 124, Stat 3296~~.]

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

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

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

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

R414-304-[6]7. Aged, Blind and Disabled Non-Institutional and Institutional Medicaid Earned Income Provisions.

(1) The Department adopts and incorporates by reference 42 CFR 435.811 and 435.831, October 1, 2012[~~2010~~] ed., and 20 CFR 416.1110 through 416.1112, April 1, 2012[~~2010~~] ed. The Department may not count as income any payments from sources that federal laws specifically prohibit from being counted as income to determine eligibility for federally-funded medical assistance programs.

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

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

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

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

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

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

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

(a) transportation to and from work;

(b) payments on the principal for business resources;

(c) net losses from previous tax years;

(d) taxes;

(e) money set aside for retirement; and

(f) work-related personal expenses.

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

(10) The eligibility agency shall disregard earned income paid by the U.S. Census Bureau to temporary census takers to prepare for and conduct the census, for individuals defined in 42 CFR 435.120, 435.122, 435.130 through 435.135, 435.137, 435.138, 435.139, 435.211, [~~435.301,~~]435.320, 435.322, 435.324, 435.340, 435.350 and 435.541. The eligibility agency shall also exclude this income for individuals described in Subsections 1634(b), (c) and (d), 1902(a)(10)(A)(i)(II), 1902(a)(10)(A)(ii)(X),[~~1902(a)(10)(A)(ii)(XII),~~] 1902(a)(10)(A)(ii)(XIII) [~~1902(a)(10)(A)(ii)(XVIII),~~]and 1902(a)(10)(E)(i) through (iv)[~~(I)~~] of Title XIX of the Social Security Act. The eligibility agency may not exclude earnings paid to temporary census takers from the post-eligibility process of determining the person's cost of care contribution for long-term care recipients.

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

[~~(12) The eligibility agency may not count as earned income any credit or refund that an individual receives under the provisions of Section 1001 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115, referred to as the Making Work Pay credit.~~

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R414-304-[7]8. [~~Family Non-Institutional Medicaid and Family Institutional Medicaid~~]Earned Income Provisions for Medically Needy Family, Child and Pregnant Woman Non-Institutional and Institutional Medicaid.

(1) The Department adopts and incorporates by reference 42 CFR 435.811,[~~and~~] 435.831, [~~2010 ed.~~]October 1, 2012 ed., and 45

CFR 233.20(a)(6)(iii) through (iv), 233.20(a)(6)(v)(B), 233.20(a)(6)(vi) through (vii), and 233.20(a)(11), October 1, 2012[~~2010~~] ed. The eligibility agency may not count as income any payments from sources that federal laws specifically prohibit from being counted as income to determine eligibility for federally-funded medical assistance programs.

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

(a) in school or training full-time;

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

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

(3) For medically needy Family Medicaid, the eligibility agency shall allow the AFDC $30 and [~~1/3~~]one-third of earned income deduction if the wage earner receives [~~1931 Family~~]Parent/Caretaker Relative Medicaid in one of the four previous months and this disregard is not exhausted.

(4) The eligibility agency shall determine countable net income from self-employment by allowing a 40 % flat rate exclusion off the gross self-employment income as a deduction for business expenses. If a self-employed individual provides verification of actual business expenses greater than the 40 % flat rate exclusion amount, the eligibility agency shall allow actual expenses to be deducted. The expenses must be business expenses allowed under federal income tax rules.

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

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

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

(8) The eligibility agency shall exclude earned income paid by the U.S. Census Bureau to temporary census takers to prepare for and conduct the census, for individuals defined in 42 CFR [~~435.110, 435.112 through 435.117, 435.119, 435.210 for groups defined under 201(a)(5) and (6), 435.211, 435.222, 435.223, and~~]435.30[~~0~~]1(b)1, [~~through~~]435.308, 435.310 and individuals defined in Title XIX of the Social Security Act Section[~~s 1902(a)(10)(A)(i)(III), (IV), (VI), (VII), 1902(a)(10)(A)(ii)(XVII), 1902(a)(47),~~] 1902(e)(1), [~~(4), (5), (6),~~](7), and [~~1931(b) and (c),~~]Section 1925[~~and 1902(l)~~]. The eligibility agency may not exclude earnings paid to temporary census takers from the post-eligibility process of determining the person's cost of care contribution for long-term care recipients.

[~~(9) Under 1931 Family Medicaid, for households that pass the 185% gross income test, if net income does not exceed the applicable BMS, the household is eligible for 1931 Family Medicaid. The eligibility agency may not deduct health insurance premiums or medical bills from gross income to determine net income for 1931 Family Medicaid.~~

~~(10) For Family Medicaid recipients who otherwise meet 1931 Family Medicaid criteria, who lose eligibility because of earned income that does not exceed 185% of the federal poverty guideline, the eligibility agency shall disregard earned income of the named relative for six months to determine eligibility for 1931 Family Medicaid. Before the end of the sixth month, the eligibility agency shall conduct a review of the household's earned income. If the earned income exceeds 185% of the federal poverty guideline, the household is eligible to receive Transitional Medicaid under the provisions of Rule R414-303 as long as it meets all other criteria.~~

~~(11) After the first six months of disregarding earned income, if the average monthly earned income of the household does not exceed 185% of the federal poverty guideline for a household of the same size, the eligibility agency shall continue to disregard earned income for an additional six months to determine eligibility for 1931 Family Medicaid. In the 12th month of receiving the income disregard, if the household continues to have earned income, the household is eligible to receive Transitional Medicaid under the provisions of Rule R414-303 as long as it meets all other criteria.~~

~~(12) The eligibility agency may not count as earned income any credit or refund that an individual receives under the provisions of Section 1001 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115, referred to as the Making Work Pay credit.~~

]

R414-304-[8]9. Aged, Blind and Disabled Non-Institutional Medicaid and Medically Needy Family, Pregnant Woman and Child Non-Institutional Medicaid Income Deductions.

(1) The Department adopts and incorporates by reference[~~shall apply~~] the financial methodologies required by 42 CFR 435.601, and the deductions defined in 42 CFR 435.831, October 1, 2012[~~2010~~] ed.[~~, which are incorporated by reference.~~]

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

(3) To determine eligibility for and the amount of a spenddown under medically needy programs, the eligibility agency shall deduct from income health insurance premiums the client or a financially responsible family member pays providing coverage for the client or any family members living with the client in the month of payment. The eligibility agency shall also deduct from income the amount of a health insurance premium the month it is due when the Department pays the premium on behalf of the client as authorized by Section 1905(a) of Title XIX of the Compilation of the Social Security Laws, except no deduction is allowed for Medicare premiums that the Department pays for [~~or reimburses to~~]recipients.

(a) The eligibility agency shall deduct the entire payment in the month it is due and may not prorate the amount.

(b) The eligibility agency may not deduct health insurance premiums to determine eligibility for the poverty-related medical assistance programs or [~~Family Medicaid coverage under Section 1931 of the Compilation of the Social Security Laws~~]coverage groups subject to the use of MAGI-based methodologies.

(4) To determine the spenddown under medically needy programs, the eligibility agency shall deduct from income health insurance premiums that the client or a financially responsible family member pays in the application month or during the three-month retroactive period. The eligibility agency shall allow the deduction either in the month paid or in any month after the month paid to the extent the full amount was not deducted in the month paid, but only through the month of application.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(14) The eligibility agency may only deduct the amount of prepaid medical expenses that equals the cost of services in a given month. The eligibility agency may not deduct from income any payments that a client makes for medical services in a month before the client receives the services.

(15) For non-institutional Medicaid programs, the eligibility agency may only deduct medically necessary expenses. The Department determines whether services for institutional care are medically necessary.

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

(17) Medical costs that a client incurs in a benefit month may not be used to meet spenddown when the client is enrolled in a Medicaid health plan. Bills for mental health services that a client incurs in a benefit month may not be used to meet spenddown if Medicaid contracts with a single mental health provider to provide mental health services to all recipients in the client's county of residence. Bills for mental health services that a client receives in a retroactive or application month that a client pays may be used to meet spenddown only if the Medicaid-contracted mental health provider does not provide the services.

R414-304-[9]10. Medicaid Work Incentive Program Income Deductions.

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

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

(b) Impairment-related work expenses;

(c) $65 plus [~~1/2~~]one-half of the remaining earned income;

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

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

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

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

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

R414-304-1[0]1. Aged, Blind and Disabled Institutional Medicaid and Family Institutional Medicaid Income Deductions.

(1) The Department [~~applies~~]adopts and incorporates by reference the financial methodologies required by 42 CFR 435.601 and the deductions defined in 42 CFR 435.725, 435.726, and 435.832, [~~2010~~]October 1, 2012 ed.[~~, which are incorporated by reference.~~] The Department [~~applies~~]also adopts and incorporates by reference Subsections 1902(r)(1) and 1924(d) of the Compilation of the Social Security Laws, in effect January 1, 2013[~~1, which are incorporated by reference~~].

(2) Health insurance premiums:

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

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

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

(a) the client receives the medical service;

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

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

(4) To determine the cost of care contribution for long-term care services, the eligibility agency may not deduct medical or remedial care expenses that the Department is prohibited from paying when the client incurs the expenses for the transfer of assets for less than fair market value. The eligibility agency may not deduct medical or remedial care expenses that the Department is prohibited from paying under [~~Section 6014 of the Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4,~~]Section 1917(f) of the Social Security Act in effect January 1, 2013, when the equity value of the individual's home exceeds the limit set by law. The eligibility agency may not deduct the expenses during or after the month that the client receives the services even when the expenses remain unpaid.

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

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

(7) The eligibility agency may only deduct the amount of prepaid medical expenses that equals the cost of services in a given month. The eligibility agency may not deduct from income any payments that a client makes for medical services in a month before the client receives the services.

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

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

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

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

(d) that the eligibility agency told the client that the Medicaid provider may not use the provider's funds to pay the client's

spenddown and that the provider may not loan the client money for the client to pay the spenddown.

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

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

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

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

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

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

(11) The eligibility agency shall require institutionalized clients to pay all countable income remaining after allowable income deductions to the institution in which they reside as their cost of care contribution.

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

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

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

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

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

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

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

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

(14) When a doctor verifies that a single person or a person whose spouse resides in a medical institution is expected to return home within six months of entering a medical institution or nursing home, the eligibility agency shall deduct a personal needs allowance equal to the [~~current Medicaid Income Limit (~~]BMS[~~)~~] for one person defined in Subsection R414-304-13[~~2~~](6), for up to six months to maintain the individual's community residence.

[~~(15) Except for an individual who is eligible for the Personal Assistance Waiver, an individual who receives assistance under the terms of a home and community-based services waiver is eligible to receive a deduction for a non-institutionalized, non-waiver-eligible spouse and dependent family member. The Department applies the provisions of Section 1924(d) of the Compilation of Social Security Laws, or the provisions of 42 U.S.C. 435.726 or 435.832 to determine the deduction for a spouse and family members.~~

] (15[~~6~~]) A client is not eligible for Medicaid coverage if medical costs are not at least equal to the contribution required towards the cost of care.

(16[~~7~~]) Medical costs that a client incurs in a benefit month may not be used to meet spenddown when the client is enrolled in a Medicaid health plan. Bills for mental health services that a client incurs in a benefit month may not be used to meet spenddown if Medicaid contracts with a single mental health provider to provide mental health services to all recipients in the client's county of residence. Bills for mental health services that a client receives in a retroactive or application month that a client pays may be used to meet spenddown only if the Medicaid-contracted mental health provider does not provide the services.

R414-304-1[~~1~~]2. Budgeting.

(1) The Department adopts and incorporates by reference 42 CFR 435.601 and 435.640, October 1, 2012 ed.,[~~2010 ed., which are incorporated by reference. The Department also adopts~~] and 45 CFR 233.20(a)(3)(iii), 233.31, and 233.33, [~~2010~~]October 1, 2012 ed., relating to financial responsibility and budgeting for non-MAGI-based Medicaid coverage groups[~~, which are incorporated by reference~~].

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

([~~2~~]3) The eligibility agency shall do prospective budgeting [~~on a monthly basis~~]to determine a household's expected monthly income.

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

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

([~~3~~]4) A best estimate of income based on the best available information is considered an accurate reflection of client income in that month.

([~~4~~]5) The eligibility agency shall use the best estimate of income to be received or made available to the client in a month to determine eligibility[~~ and spenddown~~]. For individuals eligible under

a medically needy coverage group, the best estimate of income is used to determine the individual's spenddown.

([~~5~~]6) Methods of determining the best estimate are income averaging, income anticipating, and income annualizing.

([~~6~~]7) For non-MAGI-based coverage groups, [~~T~~]the eligibility agency shall count income in the following manner:

(a) For QMB, SLMB, QI[~~-1~~], MWI program, and aged, blind, disabled, and Institutional Medicaid income is counted as it is received. Income that is received weekly or every other week is not factored;

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

([~~7~~]8) Lump sums are income in the month received. [~~Any amount of a lump sum remaining after the end of the month of receipt is a resource, unless otherwise excluded under statute or regulation.~~] Lump sum payments can be earned or unearned income.

([~~8~~]9) For non-MAGI-based coverage groups, [~~I~~]income paid out under a contract is prorated over the time period the income is intended to cover to determine the countable income for each month. The prorated amount is used instead of actual income that a client receives to determine countable income for a month.[~~If the income will be received in fewer months than the contract covers, the income is prorated over the period of the contract. If received in more months than the contract covers, the income is prorated over the period of time in which the money is received. The prorated amount of income determined for each month is the amount used to determine eligibility.~~]

([~~9~~]10) To determine the average monthly income for farm and self-employment income, the eligibility agency shall determine the annual income earned during one or more past years, or other applicable time period, and factors in any current changes in expected income for future months. Less than one year's worth of income may be used if this income has recently begun, or a change occurs making past information unrepresentative of future income. The monthly average income is adjusted during the year when information about changes or expected changes is received by the eligibility agency.

(1~~0~~1[~~0~~]) Countable educational income that a client receives other than monthly income is prorated to determine the monthly countable income. This is done by dividing the total amount by the number of calendar months that classes are in session.

[~~(11) Income from Indian trust accounts not exempt by federal law is prorated to determine the monthly countable income when the income varies from month to month, or it is received less often than monthly. This is done by dividing the total amount by the number of months it covers.~~

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

R414-304-1[~~2~~]3. Income Standards.

(1) The Department adopts and incorporates by reference Subsections 1902(a)(10)(E), 1902(l), 1902(m), 1903(f), and 1905(p) of the Compilation of the Social Security Laws, in effect January 1, 2013[~~2011, which are incorporated by reference~~].

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

(3) The income standard for the MWI for disabled individuals with earned income is equal to 250% of the federal poverty guideline for a family of the size involved. If income exceeds this amount, the [~~current Medicaid Income Standards (~~]BMS[~~)~~] appl[~~y~~]ies.

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

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

(4) The income limit for parents and caretaker relatives, pregnant women, and children under the age of 19 are defined in Section R414-303-4[~~one year of age, is equal to 133% of the federal poverty guideline for a family of the size involved~~].

(5) [~~If income exceeds this amount~~]To determine eligibility and the spenddown amount of individuals under medically needy coverage groups, the [~~current~~]BMS [~~Medicaid Income Standards (BMS) ~~]appl[~~y~~]ies.

([~~5~~]6) The [~~current Medicaid Income Standards (~~]BMS[~~)~~] [~~are~~]is as follows:

TABLE

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

R414-304-1[3]4. Aged, Blind and Disabled Medicaid, Medicaid Work Incentive, QMB, SLMB, and QI[-1] Filing Unit.

(1) The Department adopts and incorporates by reference 42 CFR 435.601 and 435.602, [2010]October 1, 2012 ed., [which are incorporated by reference. The Department adopts]and Subsections [1902(l)(1), (2), and (3),]1902(m)(1) and (2), and 1905(p) of the Compilation of the Social Security Laws, in effect January 1, [2011]2013[, which are incorporated by reference].

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

(a) the client;

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

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

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

(a) the client;

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

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

(4) The eligibility agency shall count the following individuals in the household size for a QMB, SLMB, or QI[-1] case:

(a) the client;

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

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

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

(a) the client;

(b) a spouse living in the same home;

(c) parents living with a minor child;

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

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

(6) Eligibility for aged, blind and disabled non-institutional Medicaid and the spenddown, if any; aged and disabled 100% poverty-related Medicaid; and QMB, SLMB, and QI[-1] programs is based on the income of the following individuals:

(a) the client;

(b) parents living with the minor client;

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

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

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

(a) the client;

(b) parents living with the minor client;

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

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

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

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

R414-304-1[4]5. Medically Needy Family, Pregnant Woman and Child Medicaid Filing Unit.

(1) The Department adopts and incorporates by reference 42 CFR 435.601 and 435.602, October 1, 2012 ed.,[2010 ed.,] and 45 CFR 206.10(a)(1)(iii), 233.20(a)(1) and 233.20(a)(3)(vi), October 1, 2012[2010] ed.[, which are incorporated by reference.]

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

(3) [Except for determinations under 1931 Family Medicaid, the]The eligibility agency may exclude any unemancipated minor child from the Medicaid coverage group, and may exclude an ineligible alien child from the household size at the request of the named relative who is responsible for the children. An excluded child is considered an ineligible child and is not counted as part of the household size to determine what income limit is applicable to the family. The eligibility agency may not consider income and resources of an excluded child to determine eligibility or spenddown.

(4) The eligibility agency may not [use a grandparent's income to determine eligibility or spenddown for a]include a non-parent caretaker relative in the household size of the minor child[and may not count the grandparent in the household size. Nevertheless, the eligibility agency shall count as income any cash that a grandparent donates to a minor child or to the parent of a minor child].

(5) [Except for determinations under 1931 Family Medicaid, if]If anyone in the household is pregnant, the eligibility agency shall include the expected number of unborn children in the household size.[If a medical authority confirms that a pregnant woman will have more than one child, the eligibility agency shall include all of the unborn children in that household.]

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

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

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

(9) If the eligibility agency includes or counts a person in the household size, that family member is counted as part of the

household and his income and resources are counted to determine eligibility for the household, whether or not that family member receives medical assistance. The household size determines which BMS income level [~~or, in the case of poverty-related programs, which poverty guideline income level~~]applies to determine eligibility for the client or family.

R414-304-1[5]6. Aged, Blind and Disabled Institutional [~~and Waiver Medicaid and~~]Family Institutional Medicaid Filing Unit.

(1) For aged, blind and disabled institutional[~~, and home and community-based waiver~~] Medicaid, the eligibility agency may not use income of the client's parents or the client's spouse to determine eligibility and the contribution to cost-of-care[~~, which may be referred to as a spenddown~~].

(2) For [~~F~~]family institutional[~~, and home and community-based waiver~~] Medicaid programs, the Department adopts and incorporates by reference 45 CFR 206.10(a)(1)(vii),[~~2010~~] October 1, 2012 ed.[~~, which is incorporated by reference.~~]

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

KEY: financial disclosures, income, budgeting
Date of Enactment or Last Substantive Amendment: [~~June 16, 2011~~]2014
Notice of Continuation: January 23, 2013
Authorizing, and Implemented or Interpreted Law: 26-18-3

Health, Health Care Financing, Coverage and Reimbursement Policy
R414-305
Resources

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38101
FILED: 11/01/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this change is to comply with provisions of the Patient Protection and Affordable Care Act (PPACA) that relate to determining resources for Modified Adjusted Gross Income (MAGI) and non-MAGI coverage groups.

SUMMARY OF THE RULE OR CHANGE: This amendment removes the resource test for MAGI-based coverage groups and defines the provisions for determining the countable resources for non-MAGI-based coverage groups. It also updates incorporations by reference and makes other technical changes.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Pub. L. No. 111-148 and Section 26-1-5 and Section 26-18-3

MATERIALS INCORPORATED BY REFERENCES:

- Updates Section 1917(d), (e), (f) and (g), Section 404(h) and 1613(a)(13) of the Compilation of the Social Security Laws, published by Social Security Administration, 01/01/2013
- Adds 42 CFR 435.603(g), published by Government Printing Office, 10/01/2012
- Updates 42 CFR 435.840 and 435.845, published by Government Printing Office, 10/01/2012
- Updates 20 CFR 416.1201, 416.1202, 416.1205 through 416.1224, 416.1229 through 416.1239, 416.1247 through 416.1250, published by Government Printing Office, 04/01/2012
- Updates 42 CFR 233.20(a)(3)(i)(B)(1),(2),(3),(4), and (6), and 233.20(a)(3)(vi)(A), published by Government Printing Office, 10/01/2012

ANTICIPATED COST OR SAVINGS TO:

- THE STATE BUDGET: The impact to the state budget is addressed in the companion rule filing for Rule R414-304. (DAR NOTE: The proposed amendment to Rule R414-304 is under DAR No. 38100 in this issue, November 15, 2013, of the Bulletin.)
- LOCAL GOVERNMENTS: There is no impact to local governments because they neither fund Medicaid services nor make eligibility determinations for the Medicaid program.
- SMALL BUSINESSES: This amendment does not impose any new costs or requirements because it does not affect services for Medicaid recipients and small businesses do not make eligibility determinations for the Medicaid program. In addition, this amendment does not affect business revenue because the conversion process to MAGI-based methodology does not systematically increase or decrease Medicaid eligibility.
- PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Some Medicaid recipients may realize savings roughly equivalent to the anticipated state costs because more individuals will become eligible for Medicaid services. Nevertheless, this amendment does not affect provider revenue because the conversion process to MAGI-based methodology does not systematically increase or decrease Medicaid eligibility.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs because this amendment can only result in out-of-pocket savings to a single Medicaid recipient.

Furthermore, this amendment does not affect provider revenue because the conversion process to MAGI-based methodology does not systematically increase or decrease Medicaid eligibility.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The changes may modify individual eligibility but will have no 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 AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 01/01/2014

AUTHORIZED BY: David Patton, PhD, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-305. Resources.
R414-305-2. Definitions.

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

(2) The following definitions apply in this rule:

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

[~~(b) "Department" means the Utah Department of Health.~~

~~(c) "Eligibility agency" means the Department of Workforce Services that determines eligibility for Medicaid under contract with the Department.~~

] ([~~d~~]b) "Penalty period" means a period of time during which a person is not eligible for Medicaid services for institutional care or services provided under a home and community-based waiver due to a transfer of assets for less than fair market value.

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

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

(1) To determine resource eligibility of an individual on the basis of being aged, blind or disabled, the Department adopts and incorporates by reference 42 CFR 435.840, 435.845, [~~2010~~]October 1, 2012 ed., and 20 CFR 416.1201, 416.1202, 416.1205 through 416.1224, 416.1229 through 416.1239, and 416.1247 through 416.1250, [~~2010~~]April 1, 2012 ed. The Department also adopts and incorporates by reference Section 1917(d), (e), (f) and (g) of the Compilation of the Social Security Laws in effect January 1, 201[~~1~~]3. The eligibility agency may not count as an available resource any assets that are prohibited under other federal laws from being counted as a resource to determine eligibility for federally-funded medical assistance programs. In addition, the eligibility agency applies the following rules.

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

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

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

(5) The eligibility agency shall base non-institutional and institutional Medicaid eligibility on all available resources owned by the individual, or considered available to the individual from a spouse or parent. The eligibility agency may not grant eligibility based upon the individual's intent to or action of disposing of non-liquid resources as described in 20 CFR 416.1240, [~~2010~~]April 1, 2012 ed., unless Social Security is excluding the resources for an SSI recipient while the recipient takes steps to dispose of the excess resources.

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

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

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

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

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

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

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

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

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

([~~i~~]a) the individual intends to return to the home;

([~~ii~~]b) the individual's spouse resides in the home;

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

([~~iv~~]d) a reliant relative of the individual resides in the home.

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

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

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

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

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

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

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

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

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

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

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

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

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

(24) The eligibility agency may not count as a resource any federal tax refund and refundable credit that an individual receives [~~between April 1, 2011, and December 31, 2012, pursuant to the Tax Relief Unemployment Insurance Reauthorization and Job Creation Act of 2010, Pub. L. No. 111 312, 124, Stat 3296. During that time period, the eligibility agency may not count state tax refunds as a resource~~]for 12 months after the month of receipt.

[~~(25) The eligibility agency may not count the following resources that an individual receives after December 31, 2012:~~

~~(a) Amounts that an individual receives as a result of the Making Work Pay credit defined in Section 1001 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111 5, 123 Stat. 115 for two months after the month of receipt;~~

~~(b) Amounts that an individual retains from the economic recovery payments defined in Section 2201 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111 5, 123 Stat. 115 for nine months after the month of receipt;~~

~~(c) Tax credits described in 20 CFR 416.1235 that relate to child tax credits and earned income tax credits for nine months after the month of receipt;~~

~~(d) Amounts that an individual retains from the tax credit allowed to certain government employees as defined in Section 2202 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111 5, 123 Stat. 115 for two months after the month of receipt.~~

] (2[~~6~~]5) The eligibility agency may not count as a resource, for one year after the date of receipt, any payments that an individual receives under the Individual Indian Money Account Litigation Settlement under the Claims [~~Resolution~~]Resettlement Act of 2010, Pub. L. No. 111 291, 124 Stat. 3064.

(2[~~7~~]6) The eligibility agency may not count [~~the following as countable resources:~~

~~(a) The value of any reduction in Consolidated Omnibus Budget Reconciliation Act (COBRA) premiums provided to an individual under Section 3001 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111 5, 123 Stat. 115.~~

~~(b) Certain ~~]certain property and rights of federally-recognized American Indians including certain tribal lands held in trust which are located on or near a reservation, or allotted lands located on a previous reservation; ownership interests in rents, leases, royalties or usage rights related to natural resources (including extraction of natural resources); and ownership interests and usage rights in personal property which has unique religious, spiritual, traditional or cultural significance, and rights that support subsistence or traditional lifestyles, as defined in Section 5006(b)(1) of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111 5, 123 Stat. 115.

(2[~~8~~]7) The eligibility agency shall count only the portion of an asset such as a retirement plan that is legally available to an individual when that asset has been divided between two divorced spouses pursuant to a qualified domestic relations order.

(2[~~9~~]8) Life estates.

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

(b) For Institutional Medicaid, the eligibility agency shall count life estates even if no market exists for the sale of the life estate, unless the life estate can be excluded as defined in Subsection R414-305-3(12).

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

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

. . . . . .

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

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

R414-305-[4]5. [~~Family~~]Resource Provisions for Parents and Caretaker Relatives, Pregnant Woman, and Child Under Non-MAGI-Based [~~Non-Institutional~~]Community and Institutional Medicaid[~~Resource Provisions~~].

(1) To determine resource eligibility for an individual for [~~family-related~~]Parents and Caretaker Relatives, Pregnant Woman, and Child non-MAGI-based Medicaid programs, the Department adopts and incorporates by reference 45 CFR 233.20(a)(3)(i)(B)(1), (2), (3), (4), and (6), and 233.20(a)(3)(vi)(A), [~~2010~~]October 1, 2012 ed. The Department also adopts and incorporates by reference Section 1917(d), (e), (f) and (g), Section 404(h) and 1613(a)(13) of the Compilation of the Social Security Laws in effect January 1, 201[~~1~~]3. The eligibility agency may not count as an available resource retained funds from sources that federal laws specifically prohibit from being counted as a resource to determine eligibility for federally-funded medical assistance programs. In addition, the eligibility agency shall apply the following rules.

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

(3) [~~Except for pregnant women who meet the criteria under Sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Social Security Act in effect January 1, 2011, t~~]The medically needy resource limit is $2,000 for a one-person household, $3,000 for a two-person household and $25 for each additional household member. [~~For pregnant women defined above, the resource limit is defined in Section R414-303-11.~~

~~(4) Except for the exclusion for a vehicle, the eligibility agency shall use the same methodology for treatment of resources for all medically needy and categorically needy individuals.~~]

([~~5~~]4) To determine countable resources for Medicaid eligibility, the eligibility agency shall consider all available resources owned by the individual. The agency may not consider a resource unavailable based upon the individual's intent or action of disposing of non-liquid resources.

([~~6~~]5) The eligibility agency shall count resources of a household member who has been disqualified from Medicaid for failure to cooperate with third party liability or duty of support requirements.

([~~7~~]6) If a legal guardian, conservator, authorized representative, or other responsible person controls any resources of an individual, the eligibility agency shall count the resources as the individual's. The arrangement may be formal or informal.

([~~8~~]7) If a resource is available, but a legal impediment exists, the agency may not count the resource until it becomes available. The individual must take appropriate steps to make the resource available unless one of the following conditions exist:

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

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

([~~9~~]8) [~~Except for determining countable resources for Family Medicaid under Section 1931 of the Act, t~~]The eligibility agency shall exclude a maximum of $1,500 in equity value of one vehicle.

([~~10~~]9) The eligibility agency may not count as resources the value of household goods and personal belongings that are essential for day-to-day living. The agency shall count any single household good or personal belonging with a value that exceeds $1,000 toward the resource limit. The agency may not count as a resource the value of any item that a household member needs because of the household member's medical or physical condition.

(1[~~1~~]0) The eligibility agency may not count the value of one wedding ring and one engagement ring as a resource.

(1[~~2~~]1) For a non-institutionalized individual, the eligibility agency may not count the value of a life estate as an available resource if the life estate is the individual's principal residence. If the life estate is not the principal residence, the provision in Subsection R414-305-3(2[~~9~~]8) shall apply.

(1[~~3~~]2) The eligibility agency may not count the resources of a child who is not counted in the household size to determine eligibility of other household members.

(1[~~4~~]3) For a non-institutionalized individual, the eligibility agency may not count as a resource, the value of the lot on which the excluded home stands if the lot does not exceed the average size of

residential lots for the community in which it is located. The agency shall count as a resource the value of the property in excess of an average size lot. If the individual is institutionalized, the provisions of Subsections R414-305-3(12), (13)[~~, (14),~~]and (2[~~9~~]8) shall apply to the individual's home or life estate.

(1[~~5~~]4) The agency may not count as a resource the value of water rights attached to an excluded home and lot.

(1[~~6~~]5) The eligibility agency may not count any resource or interest from a resource held within the rules of the Uniform Transfers to Minors Act. The agency shall count as a resource any money that a child receives as unearned income, which the child retains beyond the month of receipt.

(1[~~7~~]6) The eligibility agency may not count lump sum payments that an individual receives on a sales contract for the sale of an exempt home if the entire proceeds are used to purchase a new exempt home within three calendar months of when the property is sold. The eligibility agency shall grant the individual one three-month extension, if more than three months is needed to complete the actual purchase. Proceeds are defined as all payments made on the principal of the contract. Proceeds do not include interest earned on the principal.

(1[~~8~~]7) The eligibility agency shall [~~count~~]exclude as a resource retroactive benefits received from the Social Security Administration and the Railroad Retirement Board for the first nine months after receipt.

(1[~~9~~]8) The eligibility agency shall exclude from resources a burial and funeral fund or funeral arrangement up to $1,500 for each household member who is counted in the household size. Burial and funeral agreements include burial trusts, funeral plans, and funds set aside expressly for the purposes of burial. The [~~agency~~]client shall separate and clearly designate the burial funds from the non-burial funds. The agency may not count as a resource interest earned on exempt burial funds that is left to accumulate. If an individual uses exempt burial funds for some other purpose, the agency shall count the remaining funds as an available resource beginning on the date that the funds are withdrawn.

([~~20~~]19) Assets of an alien's sponsor, and the sponsor's spouse, if any, when the sponsor has signed an Affidavit of Support pursuant to Section 213A of the Immigration and Nationality Act after December 18, 1997, are considered available to the alien. The eligibility agency shall stop counting a sponsor's assets when the alien becomes a naturalized U.S. citizen, or has worked 40 qualifying quarters as defined under Title II of the Social Security Act or can be credited with 40 qualifying work quarters. After December 31, 1996, a creditable qualifying work quarter is one during which the alien did not receive any federal means-tested public benefit.

(2[~~1~~]0) The eligibility agency may not consider a sponsor's assets as being available to applicants who are eligible for Medicaid for emergency services only.

(2[~~2~~]1) The eligibility agency [~~shall~~]may not count business resources that are required for employment or self-employment. The agency shall treat non-business, income-producing property in the same manner as the SSI program as defined in 42 CFR 416.1222.

[~~(23) For Family Medicaid households who are eligible under Section 1931 of the Act, the eligibility agency may only count as a resource either the equity value of one vehicle that meets the definition of a passenger vehicle as defined in Subsection 26-18-2(6) or $1,500 of the equity of one vehicle, whichever provides the greatest disregard for the household.~~

] (2[~~4~~]2) [~~For eligibility under Family-related Medicaid programs, t~~]The eligibility agency may not count as a resource retirement funds held in an employer or union pension plan, a retirement plan or account including 401(k) plans, and Individual Retirement Accounts of a disabled parent or disabled spouse who is not included in the coverage.

(2[~~5~~]3) The eligibility agency may not count as a resource any federal tax refund and refundable credit that an individual receives [~~between April 1, 2011, and December 31, 2012, pursuant to the Tax Relief Unemployment Insurance Reauthorization and Job Creation Act of 2010, Pub. L. No. 111 312, 124, Stat 3296. During that time period, the eligibility agency may not count state tax refunds as a resource~~]for 12 months after the month of receipt.

[~~(26) The eligibility agency may not count the following resources that an individual receives after December 31, 2012:~~

~~(a) Funds that an individual receives from the Child Tax credit or the Earned Income Tax credit for nine months after the month of receipt. The agency may not count any remaining funds as a resource in the tenth month after receipt;~~

~~(b) Amounts that an individual receives as a result of the Making Work Pay credit defined in Section 1001 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111 5, 123 Stat. 115 for two months after the month of receipt;~~

~~(c) Amounts that an individual retains from the economic recovery payments defined in Section 2201 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111 5, 123 Stat. 115 for nine months after the month of receipt;~~

~~(d) Amounts that an individual retains from the tax credit allowed to certain government employees as defined in Section 2202 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111 5, 123 Stat. 115 for two months after the month of receipt.~~

] (2[~~7~~]4) The eligibility agency may not count as income, for one year after the date of receipt, any payments that an individual receives under the Individual Indian Money Account Litigation Settlement under the Claims [~~Resolution~~]Resettlement Act of 2010, Pub. L. No. 111 291, 124 Stat. 3064.

(2[~~8~~]5) The eligibility agency may not count as [~~income the following~~]resources[~~:~~

~~(a) The value of any reduction in COBRA premiums provided to an individual under Section 3001 of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111 5, 123 Stat. 115;~~

~~(b) C~~]certain property and rights of federally-recognized American Indians including:

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

([~~ii~~]b) ownership interests in rents, leases, royalties or usage rights related to natural resources (including extraction of natural resources); and

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

(2[~~9~~]6) The eligibility agency shall count only the portion of an asset such as a retirement plan that is legally available to an individual when that asset has been divided between two divorced spouses pursuant to a qualified domestic relations order.

R414-305-[5]6. Spousal Impoverishment Resource Rules for Married Institutionalized Individuals.

(1) The eligibility agency shall apply the provisions of 42 U.S.C. 1396r-5 to determine the value of the total joint resources of an institutionalized individual and a community spouse, and the spousal assessed share.

(2) The resource limit for an institutionalized individual is $2,000.

(3) At the request of either the institutionalized individual or the individual's spouse and upon receipt of relevant documentation of resources, the eligibility agency shall assess and document the total value of resources using the methodology described in Subsection R414-305-[5]6([5]4) as of the first continuous period of institutionalization or upon application for Medicaid home and community-based waiver services. The eligibility agency shall notify the requester of the results of the assessment. The agency may not require the individual to apply for Medicaid or pay a fee for the assessment.

(4) The assessment is a computation of the total value of resources in which the institutionalized individual or the community spouse has an ownership interest. The spousal share is equal to one-half of the total value computed. The eligibility agency shall count the resources for the assessment that include those the couple has on the date that one spouse becomes institutionalized or applies for Medicaid for home and community-based waiver services, and the other spouse remains in the community and is not eligible for Medicaid for home and community-based waiver services.

(a) The community spouse's assessed share of resources is one-half of the total resources. Nevertheless, the protected resource allowance for the community spouse may be less than the assessed share.

(b) Upon application for Medicaid, the eligibility agency shall set the protected share of resources for the community spouse when countable resources equal no more than the community spouse's protected share as determined under 42 U.S.C. 1396r-5(f) plus the resource limit for the institutionalized spouse.

(c) The eligibility agency shall set the community spouse's protected share of resources at the community spouse's assessed share of the resources with the following exceptions:

(i) If the spouse's assessed share of resources is less than the minimum resource standard, the protected share of resources is the minimum resource standard;

(ii) If the spouse's assessed share of resources is more than the maximum resource standard, the protected share of resources is the maximum resource standard;

(iii) The eligibility agency shall use the minimum and maximum resource standards permitted under 42 U.S.C. 1396r-5(f) to determine the community spouse's protected share.

(d) In making a decision to modify the community spouse's protected share of resources, the eligibility agency shall apply the income first provisions of 42 U.S.C. 1396r-5(d)(6).

(5) The eligibility agency shall count any resource owned by the community spouse in excess of the community spouse's protected share of resources to determine the institutionalized individual's initial Medicaid eligibility.

(6) After the eligibility agency establishes eligibility for the institutionalized spouse, the agency shall allow a protected period for the couple to either use excess resources, or change the ownership of resources held jointly or held only in the name of the institutionalized spouse.

(a) The protected period continues until the resources held in the institutionalized spouse's name do not exceed $2,000, or until the time of the next regularly scheduled eligibility redetermination, whichever occurs first.

(b) The institutionalized individual may do the following:

(i) use resources held in his name for his benefit or for the benefit of his spouse;

(ii) transfer resources to the community spouse to bring the resources held only in the name of the community spouse up to the amount of the community spouse's protected share of resources and to bring the resources held only in the name of the institutionalized spouse down to the Medicaid resource limit; or

(iii) a combination of both.

(7) The eligibility agency may not count resources held in the name of the community spouse as available to the institutionalized spouse beginning the month after the month in which the agency establishes eligibility.

(8) If an individual is otherwise eligible for institutional Medicaid, the eligibility agency may not count the community spouse's resources as available to the institutionalized individual due to an uncooperative spouse or because the spouse cannot be located if all of the following criteria are met:

(a) The individual assigns support rights to the agency;

(b) The individual cannot get medical care without Medicaid;

(c) The individual is at risk of death or permanent disability without institutional care.

R414-305-[6]7. Treatment of Trusts.

(1) The eligibility agency shall apply the criteria in Section 1902(k) of the Compilation of the Social Security Laws, 1993 ed., to determine the availability of trusts established before August 11, 1993.

(a) A Medicaid qualifying trust is a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust. The distribution of payments is determined by one or more trustees who are permitted to exercise some amount of discretion with respect to the distribution to the individual.

(b) The amount of the trust property that is counted as an available resource to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee is permitted to distribute under the terms of the trust for the individual's benefit. This amount of property is counted as available whether or not it is actually disbursed by the trustee or received by the beneficiary. It does not matter whether the trust is irrevocable [~~n~~]or whether it is established for a purpose other than to qualify for Medicaid.

(c) Payments made from the available portion of the trust do not count as income because the available portion of the trust is counted as a resource. If payments are made from any portion of the trust that is not counted as a resource, the payments are counted as income in the month received.

(2) The Department adopts the provisions of 42 U.S.C. 1396p(d)(4)(A) concerning trusts[~~Trust~~] for a Disabled Person under Age 65[~~, established in compliance with 42 U.S.C. 1396p(d)(4)(A)~~]. These trusts are commonly known as a special needs trust for a

disabled person. Assets held in a trust that compl[~~y~~]ies with the provisions in Subsection R414-305-[~~6~~]7(2) and (4) do not count as available resources.

(a) The individual trust beneficiary must meet the disability criteria found in 42 U.S.C. 1382c(a)(3). The trust must be established and assets transferred to the trust before the disabled individual reaches age 65.

(b) The trust must be established solely for the benefit of the disabled individual by a parent, grandparent, legal guardian of the individual, or the court.

(c) The trust may only contain the assets of the disabled individual. The eligibility agency shall treat any additions to the trust corpus with assets not belonging to the disabled trust beneficiary as a gift to the trust beneficiary. The additions irrevocably become part of the trust corpus and are subject to all provisions of Medicaid restrictions that govern special needs trusts.

(d) The trust must be irrevocable. No one may have any right or power to alter, amend, revoke, or terminate the trust or any of its terms, except that the trust may include language that provides that the trust may be amended but only if necessary to conform with subsequent changes to the requirements of 42 U.S.C. 1396p(d)(4)(A) or synonymous state law.

(e) The trust cannot be altered or converted from an individual trust to a "pooled trust" under 42 U.S.C. 1396p(d)(4)(C).

(f) The trust must terminate upon the death of the disabled individual or exhaustion of trust corpus and must include language that specifically provides that upon the death of the beneficiary or early termination of the trust, whichever occurs first, the trustees will notify Medicaid and will pay all amounts remaining in the trust to the State up to the total amount of medical assistance the State has paid on behalf of the individual. The trust shall comply fully with this obligation to first repay the State without requiring the State to take any action except to establish the amount to be repaid.

(g) The sole lifetime beneficiary of the trust must be the disabled individual, and the Medicaid agency must be the preferred remainder beneficiary. Distributions from the trust during the beneficiary's lifetime may be made only to or for the benefit of the disabled individual.

(h) The eligibility agency shall continue to exclude assets held in the trust from countable resources after the disabled individual reaches age 65. Subsequent additions to the trust other than interest on the corpus after the person turns 65 are not assets of an individual under age 65 and the agency shall treat the transfer as a transfer of resources for less than fair market value, which may create a period of ineligibility for certain Medicaid services.

(i) A trust that provides benefits to other persons is not an individual special needs trust and does not the meet the criteria to be excluded from resources.

(j) A corporate trustee may charge a reasonable fee for services.

(k) The trust may compensate a guardian only as provided by law. The trust may not compensate the parent of a minor child from the trust as the child's guardian.

(l) Additional trusts cannot be created within the special needs trust.

(3) The Department adopts the provisions of 42 U.S.C. 1396p(d)(4)(C) concerning [~~P~~]pooled [~~T~~]trusts for [~~D~~]disabled [~~I~~]individuals. A pooled trust is a specific trust for disabled individuals [~~established pursuant to 42 U.S.C. 1396p(d)(4)(C)~~]that meets all of the following conditions:

(a) The trust contains the assets of disabled individuals;

(b) The trust must be established and managed by an entity that has been granted non-profit status by the Internal Revenue Service. The non-profit entity must submit to the State a letter documenting the non-profit status with the trust documents;

(c) The trustees must maintain a separate account for each disabled beneficiary whose assets are placed in the pooled trust; however, for the purposes of investment and management of the funds, the trust may pool the funds from the individual accounts. If someone other than the beneficiary transfers assets to the pooled trust administrator to be used on behalf of that beneficiary of the pooled trust, the eligibility agency shall treat the assets as a gift to that beneficiary, which the administrator must add to and manage as part of the balance of the beneficiary's account and which are subject to all provisions of Medicaid restrictions that govern pooled trusts.

(d) Accounts in the trust must be established solely for the benefit of individuals who are disabled as defined in 42 U.S.C. 1382c(a)(3).

(e) The trust must be irrevocable; accounts set up in the trust must be irrevocable.

(f) Individual accounts may be established only by the parent, grandparent or legal guardian of the individual, by the individual, or by a court.

(g) An initial transfer of funds or any additions or augmentations to a pooled trust account by an individual 65 years of age or older is a transfer of assets for less than fair market value and may create a period of ineligibility for certain Medicaid services.

(h) The disabled individual cannot control any spending by the trust.

(i) Individual trust accounts may not be liquidated before the death of the beneficiary without first making payment to the State for medical assistance paid on behalf of the individual.

(j) The trust must include language that specifically provides that upon the death of the trust account beneficiary, the trustees will notify the Medicaid agency and will pay all amounts remaining in the beneficiary's account to the State up to the total medical assistance paid on behalf of the beneficiary. The trust may retain a maximum of 50% of the amount remaining in the beneficiary's account at death to be used for other disabled individuals if the trust has established provisions by which it will assure that the retained funds are used only for individuals meeting the disability criteria found in 42 U.S.C. 1382c(a)(3).

(k) A pooled trust that retains some portion of a deceased beneficiary's trust funds must describe how retained funds are used for other disabled persons. Any funds that are placed in an individual beneficiary's account or that are used to set up an account for an individual beneficiary who does not otherwise have funds to place in the pooled trust are subject to all of the provisions of Medicaid restrictions that govern pooled trusts. The pooled trust may include a plan for using retained funds only for incidental, one-time services to qualified disabled individuals who do not have accounts in the pooled trust.

(4) The following provisions apply to both individual trusts and pooled trusts described in Subsection R414-305-[~~6~~]7(2) and (3):

(a) No expenditures may be made after the death of the beneficiary before repayment to the State, except for federal and state

taxes and necessary and reasonable administrative costs of the trust incurred in closing the trust;

(b) The trust must provide that if the beneficiary has received Medicaid benefits in more than one state, each state that provided Medicaid benefits shall be repaid. If the remaining balance is insufficient to repay all benefits paid, then each state will be paid its proportionate share;

(c) The trust or an attached schedule must identify the amount and source of the initial trust property. The disabled individual must report subsequent additions to the trust corpus to the eligibility agency;

(d) If the trust is funded, in whole or in part, with an annuity or other periodic payment arrangement, the State must be named in controlling documents as the preferred remainder beneficiary in the first position up to the total amount of medical assistance paid on behalf of the individual;

(i) Any funds remaining after full repayment of the medical assistance can be paid to a secondary remainder beneficiary;

(ii) The eligibility agency shall treat any provision or action that does or will divert payments or principal from the annuity or payment arrangement to someone other than the excluded trust or the Medicaid agency as a transfer of assets for less than fair market value with the exception that any remainder after the Medicaid agency has been fully repaid may be paid to a secondary beneficiary;

(e) The eligibility agency shall count cash distributions from the trust as income in the month received;

(f) The eligibility agency shall count retained distributed amounts as resources beginning the month which follows the month that the amounts are distributed. The agency shall apply the applicable resource rules to assets purchased with trust funds and given to the beneficiary as his or her personal possessions. The disabled individual must report the receipt of payments or assets from the trust within ten days of receipt. The agency shall exclude assets purchased with trust funds if the trust retains ownership;

(g) The eligibility agency shall count distributions from the trust covering the individual's expenses for food or shelter as in-kind income to determine Medicaid eligibility in the month paid;

(h) If expenditures made from the trust also incidentally provide an ongoing and continuing benefit to other persons, those other persons who also benefit must contribute a pro-rata share to the trust for the expenses associated with their use of the acquisition;

(i) Contracts to provide personal services to the disabled individual must be in writing, describe the services to be provided, pay fair market rate consistent with rates charged in the community for the type and quality of services to be provided, and be executed in advance of any services being provided and paid. The eligibility agency may require a statement of medical need for the services from the individual's medical practitioner. If the person who is to provide the services is a family member or friend, the eligibility agency may require verification of the person's ability to carry out the needed services;

(j) Distributions from the trust made to or for the benefit of a third party that are not for the benefit of the disabled individual are treated as a transfer of assets for less than fair market value and may create a period of ineligibility for certain Medicaid services. This includes such things as payments of the expenses or travel costs of persons other than a medically necessary attendant;

(k) The beneficiary must submit an annual accounting of trust income and expenditures and a statement of trust assets to the eligibility agency upon request or upon any change of trustee.

(5) The eligibility agency may not count assets held in a pooled trust that comply with the provisions in Subsection R414-305-[~~6~~]7(3) and (4) as available resources.

(6) 42 U.S.C. 1396p(d)(4)(B), provides for an exemption from the trust provisions for qualified income trusts (also known as Miller Trusts). Special provisions for this form of trust apply, under federal law, only in those states that do not provide medically needy coverage for nursing facility services. Because Utah covers services in nursing facilities under the medically needy coverage group of the Medicaid program, the establishment of a qualified income trust shall be treated as an asset transfer for the purposes of qualifying for Medicaid. This presumption shall apply whether the individual is seeking nursing facility services or home and community-based services under one of the waiver programs.

R414-305-[~~7~~]8. Transfer of Resources for [~~A, B and D or Family~~] Non-Institutional Medicaid Coverage Groups.

The eligibility agency may not impose a penalty period for the transfer of resources to determine eligibility for individuals who are not institutionalized or eligible for home and community-based services waivers.

R414-305-[8]9. Transfer of Resources for Institutional Medicaid and Home and Community Based Services Waivers.

(1) The eligibility agency shall apply the provisions of 42 U.S.C. 1396p(c) and (e) to determine if a penalty period applies for a transfer of assets for less than fair market value.

(2) If an individual or the individual's spouse transfers the home or life estate or any other asset on or after the look-back date based on an application for long-term care Medicaid services, the transfer requirements of 42 U.S.C. 1396p(c) and (e) apply.

(3) If an individual or the individual's spouse transfers assets in more than one month after February 7, 2006, the uncompensated value of all transfers including fractional transfers are combined to determine the penalty period. The eligibility agency shall apply partial month penalty periods for transferred amounts that are less than the monthly average private pay rate for nursing home services.

(4) In accordance with 42 U.S.C. 1396p(c), the penalty period for a transfer of assets that occurs after February 7, 2006, begins the first day of the month during or after which assets are transferred, or the date on which the individual is eligible for Medicaid coverage and would otherwise receive institutional level care based on an approved application for Medicaid, but for the application of the penalty period, whichever is later.

(a) If a previous penalty period is in effect on the date that the new penalty period begins, the new penalty period begins immediately after the previous one ends.

(b) The eligibility agency shall apply penalty periods consecutively so that they do not overlap.

(5) If assets are transferred during any penalty period, the penalty period for those transfers does not begin until the previous penalty period expires.

(6) If a transfer occurs, or the eligibility agency discovers an unreported transfer after the agency approves an individual for

Medicaid for nursing home or home and community-based services, the penalty period shall begin on the first day of the month after the month that the individual transfers the asset.

(7) The statewide average private-pay rate for nursing home care in Utah that the eligibility agency shall use to calculate the penalty period for transfers is $4,526 per month.

(8) To determine if a resource is transferred for the sole benefit of a spouse, disabled or blind child, or disabled individual, a binding written agreement must be in place which establishes that the resource transferred may only be used to benefit the spouse, disabled child, or disabled individual, and must be actuarially sound. The written agreement must specify the payment amounts and schedule. Any provisions in the agreement that benefit another person at any time nullify the sole benefit provision. An excluded trust established under 42 U.S.C. 1396p(d)(4) that meets the criteria in Section R414-305-[~~6~~]7 does not have to meet the actuarially sound test.

(9) The eligibility agency may not impose a penalty period if the total value of a whole life insurance policy is:

(a) irrevocably assigned to the State;

(b) the recipient is the owner of and the insured in the policy; and

(c) no further premium payments are necessary for the policy to remain in effect.

(d) When the individual dies, the State shall distribute the benefits of the policy as follows:

(i) The State may distribute up to $7,000 to cover burial and funeral expenses. The total value of this distribution plus the value of any irrevocable burial trusts and the burial and funeral funds for the individual cannot exceed $7,000;

(ii) The State may distribute an amount that does not exceed the total amount of previously unreimbursed medical assistance correctly paid on behalf of the individual;

(iii) The State may distribute to a remainder beneficiary named by the individual any amount that remains after payments are made as defined in Subsection R414-305-[~~8~~]9(9)(d)(i) and Subsection R414-305-[~~8~~]9(9)(d)(ii).

(10) If the eligibility agency determines that a penalty period applies for an otherwise eligible institutionalized person, the agency shall notify the individual that the Department may not pay the costs for nursing home or other long-term care services during the penalty period. The notice shall include when the penalty period begins and ends.

(a) The individual may request a waiver of the penalty period based on undue hardship.

(b) The individual must send a written request for a waiver of the penalty period due to undue hardship to the eligibility agency within 30 days of the date printed on the penalty period notice.

(c) The request must include an explanation of why the individual believes undue hardship exists.

(d) The eligibility agency shall make a decision on the undue hardship request within 30 days of receipt of the request.

(11) An individual who claims an undue hardship as a result of a penalty period for a transfer of resources must meet both of the following conditions:

(a) The individual or the person who transferred the resources may not access the asset immediately; however, the eligibility agency shall require the individual to exhaust all reasonable means including legal remedies to regain possession of the transferred resource;

(i) The agency may determine that it is unreasonable to require the individual to take action if a knowledgeable source confirms that the individual[**s**]'s efforts cannot succeed;

(ii) The agency may determine that it is unreasonable to require the individual to take action based on evidence that the individual's action is more costly than the value of the resource; and

(b) Application of the penalty period for a transfer of resources deprives the individual of medical care, endangers the individual's life or health, or deprives the individual of food, clothing, shelter, or other necessities of life.

(12) If the eligibility agency waives the penalty period based on undue hardship, the agency shall notify the individual. The Department shall provide Medicaid coverage on the condition that the individual takes all reasonable steps to regain the transferred assets. The eligibility agency shall notify the individual of the date that the individual must provide verifications of the steps taken. The individual must, within the time frames set by the agency, verify to the agency all reasonable actions. The agency shall review the undue hardship waiver and the actions of the individual to try to regain the transferred assets. The time period for the review may not exceed six months. Upon review, the agency shall decide whether:

(a) The individual must take additional steps and whether undue hardship still exists, in which case the agency shall notify the individual of the continuation of undue hardship and the need to take additional steps to recover the assets;

(b) The individual has taken all reasonable steps without success, in which case the agency shall notify the individual that it requires no further action. If the individual continues to meet eligibility criteria, the eligibility agency may not apply the penalty period; or

(c) The individual has not taken all reasonable steps, in which case the eligibility agency shall discontinue the undue hardship waiver. The eligibility agency shall then apply the penalty period and the individual is responsible to repay Medicaid for services and benefits that the individual received during the months that the undue hardship waiver was in place.

(13) Based on a review of the facts about what happened to the assets, whether the individual has taken reasonable steps to recover or regain the assets, the results of those steps, and the likelihood that additional steps will prove unsuccessful or too costly, the eligibility agency may determine that the individual cannot recover or regain the transferred resource. If the agency decides that the assets cannot be recovered and that applying the penalty period may result in undue hardship, the agency may not apply a penalty period or shall end a penalty period that has already begun.

(14) The eligibility agency shall base its decision that undue hardship exists upon the medical condition and the financial situation of the individual. The agency [~~may not~~]shall compare the income and resources of the individual, individual's spouse, and parents of an unemancipated individual to the cost of providing medical care and daily living expenses to decide whether the financial situation creates an undue hardship. The agency shall send written notice of its decision on the undue hardship request. The individual has 90 days from the date printed on the notice of decision to file a request for a fair hearing.

(15) The eligibility agency shall consider the portion of an irrevocable burial trust that exceeds $7,000 a transfer of resources. The agency shall deduct the value of any fully paid burial plot from the burial trust first before determining the transferred amount.

~~**[R414-305-9. Home and Community-Based Services Waiver Resource Provisions.**~~

~~(1) The resource limit for home and community-based waiver programs is $2,000.~~

~~(2) After the first month of eligibility, the eligibility agency shall determine eligibility by counting only the resources that belong to the individual.~~

~~(3) For married individuals, the eligibility agency shall apply the provisions for spousal impoverishment resources as defined in Section R414-305-5.~~

]**R414-305-11. Treatment of Annuities.**

(1) An individual must report any annuities in which either the individual or the individual's spouse has any interest at application for Medicaid, at each review, and as part of the change reporting requirements. Parents of a minor individual must report any annuities in which the child or either of the parents has an interest.

(2) For annuities purchased after February 7, 2006, in which the individual or spouse has an interest, the provisions in 42 U.S.C. 1396p(c) apply. The eligibility agency shall treat annuities purchased after February 7, 2006, which do not meet the requirements of 42 U.S.C. 1396p(c), as a transfer of assets for less than fair market value.

(3) With the exception of annuities that meet the criteria in Subsection R414-305-11(4), the eligibility agency shall count annuities in which the individual, the individual's spouse or a minor individual's parent has an interest as an available resource to determine Medicaid eligibility, whether they are irrevocable or non-assignable. The agency shall presume that a market exists to purchase annuities or the stream of income from annuities, which make them available resources. The individual may rebut the presumption that the annuity may be sold by providing evidence that the individual has been rejected by several entities in the business of purchasing annuities or the revenue stream from annuities, in which case, the agency may not consider the annuity as an available resource.

(4) For individuals eligible under the aged, blind, or disabled category of Medicaid, the eligibility agency shall exclude an annuity from countable resources in the form of the periodic payment if it meets the following requirements[~~ of Subsection R414-305-11(4)~~]. [~~For Family-Related Medicaid programs, the agency shall count all annuities as resources if the individual can access the funds, even if the annuities qualify as retirement funds or plans.~~]

(a) The annuity is either an individual retirement annuity according to Section 408(b) of the Internal Revenue Code (IRC) of 1986 or a deemed Individual Retirement Account under a qualified employer plan according to Section 408(q) of the IRC; or

(b) The annuity is purchased with the proceeds from one of the following:

(i) As described in Sections 408(a), (c), or (p) of the IRC, a traditional IRA, accounts or trusts which are treated as a traditional IRA, or a simplified retirement account;

(ii) A simplified employee pension (Section 408(p) of the IRC); or

(iii) A Roth IRA (Section 408A of the IRC); and

(c) The annuity is irrevocable and non-assignable, the individual who was the owner of the retirement account or plan is receiving equal periodic payments at least quarterly with no deferral or balloon payments, and the scheduled payout period is actuarially sound based on the individual's life expectancy.

(d) If the individual purchases or annuitizes the annuities after February 7, 2006, the annuities must name the State as the preferred remainder beneficiary in the first position upon the individual's death, or as secondary remainder beneficiary after a surviving spouse or minor or disabled child.

(5) For family-related medically needy Medicaid programs, the eligibility agency shall count all annuities as resources if the individual can access the funds, even if the annuities qualify as retirement funds or plans.

([~~5~~]6) Annuities purchased on or after February 8, 2006, in which the individual or the spouse has an interest are a transfer of assets for less than fair market value unless the annuity names the State as the preferred remainder beneficiary in the first position, or in the second position after a surviving spouse, or a surviving minor or disabled child, up to the amount of medical assistance paid on behalf of the institutionalized individual.

(a) The State shall give individuals who have purchased annuities before applying for long-term care Medicaid, 30 days to request the issuing company to name the State as the preferred remainder beneficiary and to verify that fact to Medicaid.

(b) The individual must verify to the eligibility agency that the change in beneficiary has been made by the date requested by the agency.

(c) If the change of beneficiary is not completed and verified, the annuities are a transfer of resources and the eligibility agency shall apply the penalty period. If the eligibility agency has approved institutional Medicaid coverage pending verification, Medicaid coverage for long-term care ends and the penalty period begins the day after the closure date.

([~~6~~]7) The eligibility agency shall treat an annuity purchased before February 8, 2006, as an annuity purchased on or after February 8, 2006, if the individual or spouse take any actions that change the course of payments to be made or the treatment of the income or principal of the annuity. These actions include additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract, or other similar actions. Routine changes and automatic events that do not involve an action or decision from the individual or spouse do not cause an annuity purchased before February 8, 2006, to be treated as one purchased on or after February 8, 2006.

([~~7~~]8) If a penalty period for a transfer of assets begins because the individual or the individual's spouse has not changed an annuity to name the State as the preferred remainder beneficiary of the annuity, the penalty period for a transfer does not end until the individual completes and verifies the change of beneficiary to the eligibility agency. The eligibility agency may not rescind the penalty period.

([~~8~~]9) If the individual or spouse does not provide all information about annuities for which they have an interest by the requested due date, the eligibility agency shall deny the application. The individual may reapply, but may not protect the original application date.

([~~9~~]10) The issuer of the annuity shall inform the eligibility agency of any change in the amount of income or principal being withdrawn from the annuities, any change of beneficiaries, or any sale or transfer of the annuity. The issuer of the annuity shall also inform the agency if a surviving spouse or a surviving minor or disabled child attempts to transfer the annuity or any portion of the annuity to someone other than the agency.

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Health, Health Care Financing, Coverage and Reimbursement Policy
R414-306-4
Effective Date of Eligibility

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38083
FILED: 10/31/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this change is to comply with provisions of the Patient Protection and Affordable Care Act as they relate to Modified Adjusted Gross Income (MAGI) methodology.

SUMMARY OF THE RULE OR CHANGE: Effective 01/01/2014, this amendment implements MAGI methodology to determine Medicaid eligibility for parents, caretaker relatives, and pregnant women and children. It also clarifies retroactive eligibility and eligibility criteria for the months that precede MAGI implementation.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Pub. L. No. 111-148 and Section 26-1-5 and Section 26-18-3

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: Any anticipated costs to the state budget are incorporated within changes made to the companion filings of Rules R414-303, R414-304, and R414-305. (DAR NOTE: The proposed amendment to Rule R414-303 is under DAR No. 38099, the proposed amendment to Rule R414-304 is under DAR No. 38100, and the proposed amendment to Rule R414-305 is under DAR No. 38101 in this issue, November 15, 2013, of the Bulletin.)
♦ LOCAL GOVERNMENTS: There is no impact to local governments because they do not determine Medicaid eligibility for Medicaid recipients.
♦ SMALL BUSINESSES: This amendment does not impose any new costs or requirements on small businesses because they do not make eligibility determinations for the Medicaid program. In addition, this amendment does not affect business revenue because the conversion process to MAGI methodology does not systematically increase or decrease Medicaid eligibility.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: This amendment does not impose any new costs or requirements on Medicaid providers and on Medicaid recipients because it does not affect Medicaid services. In addition, this amendment does not affect provider revenue because the conversion process to MAGI methodology does not systematically increase or decrease Medicaid eligibility.

COMPLIANCE COSTS FOR AFFECTED PERSONS: This amendment does not impose any new costs or requirements on a single Medicaid provider or on a Medicaid recipient because it does not affect Medicaid services. In addition, this amendment does not affect provider revenue because the conversion process to MAGI methodology does not systematically increase or decrease Medicaid eligibility.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The change in eligibility process will not create any systematic change in the number of eligible recipients and will not cause any effect 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 AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 01/01/2014

AUTHORIZED BY: David Patton, PhD, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-306. Program Benefits and Date of Eligibility.
R414-306-4. Effective Date of Eligibility.

(1) Subject to the exceptions in Subsection R414-306-4(3), eligibility for any Medicaid program, and for the Specified Low-income Medicare Beneficiary (SLMB) or Qualified Individual (QI) programs begins the first day of the application month if the individual is determined to meet the eligibility criteria for that month.

(2) An applicant for Medicaid, SLMB or QI benefits may request medical coverage for the retroactive period. The retroactive

period is the three months immediately preceding the month of application.

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

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

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

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

(a) Eligibility of an individual cannot begin any earlier than the date the individual meets the state residency requirement defined in Section R414-302-[~~2~~]4;

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

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

(d) An individual who is ineligible for Medicaid while residing in a public institution or an Institution for Mental Disease (IMD) may become eligible on the date the individual is no longer a resident of either one of these institutions. If an individual is under the age of 22 and is a resident of an IMD, the individual remains a resident of the IMD until he is unconditionally released.

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

(5) The eligibility agency shall determine retroactive eligibility by using the eligibility criteria in effect during the retroactive month. Modified Adjusted Gross Income (MAGI) methodology is effective only on or after January 1, 2014, and the eligibility agency may not apply MAGI methodology before that date.

([~~5~~]6) The agency may use the same application to determine eligibility for the month following the month of application if the applicant is determined ineligible for both the retroactive period and the application month. In this case, the application date changes to the date eligibility begins. The retroactive period associated with the application changes to the three months preceding the new application date.

(7) The effective date of eligibility is January 1, 2014, for applicants who file for eligibility from October 1, 2013, through December 31, 2013, and are not found eligible using 2013 eligibility criteria, but are found eligible for a coverage group using MAGI methodology.

([~~6~~]8) Medicaid eligibility for certain services begins when the individual meets the following criteria:

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

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

([~~7~~]9) An individual determined eligible for QI benefits in a calendar year is eligible to receive those benefits throughout the remainder of the calendar year, if the individual continues to meet the eligibility criteria and the program still exists. Receipt of QI benefits in one calendar year does not entitle the individual to QI benefits in any succeeding year.

([~~8~~]10) After being approved for Medicaid, a client may later request coverage for the retroactive period associated with the approved application if the following criteria are met:

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

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

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

([~~9~~]11) [~~A client cannot request coverage~~]The Department may not provide retroactive coverage if a client requests coverage for the retroactive period associated with a denied application after the date of denial. The client, however, may reapply and the eligibility agency may consider[~~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: [~~November 1, 2010~~]2014
Notice of Continuation: January 23, 2013
Authorizing, and Implemented or Interpreted Law: 26-18

Health, Health Care Financing, Coverage and Reimbursement Policy
R414-307
Eligibility for Home and Community-Based Services Waivers

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38098
FILED: 11/01/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this change is to comply with provisions of the Patient Protection and Affordable Care Act

(PPACA) for eligibility under the home and community-based services waivers for married individuals with a community spouse.

SUMMARY OF THE RULE OR CHANGE: This amendment requires the Department to apply the provisions of Section 1924 of the Social Security Act in determining eligibility and the post-eligibility deductions under the home and community-based services waivers for married individuals with a community spouse for the waiver programs.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Pub. L. No. 111-148 and Section 26-1-5 and Section 26-18-3

MATERIALS INCORPORATED BY REFERENCES:

♦ Adds Section 1917(f) of the Compilation of the Social Security Laws, published by Social Security Administration, 01/01/2013

ANTICIPATED COST OR SAVINGS TO:

♦ THE STATE BUDGET: The impact to the state budget is addressed in the companion rule filing for Rule R414-304. (DAR NOTE: The proposed amendment to Rule R414-304 is under DAR No. 38100 in this issue, November 15, 2013, of the Bulletin.)

♦ LOCAL GOVERNMENTS: There is no impact to local governments because they neither fund Medicaid services nor make eligibility determinations for the Medicaid program.

♦ SMALL BUSINESSES: This amendment does not impose any new costs or requirements because it does not affect services for Medicaid recipients and small businesses do not make eligibility determinations for the Medicaid program. In addition, this amendment does not affect business revenue because the conversion process to MAGI-based methodology does not systematically increase or decrease Medicaid eligibility.

♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Some Medicaid recipients may realize savings roughly equivalent to the anticipated state costs because more individuals will become eligible for Medicaid services. Nevertheless, this amendment does not affect provider revenue because the conversion process to MAGI-based methodology does not systematically increase or decrease Medicaid eligibility.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs because this amendment can only result in out-of-pocket savings to a single Medicaid recipient. Furthermore, this amendment does not affect provider revenue because the conversion process to MAGI-based methodology does not systematically increase or decrease Medicaid eligibility.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The changes may modify individual eligibility but will have no 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 AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 01/01/2014

AUTHORIZED BY: David Patton, PhD, Executive Director

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

R414-307. Eligibility for Home and Community-Based Services Waivers.

R414-307-3. General Requirements for Home and Community-Based Services Waivers.

(1) The Department shall apply the provisions of Sec. 2404 of Pub. L. No. 111 148, Patient Protection and Affordable Care Act, which refers to applying the provisions of Section 1924 of the Social Security Act to married individuals who are eligible for home and community-based waiver services.[~~The following provisions apply to all applicants and recipients of home and community- based services waivers:~~]

([~~1~~]2) To qualify under a home and community-based services waiver, an individual must meet:

(a) the medical eligibility criteria defined in the waiver implementation plan adopted in Rule R414-61 applicable to the specific waiver under which the individual is seeking services, as verified by the referring agency case manager;

(b) the eligibility criteria for one of the Medicaid coverage groups selected for coverage in the specific waiver implementation plan under which the individual is seeking services;[~~and~~]

(c) the non-financial Medicaid criteria defined in Rule R414-302; and

(d) the requirements in this rule applicable to all waiver applicants and recipients, as well as requirements specific to the waiver for which the individual is seeking eligibility.

([~~2~~]3) The provisions found in Rule R414-301 apply to applicants and recipients of home and community-based services waivers.

([~~3~~]4) For individuals claiming a disability, the disability provisions of Rule R414-303 apply.

([~~4~~]5) Except where otherwise stated in this rule, the income provisions of Rule R414-304 apply to waiver applicants and recipients.

([~~5~~]6) Except where otherwise stated in this rule, the resource provisions of Rule R414-305 apply to waiver applicants and recipients.

([~~6~~]7) The benefit provisions of Rule R414-306 apply to waiver applicants and recipients.

([~~7~~]8) The provisions found in Rule R414-308 that apply to eligibility determinations, redeterminations, change reporting, verification, and improper medical assistance also apply to waiver applicants and recipients.

([~~8~~]9) The Department shall limit the number of individuals covered by a home and community-based[~~-~~] services waiver as provided in the adopted waiver implementation plan.

([~~9~~]10) The Department adopts and incorporates by reference, Section 1917(f) of the Social Security Act, effective January 1, 2013.[~~shall not pay for waiver services~~] An individual is ineligible for nursing facility and other long-term care services when an individual has home equity that exceeds the limit set forth [~~by Pub. L. No. 109-171~~]in Section 1917(f).

(a) The Department sets that limit at the minimum level allowed under [~~Pub. L. No. 109-171~~]Section 1917(f).

(b) An individual who has excess home equity and meets eligibility criteria under a community Medicaid eligibility group defined in the Utah Medicaid State Plan may receive Medicaid for services other than long-term care services provided under the plan or the home and community-based waiver[~~-services~~].

(c) An individual who has excess home equity and does not qualify for a community Medicaid eligibility group, is ineligible for Medicaid under both the special income group and the medically needy waiver group.

R414-307-4. Special Income Group.

The following requirements apply to individuals who qualify for a Medicaid home and community-based services waiver under the special income group defined in 42 CFR 435.217 because they do not meet community Medicaid rules but would be eligible for Medicaid if they were living in a medical institution:

(1) If the individual's spouse meets the definition of a community spouse, the eligibility agency shall apply the income and resource provisions defined in Section 1924 of the Social Security Act and Section R414-305-3.

(2) If the individual does not have a spouse, or the individual's spouse does not meet the definition of a community spouse, the eligibility agency may only count the individual's resources to determine eligibility. If both members of a married couple who live together apply for waiver services and meet the criteria for the special income group, the eligibility agency shall count one-half of jointly-held assets as available to each spouse. Each spouse must pass the medically needy resource test for one person.

(3) The eligibility agency may only count income determined under the most closely associated cash assistance program to decide if the individual passes the income eligibility test for the special income group. The eligibility agency may not count income of the individual's spouse except for actual contributions from the spouse.

(4) If the individual is a minor child, the eligibility agency may not count income and resources of the child's parents to decide if the child passes the income and resource tests for the special income group. The eligibility agency shall count actual contributions from a parent, including court-ordered support payments as income of the child.

(5) The individual's income cannot exceed three times the payment that would be made to an individual with no income under Section 1611(b)(1) of the Social Security Act.

(6) The eligibility agency shall apply the transfer of asset provisions of Section 1917 of the Social Security Act[~~, as amended by Pub. L. No. 109-171~~] in effect January 1, 2013.

(7) The individual's cost-of-care contribution [~~is the income amount remaining after post-eligibility deductions for the applicable waiver. The individual must pay the cost-of-care contribution to the eligibility agency each month for Medicaid waiver eligibility~~]is determined by deducting from the individual's total income, the post-eligibility allowances for the specific waiver for which the individual qualifies.

[~~(8) The eligibility agency shall deduct medical expenses incurred by the individual in accordance with Section R414-304-9.~~

] ([~~9~~]8) The eligibility agency shall determine special income group eligibility for an individual starting the month that waiver services begin. The eligibility agency shall determine eligibility for prior months using the community Medicaid or institutional Medicaid rules applicable to the individual's situation.

R414-307-5. Medically Needy Waiver Group.

The following requirements apply to individuals applying for or determined eligible for the New Choices Waiver or the Individuals with Physical Disabilities Waiver who meet the eligibility criteria for a medically needy coverage group defined in 42 CFR 435.301 that the Department has selected for coverage under the implementation plan for the specific waiver:

(1) If an individual's spouse meets the definition of a community spouse, the eligibility agency shall apply the resource provisions defined in Section 1924 of the Social Security Act and Section R414-305-3.

(2) If the individual does not have a spouse or the individual's spouse does not meet the definition of a community spouse, the eligibility agency may only count the individual's resources to determine eligibility. When both members of a married couple who live together apply for waiver services and meet the criteria for the medically needy waiver group, the eligibility agency shall count one-half of jointly-held assets available to each spouse. Each spouse must pass the medically needy resource test for one person.

(3) The eligibility agency may only count income of the individual determined under the most closely associated cash assistance program to decide eligibility for the medically needy waiver group. The eligibility agency may not count income of the individual's spouse except for actual contributions from the spouse.

(4) If the individual is a minor child, the eligibility agency may only count income and resources of the child and may not count income and resources of the child's parents to decide if the child passes the income and resource tests for the medically needy waiver group. The eligibility agency shall count actual contributions from a parent, including court-ordered support payments as income of the child.

(5) The individual's income must exceed three times the payment that would be made to an individual with no income under Section 1611(b)(1) of the Social Security Act.

(6) The eligibility agency shall apply the income deductions allowed by the community Medicaid category under which the individual qualifies. The eligibility agency shall compare countable income to the applicable medically needy income limit for a one-person household to determine the individual's spenddown.

(a) The individual's medical expenses, including the cost of long-term care services, must exceed the spenddown amount.

(b) If an individual does not have a community spouse, [~~T~~]the individual must pay the spenddown to the eligibility agency for Medicaid waiver eligibility.

(c) An individual who has a community spouse is subject to the post-eligibility provisions of Section 1924 of the Social Security Act. The eligibility agency determines the individual's cost-of-care contribution by deducting from the individual's total income, the post-eligibility allowances defined in the implementation plan of the specific waiver for which the individual qualifies.

(7) The eligibility agency [~~shall~~]deducts medical expenses incurred by the individual in accordance with Section R414-304-[~~9~~]11.

(8) The eligibility agency shall determine an individual's eligibility for the medically needy waiver group starting the month that waiver services begin. The eligibility agency shall determine eligibility for prior months using the community Medicaid or institutional Medicaid rules applicable to the individual's situation.

R414-307-6. New Choices Waiver Eligibility Criteria.

[~~The following eligibility requirements apply to the New Choices Waiver:~~

] (1) To qualify for the New Choices Waiver, [~~A~~]an individual must be 65 years of age [~~65~~]or older, or [~~age 18 through age 64~~]at least 18 through 64 years of age and disabled as defined in Section 1614(a)(3) of the Social Security Act. For the purpose of this waiver, an individual is 18 years of age beginning the first month after the month of the individual's 18th birthday.

(2) A[~~n~~] single individual eligible under the special income group, or any married individual with a community spouse, may be required to pay a contribution toward the cost-of- care to receive home and community- based services. The eligibility agency [~~shall~~] determines a client's cost-of-care contribution as follows:

(a) The eligibility agency [~~shall~~]counts all of the client's income unless [~~such~~]the income is excluded under other federal laws that exclude certain income from being counted to determine eligibility for federally-funded, needs-based medical assistance.

(b) The eligibility agency [~~shall~~]deducts the following amounts from the individual's income[~~.~~]:

(i) A personal needs allowance equal to 100% of the federal poverty guideline for a household of one[~~.~~];

(ii) For individuals with earned income, up to $125 of gross-earned income[~~.~~];

(iii) Actual monthly shelter costs not to exceed $300. This deduction includes mortgage, insurance, property taxes, rent, and other shelter expenses[~~.~~];

(iv) A deduction for monthly utility costs equal to the standard utility allowance Utah uses under Section 5(e) of the Food Stamp Act of 1977. If the waiver client shares utility expenses with others, the allowance is prorated accordingly[~~.~~];

(v) In the case of a married individual with a community spouse, [~~A~~]an allowance for a community spouse and dependent family members [~~living~~]who live with the community spouse, in accordance with the provisions of Section 1924 of the Social Security Act[~~.~~];

(vi) In the case of an individual who does not have a community spouse or whose spouse is also eligible for institutional or waiver services, an allowance for a dependent family member that is equal to one-third of the difference between the minimum monthly spousal needs allowance defined in Section 1924 of the Social Security Act and the family member's monthly income. If more than one individual who qualifies for a Medicaid home and community-based waiver or institutional Medicaid coverage contributes income to the dependent family member, the combined income deductions of [~~such~~]these individuals cannot exceed one-third of the difference between the minimum monthly spousal needs allowance and the family member's monthly income[~~.~~];

(vii) Medical and remedial care expenses incurred by the individual in accordance with Section R414-304-[~~9~~]11.

(c) The income deduction to provide an allowance to a spouse or a dependent family member cannot exceed the amount the individual actually gives to such spouse or dependent family member.

(d) The remaining amount of income after [~~such~~]these deductions is the individual's cost-of-care contribution.

(3) The individual must pay the contribution to cost-of-care to the eligibility agency each month to receive home and community-based services.

[~~(4) The eligibility agency shall count parental and spousal income only if the client receives a cash contribution from a parent or spouse.~~

]

R414-307-7. Community Supports Home and Community-Based Services Waiver for Individuals with Intellectual Disabilities and Other Related Conditions.

(1) Medicaid eligibility for the Community Supports Home and Community-Based Services waiver is limited to individuals with intellectual disabilities and other related conditions.

(2) An individual's resources must be equal to or less than the Medicaid resource limit applicable to an institutionalized person. The spousal impoverishment resource provisions for married, institutionalized individuals in Section R414-305-3 apply to a married individual.

(3) An eligible individual may be required to pay a contribution toward the cost-of- care to receive home and community-based services. The eligibility agency shall determine an individual's cost-of-care contribution as follows:

(a) The eligibility agency shall count all of the individual's income unless such income is excluded under other federal laws that exclude certain income from being counted to determine eligibility for federally-funded, needs-based medical assistance.

(b) The eligibility agency shall deduct the following amounts from the individual's income:

(i) For an individual with earned income, earned income up to the substantial gainful activity level of earnings defined in Section 223(d)(4) of the Compilation of the Social Security Laws in effect April 4, 2012, to determine countable earned income.

(ii) A personal needs allowance for the individual equal to 100% of the federal poverty level for one person.

(iii) In the case of a married individual with a community spouse, [~~A~~]a deduction for a community spouse and dependent family members living with the community spouse in accordance with the provisions of Section 1924 of the Social Security Act.

(iv) In the case of an individual who does not have a community spouse or whose spouse is also eligible for institutional or waiver services, an allowance for a dependent family member that is equal to one-third of the difference between the minimum monthly spousal needs allowance defined in Section 1924 of the Social Security Act and the family member's monthly income. If more than one

individual who qualifies for a Medicaid home and community-based waiver or institutional Medicaid coverage contributes income to the dependent family member, the combined income deductions of such individuals cannot exceed one-third of the difference between the minimum monthly spousal needs allowance and the family member's monthly income.

(v) Health insurance premiums for the waiver-eligible recipient paid by the recipient, or medical expenses incurred by the recipient in accordance with Section R414-304-[9]11.

(c) The income deduction to provide an allowance to a spouse or a dependent family member cannot exceed the amount the individual actually gives to such spouse or dependent family member.

(d) The remaining amount of income after such deductions is the individual's cost-of-care contribution.

(4) The individual must pay the contribution to cost-of-care to the eligibility agency each month to receive home and community-based services.

(5) The eligibility agency shall count parental and spousal income only if the individual receives a cash contribution from a parent or spouse.

(6) The provisions of Section R414-305-[8]9 concerning transfers of assets apply to individuals seeking eligibility or receiving benefits under this home and community-based services waiver.

R414-307-8. Home and Community-Based Services Waiver for Individuals Age 65 and Older.

(1) Medicaid eligibility for Home and Community-Based Services for individuals [~~age~~]65 years of age and older is limited to individuals eligible for Aged Medicaid who could qualify for skilled nursing home care.

(2) A client's resources must be equal to or less than the Medicaid resource limit applicable to an institutionalized person. The spousal impoverishment resource provisions for married, institutionalized individuals in Section R414-305-3 apply to a married individual.

(3) An eligible client may be required to pay a contribution toward the cost-of-care to receive home and community-based services. The eligibility agency shall determine a client's cost-of-care contribution as follows:

(a) The eligibility agency shall count all income unless such income is excluded under other federal laws that exclude certain income from being counted to determine eligibility for federally-funded, needs-based medical assistance. The eligibility agency shall count a spouse's income only if the client receives a cash contribution from a spouse.

(b) The eligibility agency shall deduct the following amounts from the individual's income:

(i) A personal needs allowance for the individual equal to 100% of the federal poverty level for one person[-];

(ii) For individuals with earned income, up to $125 of gross-earned income[-];

(iii) [~~An allowance for shelter expenses as defined in the waiver implementation plan.~~]Actual monthly shelter costs not to exceed $300. This deduction includes mortgage, insurance, property taxes, rent, and other shelter expenses;

(iv) A deduction for monthly utility costs equal to the standard utility allowance Utah uses under Section 5(e) of the Food Stamp Act of 1977. If the waiver client shares utility expenses with others, the allowance is prorated accordingly;

(v) In the case of a married individual with a community spouse, a deduction for a community spouse and dependent family members who live with the community spouse in accordance with the provisions of Section 1924 of the Social Security Act;

[~~(iv) A deduction for a community spouse and dependent family members under the spousal impoverishment provisions for Institutional Medicaid defined in Section R414-304-10.~~

] (vi) In the case of an individual who does not have a community spouse or whose spouse is also eligible for institutional or waiver services, an allowance for a dependent family member that is equal to one-third of the difference between the minimum monthly spousal needs allowance defined in Section 1924 of the Social Security Act and the family member's monthly income. If more than one individual who qualifies for a Medicaid home and community-based waiver or institutional Medicaid coverage contributes income to the dependent family member, the combined income deductions of such individuals cannot exceed one-third of the difference between the minimum monthly spousal needs allowance and the family member's monthly income[-];

(vii) Health insurance premiums for the waiver-eligible recipient paid by the recipient, or medical expenses incurred by the recipient in accordance with Section R414-304-[9]11.

(c) The income deduction to provide an allowance to a spouse or a dependent family member cannot exceed the amount the individual actually gives to such spouse or dependent family member.

(d) The remaining amount of income after such deductions is the individual's cost-of-care contribution.

(4) The individual must pay the contribution to cost-of-care to the eligibility agency each month to receive home and community-based services.

(5) The provisions of Section R414-305-[8]9 concerning transfers of assets apply to individuals seeking eligibility or receiving benefits under this home and community-based services waiver.

R414-307-10. Home and Community-Based Services Waiver for Individuals with Acquired Brain Injury.

(1) To qualify for services under this waiver, the individual must be at least 18 years of age. The person is considered to be 18 years of age in the month in which the 18th birthday falls.

(2) All other eligibility requirements follow the rules for the Home and Community-Based Services Waiver for Aged Individuals found in Section R414-307-8, except for Subsection R414-307-8(1).

R414-307-11. Home and Community-Based Services Waiver for Individuals with Physical Disabilities.

(1) To qualify for the waiver for individuals with physical disabilities, the individual must meet non-financial criteria for Aged, Blind, or Disabled Medicaid.

(2) A client's resources must be equal to or less than $2000. The spousal impoverishment resource provisions for married, institutionalized clients in Section R414-305-3 apply to this rule.

(3) Countable income is determined using income rules of Aged, Blind, or Disabled Institutional Medicaid. The eligibility agency [~~shall~~]counts all income unless [~~such~~]the income is excluded under other federal laws that exclude certain income from being counted to determine eligibility for federally-funded, needs-based medical assistance. Eligibility is determined counting only the gross income of the client.

(4) The eligibility agency [~~shall~~]counts a spouse's income only if the client receives a cash contribution from a spouse.

(5) An individual whose income does not exceed 300% of the federal benefit rate, or any married individual with a community spouse may be required to pay a cost-of-care contribution. The following provisions apply to the determination of cost-of-care contribution.

(a) The eligibility agency counts all of the client's income except income that is excluded under other federal laws from being counted to determine eligibility for federally-funded, needs-based medical assistance.

(b) The eligibility agency deducts the maximum allowance available, which is a personal needs allowance equal to 300% of the federal benefit rate payable under Section 1611(b)(1) of the Social Security Act for an individual with no income. No other deductions from income are allowed.

([~~5~~]6) [~~The client's income cannot~~]An individual who does not have a community spouse and whose income exceeds three times the [~~SSI~~]federal benefit [~~amount~~]rate payable under Section 1611(b)(1) of the Social Security Act[~~, except that individuals with income over this amount can~~]may pay a spenddown to become eligible. To determine the spenddown amount, the income rules and medically needy income standard for non-institutionalized aged, blind or disabled individuals in Rule R414-304 apply except that income is not deemed from the client's spouse.

[~~(6) The eligibility agency may not assess a cost-of-care contribution for an individual with income that does not exceed three times the SSI benefit amount.~~

] (7) The provisions of Section R414-305-[~~8~~]9 concerning transfers of assets apply to individuals seeking eligibility or receiving benefits under this home and community-based services waiver.

KEY: eligibility, waivers, special income group
Date of Enactment or Last Substantive Amendment: [~~October 1, 2012~~]2014
Notice of Continuation: April 17, 2012
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3

Health, Health Care Financing, Coverage and Reimbursement Policy
R414-308
Application, Eligibility Determinations and Improper Medical Assistance

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38097
FILED: 11/01/2013

RULE ANALYSIS
PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this change is to comply with provisions of the Patient Protection and Affordable Care Act (PPACA) that relate to the treatment of applications and reviews for Modified Adjusted Gross Income (MAGI) and non-MAGI coverage groups.

SUMMARY OF THE RULE OR CHANGE: This amendment defines the general provisions for accepting and processing applications, making eligibility determinations, and processing reviews for MAGI-based and non-MAGI-based coverage groups. This amendment also addresses the process for applications received from 10/01/2013, through 12/31/2013, in relation to denied applications and a redetermination of eligibility using the new MAGI-based methodology. This amendment also updates incorporations by reference and makes other technical changes.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Pub. L. No. 111-148 and Section 26-1-5 and Section 26-18-3

MATERIALS INCORPORATED BY REFERENCES:
- ♦ Updates 42 CFR 431.206, published by Government Printing Office, 10/01/2012
- ♦ Updates 42 CFR 431.210, published by Government Printing Office, 10/01/2012
- ♦ Updates 42 CFR 431.211, published by Government Printing Office, 10/01/2012
- ♦ Updates 42 CFR 431.213, published by Government Printing Office, 10/01/2012
- ♦ Adds 42 CFR 435.916, published by Government Printing Office, 10/01/2012
- ♦ Adds 42 CFR 435.911, published by Government Printing Office, 10/01/2012
- ♦ Adds 42 CFR 435.907, published by Government Printing Office, 10/01/2012
- ♦ Updates 42 CFR 431.214, published by Government Printing Office, 10/01/2012
- ♦ Adds 78 FR 42303, published by Government Printing Office, 07/15/2013
- ♦ Adds 42 CFR 435.912, published by Government Printing Office, 10/01/2012
- ♦ Adds 42 CFR 435.919, published by Government Printing Office, 10/01/2012

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: The impact to the state budget is addressed in the companion rule filing for Rule R414-304. (DAR NOTE: The proposed amendment to Rule R414-304 is under DAR No. 38100 in this issue, November 15, 2013, of the Bulletin.)
♦ LOCAL GOVERNMENTS: There is no impact to local governments because they neither fund Medicaid services nor make eligibility determinations for the Medicaid program.
♦ SMALL BUSINESSES: This amendment does not impose any new costs or requirements because it does not affect services for Medicaid recipients and small businesses do not make eligibility determinations for the Medicaid program. In addition, this amendment does not affect business revenue because the conversion process to MAGI-based methodology does not systematically increase or decrease Medicaid eligibility.

♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Some Medicaid recipients may realize savings roughly equivalent to the anticipated state costs because more individuals will become eligible for Medicaid services. Nevertheless, this amendment does not affect provider revenue because the conversion process to MAGI-based methodology does not systematically increase or decrease Medicaid eligibility.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs because this amendment can only result in out-of-pocket savings to a single Medicaid recipient. Furthermore, this amendment does not affect provider revenue because the conversion process to MAGI-based methodology does not systematically increase or decrease Medicaid eligibility.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The changes may modify individual eligibility but will have no 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 AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 01/01/2014

AUTHORIZED BY: David Patton, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-308. Application, Eligibility Determinations and Improper Medical Assistance.
R414-308-1. Authority and Purpose.

(1) This rule is authorized by Section 26-18-3.

(2) The purpose of this rule is to establish requirements for medical assistance applications, eligibility decisions and reviews, eligibility period, verifications, change reporting, notification and improper medical assistance for Medicaid and Medicare cost sharing programs.[~~the following programs:~~

~~(a) Medicaid;~~

~~(b) Qualified Medicare Beneficiaries;~~

~~(c) Specified Low-Income Medicare Beneficiaries; and~~

~~(d) Qualified Individuals.~~]

R414-308-2. Definitions.

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

(2) In addition, the following definitions apply:

(a) [~~"Cost-of-care" means the amount of income that an institutionalized individual must pay to the medical facility for long-term care services based on the individual's income and allowed deductions.~~

~~(b) "Department" means the Utah Department of Health.~~

~~(c)~~]"Due date" means the date that a recipient is required to report a change or provide requested verification to the eligibility agency.

[~~(d) "Due process month" means the month that allows time for the recipient to return all verification, and for the eligibility agency to determine eligibility and notify the recipient.~~

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

] ([~~f~~]b) "Eligibility review" means a process by which the eligibility agency reviews current information about a recipient's circumstances to determine whether the recipient is still eligible for medical assistance.

([~~g~~]c) "Open enrollment" means a period of time when the eligibility agency accepts applications.

R414-308-3. Application and Signature.

(1) The Department adopts and incorporates by reference, 42 CFR 435.907, October 1, 2012 ed., concerning the application requirements for medical assistance programs.[~~An individual may apply for medical assistance by completing and signing under penalty of perjury any Department-approved application form for medical assistance and delivering it to the eligibility agency. If available, an individual may complete an on-line application for medical assistance and send it electronically to the eligibility agency.~~]

(a) The applicant or authorized representative must complete and sign the application under penalty of perjury. If an applicant cannot write, the applicant must make his mark on the application form and have at least one witness to the signature.

(b) [~~When completing an on-line application, the individual must either send the eligibility agency an original signature on a printed signature page, or if available on-line, submit an electronic signature that conforms with state law for electronic signatures.~~

~~(c)~~]A representative may apply on behalf of an individual. A representative may be a legal guardian, a person holding a power of attorney, a representative payee or other responsible person acting on behalf of the individual. In this case, the eligibility agency may send notices, requests and forms to both the individual and the individual's representative, or to just the individual's representative. The eligibility agency may assign someone to act as the authorized representative when the individual requires help to apply and cannot appoint a representative.

([~~d~~]c) If the Division of Child and Family Services (DCFS) has custody of a child and the child is placed in foster care, DCFS completes the application. DCFS determines eligibility for the child pursuant to a written agreement with the Department. DCFS also

determines eligibility for children placed under a subsidized adoption agreement. The Department does not require an application for Title IV-E eligible children.

[~~(c) An authorized representative may apply for the individual if unusual circumstances or death prevent an individual from applying on his own. The individual must sign the application form if possible. If the individual cannot sign the application, the representative must sign the application. The eligibility agency may assign someone to act as the authorized representative when the individual requires help to apply and cannot appoint a representative.~~

~~(2) The application date is the day that the eligibility agency receives the request or verification from the recipient. The eligibility agency treats the following situations as a new application without requiring a new application form. The effective date of eligibility for these situations depends on the rules for the specific program:~~

~~(a) A household with an open medical assistance case asks to add a new household member by contacting the eligibility agency;~~

~~(b) The eligibility agency ends medical assistance when the recipient fails to return requested verification, and the recipient provides all requested verification to the eligibility agency before the end of the calendar month that follows the closure date. The eligibility agency waives the open enrollment period requirement during that calendar month for programs subject to open enrollment;~~

~~(c) A medical assistance program other than PCN ends due to an incomplete review, and the recipient responds to the review request in the calendar month that follows the closure date. The provisions of Section R414-310-14 apply to recertification for PCN enrollment;~~

~~(d) Except for PCN and UPP that are subject to open enrollment periods, the eligibility agency denies an application when the applicant fails to provide all requested verification, but provides all requested verification within 30 calendar days of the denial notice date. The new application date is the date that the eligibility agency receives all requested verification and the retroactive period is based on that date. The eligibility agency does not act if it receives verification more than 30 calendar days after it denies the application. The recipient must complete a new application to reapply for medical assistance;~~

~~(e) For PCN and UPP applicants, the eligibility agency denies an application when the applicant fails to provide all requested verification, but provides all requested verification within 30 calendar days of the denial notice date and the eligibility agency has not stopped the open enrollment period. If the eligibility agency has stopped enrollment, the applicant must wait for an open enrollment period to reapply.~~

~~(3) If a medical assistance case closes for one or more calendar months, the recipient must complete a new application form to reapply.~~

~~(4) A child under the age of 19, or a pregnant woman who is eligible for a presumptive eligibility period, must file an application for medical assistance with the eligibility agency in accordance with the requirements of Sections 1920 and 1920A of the Social Security Act.~~

~~(5) The eligibility agency shall process low-income subsidy application data transmitted from the Social Security Administration (SSA) in accordance with 42 U.S.C. Sec. 1935(a)(4) as an application for Medicare cost sharing programs. The eligibility agency shall take appropriate steps to gather the required information and verification from the applicant to determine the applicant's eligibility.~~

~~(a) Data transmitted from SSA is not an application for Medicaid.~~

~~(b) An individual who wants to apply for Medicaid when contacted for information to process the application for Medicare cost-sharing programs must complete and sign a Department-approved application form for medical assistance. The date of application for Medicaid is the date that the eligibility agency receives the application for Medicaid.~~

] ([~~6~~]2) The application date for medical assistance is the date that the eligibility agency receives the application during normal business hours on a week day that does not include Saturday, Sunday or a state holiday except as described below:

(a) When the individual applies through the federally facilitated marketplace (FFM) and the application is transferred from the FFM for a Medicaid eligibility determination, the date of application is the date the individual applies through the FFM.

([~~a~~]b) If the application is delivered to the eligibility agency after the close of business, the date of application is the next business day;

([~~i~~]c) If the applicant delivers the application to an outreach location during normal business hours, the date of application is that business day when outreach staff is available to receive the application. [~~;~~

~~(ii)~~] If the applicant delivers the application to an outreach location on a non-business day or after normal business hours, the date of application is the last business day that a staff person from the eligibility agency was available at the outreach location to receive or pick up the application;

([~~b~~]d) When the eligibility agency receives application data transmitted from the Social Security Administration (SSA) pursuant to the requirements of 42 U.S.C. Sec. [~~1396u-5(a)(4)~~]1320b-14(c), the eligibility agency shall use the date that the individual submits the application for the low-income subsidy to the SSA as the application date for Medicare cost sharing programs. The application processing period for the transmitted data begins on the date that the eligibility agency receives the transmitted data. The transmitted data meets the signature requirements for applications for Medicare cost sharing programs;

([~~e~~]e) If an application is filed through the "myCase" system, the date of application is the date the application is submitted to the eligibility agency online.

([~~7~~]3) The eligibility agency shall accept a signed application that an applicant sends by facsimile as a valid application.

([~~8~~]4) If an applicant submits an unsigned or incomplete application form to the eligibility agency, the eligibility agency shall notify the applicant that he must sign and complete the application no later than the last day of the application processing period. The eligibility agency shall send a signature page to the applicant and give the applicant at least ten days to sign and return the signature page. When the application is incomplete, the eligibility agency shall notify the applicant of the need to complete the application and offer ways to complete the application.

(a) The date of application for an incomplete or unsigned application form is the date that the eligibility agency receives the application if the agency receives a signed signature page and completed application within the application processing period.

(b) If the eligibility agency does not receive a signed signature page and completed application form within the application processing period, the application is void and the eligibility agency shall send a denial notice to the applicant.

(c) If the eligibility agency receives a signed signature page and completed application within 30 calendar days after the notice of denial date, the date of receipt is the new application date and the provisions of Section R414-308-[~~6~~]3(2) apply.

(d) If the eligibility agency receives a signed signature page and completed application more than 30 calendar days after it sends the denial notice, the applicant must reapply by completing and submitting a new application form. The new application date is determined in accordance with this rule[~~when the eligibility agency receives a new application~~].

(5) The eligibility agency treats the following situations as a new application without requiring a new application form. The application date is the day that the eligibility agency receives the request or verification from the recipient. The effective date of eligibility for these situations depends on the rules for the specific program:

(a) A household with an open medical assistance case asks to add a new household member by contacting the eligibility agency;

(b) The eligibility agency ends medical assistance when the recipient fails to return requested verification, and the recipient provides all requested verification to the eligibility agency before the end of the calendar month that follows the closure date. The eligibility agency waives the requirement for the open enrollment period during that calendar month for programs subject to open enrollment;

(c) A medical assistance program other than PCN ends due to an incomplete review, and the recipient responds to the review request within the three calendar months that follow the closure date. The provisions of Section R414-310-14 apply to recertification for PCN enrollment;

(d) Except for PCN and UPP that are subject to open enrollment periods, the eligibility agency denies an application when the applicant fails to provide all requested verification, but provides all requested verification within 30 calendar days of the denial notice date. The new application date is the date that the eligibility agency receives all requested verification and the retroactive period is based on that date. The eligibility agency does not act if it receives verification more than 30 calendar days after it denies the application. The recipient must complete a new application to reapply for medical assistance;

(e) For PCN and UPP applicants, the eligibility agency denies an application when the applicant fails to provide all requested verification, but provides all requested verification within 30 calendar days of the denial notice date and the eligibility agency has not stopped the open enrollment period. If the eligibility agency has stopped enrollment, the applicant must wait for an open enrollment period to reapply.

(6) The eligibility agency shall use the 2013 eligibility criteria in effect from October 1, 2013, through December 31, 2013, when considering applications that it receives during that time period. The agency may also use the three-month retroactive period.

(7) For an individual who applies for and is found ineligible for Medicaid from October 1, 2013, and December 31, 2013, the eligibility agency shall redetermine eligibility under the policies that become effective January 1, 2014, using the modified adjusted gross income (MAGI)-based methodology without requiring a new application.

(a) Medicaid eligibility may begin no earlier than January 1, 2014, for an individual who becomes eligible using the MAGI-based methodology;

(b) For applications received on or after January 1, 2014, the eligibility agency shall apply the MAGI-based methodology first to determine Medicaid eligibility.

(c) The eligibility agency shall determine eligibility for other Medicaid programs that do not use MAGI-based methodology if the individual meets the categorical requirements of these programs, which may include a medically needy eligibility group for individuals found ineligible using the MAGI-based methodology.

(8) If a medical assistance case closes for one or more calendar months, the recipient must complete a new application form to reapply, except as defined in Subsection R414-308-6(7).

(9) An individual determined eligible for a presumptive eligibility period must file an application for medical assistance with the eligibility agency in accordance with the requirements of Sections 1920, 1920A and 1920B of the Social Security Act.

(10) The eligibility agency shall process low-income subsidy application data transmitted from SSA in accordance with 42 U.S.C. Sec. 1320b-14(c) as an application for Medicare cost sharing programs. The eligibility agency shall take appropriate steps to gather the required information and verification from the applicant to determine the applicant's eligibility.

(a) Data transmitted from SSA is not an application for Medicaid.

(b) An individual who wants to apply for Medicaid when contacted for information to process the application for Medicare cost sharing programs must complete and sign a Department-approved application form for medical assistance. The date of application for Medicaid is the date that the eligibility agency receives the application for Medicaid.

R414-308-5. Eligibility Decisions or Withdrawal of an Application.

(1) The Department adopts and incorporates by reference 42 CFR 435.911, 435.912 and 435.919, October 1, 2012 ed., regarding eligibility determinations and timely determinations.[~~The eligibility agency shall determine whether the applicant is eligible within the time limits established in 42 CFR 435.911, 2010 ed., which is incorporated by reference.~~] The eligibility agency shall provide proper notice about a recipient's eligibility, changes in eligibility, and the recipient's right to request a fair hearing in accordance with the provisions of 78 FR 42303, which is incorporated by reference and 42 CFR 431.206, 431.210, 431.211, 431.213, 431.214, [~~2010~~]October 1, 2012 ed., [~~which are incorporated by reference; and 42 CFR 435.912 and 435.919, 2010 ed.,~~] which are incorporated by reference.

(2) The eligibility agency shall extend the time limit if the applicant asks for more time to provide requested information before the due date. The eligibility agency shall give the applicant at least ten more days after the original due date to provide verifications upon the applicant's request. The eligibility agency may allow a longer period of time for the recipient to provide verifications if the agency determines that the delay is due to circumstances beyond the recipient's control.

(3) If an individual who is determined presumptively eligible files an application for medical assistance in accordance with the requirements of Sections 1920 and 1920A of the Social Security Act, the eligibility agency shall continue presumptive eligibility until it makes an eligibility decision based on that application. The filing of additional applications by the individual does not extend the presumptive eligibility period.

(4) An applicant may withdraw an application for medical assistance any time before the eligibility agency makes an eligibility decision. An individual requesting an assessment of assets for a married couple under 42 U.S.C. 1396r-5 may withdraw the request any time before the eligibility agency completes the assessment.

R414-308-6. Eligibility Period and Reviews.

(1) The eligibility period begins on the effective date of eligibility as defined in Section R414-306-4, which may be after the first day of a month, subject to the following requirements.

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

(i) a spenddown of excess income for medically needy Medicaid coverage;

(ii) a Medicaid Work Incentive (MWI) premium; or

(iii) [~~an asset copayment for poverty level, pregnant woman coverage; and~~

~~(iv)~~]a cost-of-care contribution for home and community-based waiver services.

(b) A required spenddown, MWI premium, or cost-of-care contribution is due each month for a recipient to receive Medicaid coverage.[~~A recipient must pay an asset copayment before eligibility is granted for poverty level, pregnant woman coverage.~~]

(c) The recipient must make the payment or provide proof of medical expenses within 30 calendar days from the mailing date of the application approval notice, which states how much the recipient owes.

(d) For ongoing months of eligibility, the recipient has until the close of business on the tenth day of the month after the benefit month to meet the spenddown or the cost-of-care contribution for waiver services, or to pay the MWI premium. If the tenth day of the month is a non-business day, the recipient has until the close of business on the first business day after the tenth. Eligibility begins on the first day of the benefit month once the recipient meets the required payment. If the recipient does not meet the required payment by the due date, the recipient may reapply for retroactive benefits if that month is within the retroactive period of the new application date.

(e) A recipient who lives in a long-term care facility and owes a cost-of-care contribution to the medical facility must pay the medical facility directly. The recipient may use unpaid past medical bills, or current incurred medical bills other than the charges from the medical facility, to meet some or all of the cost-of-care contribution subject to the limitations in Section R414-304-9. An unpaid cost-of-care contribution is not allowed as a medical bill to reduce the amount that the recipient owes the facility.

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

[~~(g) Eligibility for the poverty level, pregnant woman program does not exist when the recipient fails to pay a required asset copayment.~~

] ([~~h~~]g) The eligibility agency shall continue eligibility for a resident of a nursing home even when an eligible resident fails to pay the nursing home the cost-of-care contribution. The resident, however, must continue to meet all other eligibility requirements.

(2) The eligibility period ends on:

(a) the last day of the month in which the eligibility agency determines that the recipient is no longer eligible for medical assistance and sends proper closure notice;

(b) the last day of the month in which the eligibility agency sends proper closure notice when the recipient fails to provide required information or verification to the eligibility agency by the due date;

(c) the last day of the month in which the recipient asks the eligibility agency to discontinue eligibility, or if benefits have been issued for the following month, the end of that month;

(d) for time-limited programs, the last day of the month in which the time limit ends;

(e) for the [~~poverty level,~~]pregnant woman program, the last day of the month which is at least 60 days after the date [~~that~~]the pregnancy ends, except that for [~~poverty level,~~]pregnant woman coverage for emergency services only, eligibility ends on the last day of the month in which the pregnancy ends; or

(f) the date [~~that~~]the individual dies.

(3) A presumptive eligibility period begins on the day [~~that~~] the qualified entity determines an individual to be presumptively eligible. The presumptive eligibility period shall end on the earlier of:

(a) the day [~~that~~]the eligibility agency makes an eligibility decision for medical assistance based on the individual's application when that application is filed in accordance with the requirements of Sections 1920 and 1920A of the Social Security Act; or

(b) in the case of an individual who does not file an application in accordance with the requirements of Sections 1920 and 1920A of the Social Security Act, the last day of the month that follows the month in which the individual becomes presumptively eligible.

(4) For an individual selected for coverage under the Qualified Individuals Program, the eligibility agency shall extend eligibility through the end of the calendar year if the individual continues to meet eligibility criteria and the program still exists.

(5) The eligibility agency shall complete a periodic review of a recipient's eligibility for medical assistance in accordance with the requirements of 42 CFR 435.916, October 1, 2012 ed., which the Department adopts and incorporates by reference, at least once every 12 months. The eligibility agency shall review factors that are subject to change to determine if the recipient continues to be eligible for medical assistance.

(6) For non-MAGI-based coverage groups, [~~T~~]the eligibility agency may complete an eligibility review more frequently when it:

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

(b) knows the recipient has fluctuating income;

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

(d) needs to meet workload demands.

[~~(7) The eligibility agency shall use available, reliable sources to gather information needed to complete the review. The eligibility agency may complete an eligibility review without requiring the recipient to provide additional information.~~

] ([8]7) [~~The eligibility agency may ask the recipient to respond to a request to complete the review process during the review month.~~]If [~~the~~]a recipient fails to respond to [~~the~~]a request for

information to complete the review, the eligibility agency shall end eligibility effective at the end of the review month and send proper notice to the recipient.

(a) If the recipient responds to the review or reapplies [~~in the month that follows the review month~~]within three calendar months of the review closure date, the eligibility agency shall consider the response to be a new application without requiring the client to reapply. The application processing period shall apply for the new request for coverage.

[~~(a) The eligibility agency may ask the recipient for verification to redetermine eligibility.~~

~~(b) Upon receiving the verification, the eligibility agency shall redetermine eligibility and notify the recipient.~~

] ([~~i~~]b) If the recipient becomes eligible based on this reapplication, the recipient's eligibility becomes effective the first day of the month after the closure date if verification is provided timely.[

~~(ii)~~] If the recipient fails to return verification [~~within the application processing period~~]timely or if the recipient is determined to be ineligible, the eligibility agency shall send a denial notice to the recipient.

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

[~~(d) If the case is closed for one or more calendar months, the recipient must reapply.~~

~~(9) If the recipient responds to the request during the review month, the eligibility agency may request verification from the recipient.~~

~~(a) The eligibility agency shall send a written request for the necessary verification.~~

~~(b) The recipient has at least ten calendar days from the notice date to provide the requested verification to the eligibility agency.~~

~~(10) If the recipient responds to the review and provides all verification by the due date within the review month, the eligibility agency shall determine eligibility and notify the recipient of its decision.~~

] ([~~a~~]8) If the eligibility agency sends proper notice of an adverse decision in the review month, the agency shall change eligibility for the following month.

([~~b~~]9) If the eligibility agency does not send proper notice of an adverse change for the following month, the agency shall extend eligibility to the following month. [~~This additional month of eligibility is called the due process month.~~]Upon completing an eligibility determination, the eligibility agency shall send proper notice of the effective date of any adverse decision.

(1[~~1~~]0) If the recipient responds to the review in the review month and the verification due date is in the following month, the eligibility agency shall extend eligibility to the [~~due process~~]following month. The recipient must provide all verification by the verification due date.

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

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

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

(1[~~2~~]1) The eligibility agency shall provide ten-day notice of case closure if the recipient is determined ineligible or if the recipient fails to provide all verification by the verification due date.

(1[~~3~~]2) The eligibility agency may not extend coverage under certain medical assistance programs in accordance with state and federal law. The agency shall notify the recipient before the effective closure date.

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

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

R414-308-7. Change Reporting and Benefit Changes.

(1) A recipient must report to the eligibility agency reportable changes in the recipient's circumstances. Reportable changes are defined in Section R414-301-2.

(a) The due date for reporting changes is the close of business ten calendar days after the recipient learns of the change.

(b) When the change is receipt of income from a new source, or an increase in income for the recipient, the due date for reporting the income change is the close of business ten calendar days after the change.

(c) The date of report is the date that the recipient reports the change to the eligibility agency during normal business hours, or the date that the eligibility agency receives the information from another source.

(d) The agency shall accept change reports transferred from other insurance affordability programs.

(2) The eligibility agency may receive information from credible sources other than the recipient such as computer income matches and from anonymous citizen reports. The eligibility agency shall verify information from other sources that may affect the recipient's eligibility before using the information to change the recipient's eligibility for medical assistance. The eligibility agency shall verify information from citizen reports through other reliable proofs.

(3) If the eligibility agency needs verification from the recipient, the agency shall send the recipient a written request. The eligibility agency shall give the recipient at least ten calendar days from the notice date to respond. The due date for providing verification of changes is the close of business on the date that the eligibility agency sets as the due date in a written notice to the recipient.

(4) A recipient must provide change reports, forms or verifications to the eligibility agency by the close of business on the due date.

(5) If the information about a change causes an increase in a recipient's benefits and the eligibility agency asks the recipient for verification, the eligibility agency shall increase benefits as follows:

(a) An increase in benefits is effective on the first day of the month after the change report month if the recipient returns all verification within ten calendar days of the request date or by the end of the change report month, if longer;

(b) An increase in benefits is effective on the first day of the month after the date that the eligibility agency receives all verification if the recipient does not return verification by the due date, but returns verification in the calendar month that follows the report month.

(6) If the reported information causes an increase in a recipient's benefits and the eligibility agency does not request verification, the increase in benefits is effective on the first day of the month that follows the change report month.

(7) If a change adversely affects the recipient's eligibility for benefits, the eligibility agency shall change the effective date of eligibility to the first day of the month after the month in which it sends proper notice of the change.

(a) The eligibility agency shall change the effective date if it has enough information to adjust benefits, regardless of whether the recipient returns verification.

(b) The eligibility agency shall send a written request to the recipient for verification if it does not have enough information to adjust benefits. The recipient has at least ten days after the date of the request to return verification.

(i) Upon receiving verification, the eligibility agency shall adjust benefits to become effective on the first day of the month after the agency sends proper notice.

(ii) If the recipient does not return verification timely, the eligibility agency shall discontinue benefits after the month in which the agency sends proper notice.

(8) If the recipient returns all requested verification related to a change report in the month that follows the effective closure date, the eligibility agency shall treat the date of receipt as an application date and may not require the recipient to complete a new application form. The eligibility agency shall review the verification to determine whether the recipient is still eligible and notify the recipient of its decision. The eligibility agency may not change the review date unless it updates all factors of eligibility.

(9) If the eligibility agency cannot determine the effect of a change without verification from the recipient, the agency shall discontinue benefits if it does not receive the requested verification by the due date. If a change does not affect all household members and the recipient does not return verification, the eligibility agency shall discontinue benefits only for those individuals affected by the change.

(10) An overpayment may occur if the recipient does not report changes timely, or if the recipient does not return verification by the verification due date.

(a) The eligibility agency shall determine whether an overpayment has occurred based on when the agency could have made the change if the recipient had reported the change on time or returned verification by the due date.

(b) If a recipient fails to report a change timely or return verification or forms by the due date, the recipient must repay all services and benefits paid by the Department for which the recipient is ineligible.

(11) If a due date falls on a non-business day, the due date is the close of business on the next business day.

R414-308-8. Case Closure and Redetermination.

(1) The eligibility agency shall end medical assistance when the recipient requests the agency to close his case, when the recipient fails to respond to a request to complete the eligibility review, when the recipient fails to provide all verification needed to determine continued eligibility, or when the agency determines that the recipient is no longer eligible.

(2) If a recipient fails to complete the review process in accordance with Section R414-308-6, the eligibility agency shall close the case and notify the recipient.

(3) Before terminating a recipient's medical assistance, the eligibility agency shall determine whether the recipient is eligible for any other available medical assistance provided under Medicaid, the Medicare Cost Sharing programs, the Children's Health Insurance Program (CHIP), the Primary Care Network (PCN), and Utah's Premium Partnership for Health Insurance (UPP).

(a) The eligibility agency may not require a recipient to complete a new application to make the redetermination. The agency, however, may request more information from the recipient to determine whether the recipient is eligible for other medical assistance programs. If the recipient does not provide the necessary information by the close of business on the due date, the recipient's medical assistance ends.

(b) When determining eligibility for other programs, the eligibility agency may only enroll an individual in a medical assistance program during an open enrollment period, or when that program allows a person who becomes ineligible for Medicaid to enroll during a period when enrollment is closed. Open enrollment applies only to the PCN and UPP programs.

(4) The eligibility agency shall comply with the requirements of 42 CFR 435.1200, regarding transfer of the electronic file for the purpose of determining eligibility for other insurance affordability programs.

R414-308-9. Improper Medical Coverage.

(1) Improper medical coverage occurs when:

(a) an individual receives medical assistance for which the individual is not eligible. This assistance includes benefits that an individual receives pending a fair hearing or during an undue hardship waiver when the individual fails to take actions required by the eligibility agency;

(b) an individual receives a benefit or service that is not part of the benefit package for which the individual is eligible;

(c) an individual pays too much or too little for medical assistance benefits; or

(d) the Department pays in excess or not enough for medical assistance benefits on behalf of an eligible individual.

(2) As applied in this section, services and benefits include all amounts that the Department pays on behalf of the recipient during the period in question and includes:

(a) premiums that the recipient pays to any Medicaid health plan or managed care plan including any payments for administration costs, Medicare, and private insurance plans;

(b) payments for prepaid mental health services; and

(c) payments made directly to service providers or to the recipient.

(3) If the eligibility agency determines that a recipient is ineligible for the services and benefits that he receives, the recipient must repay to the Department any costs that result from the services and benefits.

(4) The eligibility agency shall reduce the amount that the recipient must repay by the amount that the recipient pays to the eligibility agency for a Medicaid spenddown, a cost-of-care contribution, or a MWI premium for the month.

[~~(5) If a recipient who pays an asset copayment for coverage under Prenatal Medicaid is found to be ineligible for the entire period of coverage under Prenatal Medicaid, the eligibility agency shall reduce the amount that the recipient must repay by the amount that the recipient pays to the agency in the form of the prenatal asset copayment.~~]

([~~6~~]5) If the recipient is eligible but the overpayment is because the spenddown, the MWI premium, [~~the asset copayment for prenatal services,~~]or the cost-of-care contribution is incorrect, the recipient must repay the difference between the correct amount that the recipient should pay and the amount that the recipient has paid.

([~~7~~]6) If the eligibility agency determines that the recipient is ineligible due to having resources that exceed the resource limit, the recipient must pay the lesser of the cost of services or benefits that the recipient receives, or the difference between the recipient's countable resources and the resource limit for each month resources exceed the limit.

([~~8~~]7) A recipient may request a refund from the Department if the recipient believes that:

(a) the monthly spenddown, [~~the asset copayment for prenatal services,~~]or cost-of-care contribution that the recipient pays to receive medical assistance is less than what the Department pays for medical services and benefits for the recipient; or

(b) the amount that the recipient pays in the form of a spenddown, an MWI premium, or a cost-of-care contribution for long-term care services, [~~or an asset copayment for prenatal services~~] exceeds the payment requirement.

([~~9~~]8) Upon receiving the request, the Department shall determine whether it owes the recipient a refund.

(a) In the case of an incorrect calculation of a spenddown, MWI premium, or cost-of-care contribution, [~~or asset copayment for poverty level, pregnant woman services,~~]the refundable amount is the difference between the incorrect amount that the recipient pays to the Department for medical assistance and the correct amount that the recipient should pay, less the amount that the recipient owes to the Department for any other past due, unpaid claims.

(b) If the spenddown[~~, asset copayment for poverty level, pregnant woman services,~~] or a cost-of-care contribution for long-term care exceeds medical expenditures, the refundable amount is the difference between the correct spenddown[~~, asset copayment,~~] or cost-of-care contribution that the recipient pays for medical assistance and the amount that the Department pays on behalf of the recipient for services and benefits, less the amount that the recipient owes to the Department for any other past due, unpaid claims. The Department shall issue the refund only after the 12-month time period that medical providers have to submit claims for payment.

(c) The Department may not issue a cash refund for any portion of a spenddown or cost-of- care contribution that is met with medical bills. Nevertheless, the Department may pay additional covered medical bills used to meet the spenddown or cost-of-care contribution equal to the amount of refund that the Department owes the recipient, or apply the bill amount toward a future spenddown or cost-of-care contribution.

([~~10~~]9) A recipient who pays a premium for the MWI program may not receive a refund even when the Department pays for services that are less than the premium that the recipient pays for MWI.

(1[~~1~~]0) If the cost-of-care contribution that a recipient pays a medical facility is more than the Medicaid daily rate for the number of days that the recipient is in the medical facility, the recipient may request a refund from the medical facility. The Department shall refund the amount that it owes the recipient only when the medical facility sends the excess cost-of-care contribution to the Department.

(1[~~2~~]1) If the sponsor of an alien does not provide correct information, the alien and the alien's sponsor are jointly liable for any overpayment of benefits. The Department shall recover the overpayment from both the alien and the sponsor.

KEY: public assistance programs, applications, eligibility, Medicaid
Date of Enactment or Last Substantive Amendment: [~~October 1, 2013~~]2014
Notice of Continuation: January 23, 2013
Authorizing, and Implemented or Interpreted Law: 26-18

Health, Family Health and Preparedness, Emergency Medical Services
R426-100
Air Medical Service Rules

NOTICE OF PROPOSED RULE
(Repeal)
DAR FILE NO.: 38079
FILED: 10/30/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The rule was recently enacted to ensure coverage since the previous rule had lapsed. The rule now needs to be repealed because it is replaced by rules as part of the new Title R426 rules.

SUMMARY OF THE RULE OR CHANGE: The rule is repealed in its entirety to remove duplicate requirements previously made effective on 10/18/2013.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Title 26, Chapter 8a

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: No effect on state budget because the repeal contains rules that are currently contained in other rules of Title R426. The effect of this repeal will not change the operational requirements that already exist.

♦ LOCAL GOVERNMENTS: No new fiscal impacts from recently replaced air ambulance rules. Fiscal impacts of past air ambulance rules have not applied to local governments due to the air ambulance industry in Utah is currently under cooperate ownerships.
♦ SMALL BUSINESSES: Current providers are all larger than 50 employees. Future business would be required to meet the same operational standards for equipment and staffing.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: No new fiscal impacts to currently existing licensed air ambulance providers. This rule is a repeal for duplicate operational requirements. Licensed providers already have surpassed the minimal requirements required by this rule.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Affected persons are currently paying for air ambulance services that are provided by the licensed agencies. No changes are expected due to this rule repeal.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There is no effect on business.

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

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 12/23/2013

AUTHORIZED BY: David Patton, PhD, Executive Director

R426. Health, Family Health and Preparedness, Emergency Medical Services.
[~~R426-100. Air Medical Service Rules.~~
~~R426-100-1. Authority and Purpose.~~
~~(1) This Rule is established under Chapter 8, Title 26a.~~
~~(2) The purpose of this Rule is to set forth air ambulance policies and rules and standards adopted by the Utah Emergency Medical Services Committee which promote and protect the health and safety of the people of this state.~~

~~R426-100-2. Requirements for Licensure.~~
~~(1) The Department may issue licenses and vehicle permits to air medical services conforming to R426-2 for Advanced Life Support Air Medical Service and for Specialized Life Support Air Medical Service. A Specialized Life Support Air Medical Service license must list, on the license, the specialties for which the Specialized Life Support Air Medical Service is licensed.~~
~~(2) A person may not furnish, operate, conduct, maintain, advertise, or provide air medical transport services to patients within the state or from within the state to out of state unless licensed by the Department.~~
~~(3) An air medical service shall comply with all state and federal requirements governing the specific vehicles utilized for air medical transport services.~~
~~(4) An air medical service must provide air medical services 24 hours a day, every day of the year as allowed by weather conditions except when the service is committed to another medical emergency or is unavailable due to maintenance requirements.~~
~~(5) To become licensed as an air medical service, an applicant must submit to the Department an application and appropriate fees for an original license which shall include the following:~~
~~(a) Certified Articles of Incorporation, if incorporated.~~
~~(b) The name, address, and business type of the owner of the air medical service or proposed air medical service.~~
~~(c) The name and address of the air ambulance operator(s) providing air ambulance(s) to the service.~~
~~(d) The name under which the applicant is doing business or proposes to do business.~~
~~(e) A statement summarizing the training and experience of the applicant in the air transportation and care of patients.~~
~~(f) A description and location of each dedicated and back-up air ambulance(s) procured for use in the air medical service, including the make, model, year of manufacture, FAA-N number, insignia, name or monogram, or other distinguishing characteristics.~~
~~(g) A copy of current Federal Aviation Administration (FAA) Air Carrier Operating Certificate authorizing FAR, Part 135, operations.~~
~~(h) A copy of the current certificate of insurance for the air ambulance.~~
~~(i) A copy of the current certificate of insurance demonstrating coverage for medical malpractice.~~
~~(j) The geographical service area, location and description of the place or places from which the air ambulance will operate.~~
~~(k) Name of the training officer responsible for the air medical personnel continuing education.~~
~~(l) The name of the air medical service medical director.~~
~~(m) A proposed roster of medical personnel which includes level of certification or licensure.~~
~~(n) A statement detailing the level of care for which the air medical service wishes to be licensed, either advanced or specialized.~~
~~(6) Upon receipt of an appropriately completed application for an air medical service license and submission of license fees, the Department shall collect supporting documentation and review each application. After review and before issuing a license to a new air medical service, the Department shall directly inspect the vehicle(s), the air medical equipment, and required documentation.~~
~~(7) The Department shall issue an air medical service license and air ambulance permit for a period of four years from the date of issue and which shall remain valid for the period unless revoked or suspended by the Department. The department may conduct inspections to assure compliance.~~

(8) Upon change of ownership, an air medical service license and air ambulance permit terminates and the new owner or operator must file within ten business days of acquisition an application for renewal of the air medical service license and air ambulance permit.

(9) Air medical services must have an agreement to allow hospital emergency department physicians, nurses, and other personnel who participate in emergency medical services to fly on air ambulances.

(10) Air medical services must provide reports to the Department, for each mission made, on forms or a data format specified by the Department.

(11) Effective July 1, 1998, successful completion of the CAMTS certification process is required for licensure and relicensure by the Department as an air medical service.

(a) Air medical services licensed under R426-2 as of July 1, 1997 must achieve CAMTS certification as of July 1, 1998, and meet requirements of R426-2 for relicensure.

(b) Air medical services licensed under R426-2 after July 1, 1997 must submit an application for CAMTS certification within one year of receiving a license under this rule.

R426-100-3. Personnel Requirements.

(1) Emergency Medical Technicians and Paramedics, when responding to a medical emergency, shall display their certification patch or identification card on outer clothing to identify competency level at the scene.

(2) Air medical service providing basic life support must have at least one medical attendant who is an Emergency Medical Technician-Intermediate (EMT-I), EMT-Paramedic, Physician's Assistant, Registered Nurse, or MD.

(3) Air medical services providing advanced life support must have at least one medical attendant who is an EMT-P, PA, RN, or MD. This attendant shall be the primary medical attendant. The second medical attendant may be an EMT-P, PA, Respiratory Therapist, RN, or MD.

(4) Air medical services providing specialized life support must have at least one medical attendant who is a RN or MD. This attendant shall be the primary medical attendant. The second medical attendant may be an EMT-P, PA, RT, RN, or MD.

(5) All Basic, Advanced, and Specialized Life Support Medical Attendants must:

(a) Have a current CPR card or certificate meeting standards approved by the Department.

(b) Have verification in the air medical service file of initial and annual training in altitude physiology, safety, stress management, infection control, hazardous materials, survival training, disaster training, triage, and Utah emergency medical system communications.

(c) Be knowledgeable in the application, operation, care, and removal of all medical equipment used in the care of the patient. The air medical personnel shall have a knowledge of potential in-flight complications, which may arise from the use of the medical equipment and it's in-flight capabilities and limitations.

(d) Have available during transport, a current copy of all written protocols authorized for use by the air medical service medical director. Patient care shall be governed by these authorized written protocols.

(6) Air medical services licensed for specialized life support shall meet the following requirements:

(a) Maintain clinical competency by keeping a current completion card in specialty education programs required by the air medical service job description (e.g., American Heart Association/American Academy of Pediatrics Neonatal Association or Pediatric Advanced Life Support pertinent to appropriate specialty).

(b) Attend continuing education for specialty care providers that is specific and appropriate to the mission statement and scope of care for air medical services.

(c) Annually demonstrate to the air medical service medical director a knowledge and competency of specialized care and treatment of patients.

(7) All air medical services shall have an air medical service medical director who is a physician licensed in the state in which the ground base is located for the air ambulance, knowledgeable and responsible for the air medical care of patients.

(8) The air medical service applicant shall provide in writing to the Department the name of the air medical service medical director. If the air medical service medical director is replaced or removed, the air medical service shall notify the Department within thirty days after the action.

(a) The air medical service medical director:

(i) Shall have initial and annual training in altitude physiology, air ambulance safety, stress management, infection control, hazardous materials, survival training, disaster training, triage, and Utah emergency medical system communications. The air medical service shall document this training and make it available for inspection by the Department.

(ii) Shall have a current completion card in Advanced Cardiac Life Support according to the current standards of the American Heart Association.

(iii) Shall have a current completion card in Advanced Trauma Life Support according to the current standards of the American College of Surgeons.

(iv) Shall have a current specialty education completion card in Neonatal Resuscitation Program, Pediatric Advanced Life Support, and other similar courses or equivalent education in these areas.

(v) Shall have access to all specialty physicians as consultants.

(b) It is the responsibility of the air medical director to:

(i) Authorize written protocols for use by air medical attendants and review policies and procedures of the air medical service.

(ii) Develop and review treatment protocols, assess field performance, and critique at least 10% of the air medical service runs.

R426-100-4. Air Ambulance Vehicle Requirements.

(1) An air ambulance must have a permit from the Department to operate in Utah. Each air ambulance shall carry a decal showing the permit expiration date and permit number issued by the Department as evidence of compliance with R426-2. The permit holder shall meet all Federal Aviation Regulations specific to the operation of the air medical service.

(2) All air medical services shall notify the Department whenever the ground base location of a permitted vehicle is permanently changed.

(3) Air ambulances shall be maintained in good mechanical repair and sanitary condition on premises, properly equipped, maintained , and operated to provide quality service.

(4) Air ambulance requirements are as follows:

(a) The air ambulance must have sufficient space to accommodate at least one patient on a stretcher.

(b) The air ambulance must have sufficient space to accommodate at least two medical attendant seats.

(c) The patient stretcher shall be FAA-approved. It must be installed using the FAA 337 form or a "Supplemental Type Certificate." The stretcher shall be of sufficient length and width to support a patient in full supine position who is ranked as a 95th percentile American male that is 6 feet tall and weighing 212 pounds. The head of the stretcher shall be capable of being elevated at least 30 degrees.

(d) The air ambulance doors shall be large enough to allow a stretcher to be loaded without rotating it more than 30 degrees about the longitudinal roll axis, or 45 degrees about the lateral pitch axis.

(e) The stretcher shall be positioned so as to allow the medical attendants a clear view and access to any part of the patient's body that may require medical attention. Seat-belted medical attendants must have access to the patient's head and upper body.

(f) The patient, stretcher, attendants, seats, and equipment shall be so arranged as to not block the pilot, medical attendants, or patients from easily exiting the air ambulance.

(g) The air ambulance shall have FAA- approved two point safety belts and security restraints adequate to stabilize and secure any patient, patient stretcher, medical attendants, pilots, or other individuals.

(h) The air ambulance shall have a temperature and ventilation system for the patient treatment area.

(i) The patient area shall have overhead or dome lighting of at least 40-foot candle at the patient level, to allow adequate patient care. During night operations the pilot's cockpit shall be protected from light originating from the patient care area.

(j) The air ambulance shall have a self contained interior lighting system powered by a battery pack or portable light with a battery source.

(k) The pilots, flight controls, power levers, and radios shall be physically protected from any intended or accidental interference by patient, air medical personnel or equipment and supplies.

(l) The patient must be sufficiently isolated from the cockpit to minimize in-flight distractions and interference which would affect flight safety.

(m) The interior surfaces shall be of material easily cleaned, sanitized, and designed for patient safety. Protruding sharp edges and corners shall be padded.

(n) Patients whose medical problems may be adversely affected by changes in altitude may only be transported in a pressurized air ambulance.

(o) The air medical service shall provide all medical attendants with sound ear protectors sufficient to reduce excessive noise pollution arising from the air ambulance during flight.

(p) There shall be sufficient medical oxygen to assure adequate delivery of oxygen necessary to meet the patient medical needs and anticipated in-flight complications. The medical oxygen must:

(i) be installed according to FAA regulation;

(ii) have an oxygen flow rate determined by in-line pressure gauges mounted in the patient care area with each outlet clearly identified and within reach of a seat-belted medical attendant;

(iii) allow the oxygen flow to be stopped at or near the oxygen source from inside the air ambulance;

(iv) have gauges that easily identify the quantity of medical oxygen available;

(v) be capable of delivering fifteen liters/minute at fifty psi;

(vi) have a portable oxygen bottle available for use during patient transfer to and from the air ambulance;

(vii) have a fixed back-up source of medical oxygen in the event of an oxygen system failure;

(viii) the oxygen flow meters shall be recessed, padded, or by other means mounted to prevent injury to patients or medical attendants; and

(ix) "No smoking" signs shall be prominently displayed inside the air ambulance.

(q) The air ambulance electric power must be provided through a power source capable to operate the medical equipment and a back-up source of electric power capable of operating all electrically powered medical equipment for one hour.

(r) The air ambulance must have at least two positive locking devices for intravenous containers padded, recessed, or mounted to prevent injury to air ambulance occupants. The containers shall be within reach of a seat-belted medical attendant.

(s) The air ambulance must be fitted with a metal hard lock container, fastened by hard point restraints to the air ambulance, or must have a locking cargo bay for all controlled substances left in an unattended.

(t) An air ambulance shall have properly maintained survival gear appropriate to the service area and number of occupants.

(u) An air ambulance shall have an equipment configuration that is installed according to FAA criteria and in such a way that the air medical personnel can provide patient care.

(v) The air ambulance shall be configured in such a way that the air medical personnel have access to the patient in order to begin and maintain basic and advanced life support care.

(w) The air ambulance shall have space necessary to allow patient airway maintenance and to provide adequate ventilatory support from the secured, seat-belted position of the medical personnel.

R426-100-5. Equipment Standards.

(1) Air ambulances must maintain minimum quantities of supplies and equipment for each air medical transport as listed in the document R426 Appendix in accordance with the air medical service's licensure level. Due to weight and safety concerns on specialized air transports, the air medical service medical director shall insure that the appropriate equipment is carried according to the needs of the patient to be transported. All medications shall be stored according to manufacturer recommendations.

(2) All medical equipment except disposable items, shall be designed, constructed, and made of materials that under normal conditions and operations, are durable and capable of withstanding repeated cleaning.

(3) The equipment and medical supplies shall be maintained in working condition and within legal specifications.

(4) All non-disposable equipment shall be cleaned or sanitized after each air medical transport.

(5) Medical equipment shall be stored and readily accessible by air medical personnel.

~~(6) Before departing, the air medical personnel shall notify the pilot of any add-on equipment for weight and balance considerations.~~

~~(7) Physical or chemical restraints must be available and used for combative patients who could possibly hurt themselves or any other person in the air ambulance.~~

~~R426-100-6. Operational Standards.~~

~~(1) The pilot may refuse transport to any individual who the pilot considers to be a safety hazard to the air ambulance or any of its passengers.~~

~~(2) Records made for each trip on forms or data format specified by the Department, and a copy shall remain at the receiving facility for continuity of care.~~

~~(3) The air medical service must maintain a personnel file for personnel which shall include their qualifications and training.~~

~~(4) All air medical services must have an operational manual or policy and procedures manual available for all air medical personnel.~~

~~(5) All air medical service records shall be available for inspection by representatives of the Department.~~

~~(6)(a) All air ambulances shall be equipped to allow air medical service personnel to be able to:~~

~~(i) Communicate with hospital emergency medical departments, flight operations centers, air traffic control, emergency medical services, and law enforcement agencies.~~

~~(ii) Communicate with other air ambulances while in flight.~~

~~(b) The pilot must be able to override any radio or telephonic transmission in the event of an emergency.~~

~~(7) The management of the air medical service shall be familiar with the federal regulations related to air medical services.~~

~~(8) Each air medical service must have a safety committee, with a designated safety officer. The committee shall meet at least quarterly to review safety issues and submit a written report to the air medical service management and maintain a copy on file at the air medical service office.~~

~~(9) All air medical service shall have a quality management team and a program implemented by this team to assess and improve the quality and appropriateness of patient care provided by the air medical service.~~

~~R426-100-7. Statutory Penalties.~~

~~A person who violates this rule is subject to the provisions of Title 26, Chapter 23.~~

~~KEY: emergency medical services, air medical services~~
~~Date of Enactment or Last Substantive Amendment: May 30, 2013~~
~~Authorizing, and Implemented or Interpreted Law: 26-8~~]

Health, Family Health and Preparedness, Licensing
R432-2-5
Requirements for a Satellite Service Operation

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38086
FILED: 10/31/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The wording in this rule was confusing, therefore the facilities and our staff have often had difficulty in determining if a particular situation was a satellite location or not. The agency often refers to the Code of Federal Regulation (CFR) as it defined a satellite as being no further than 250 yards from the facility. The change in the wording incorporates the CFR definition into the rule to help ensure consistency and reduce confusion. Also the agency updated the wording of Uniform Building Code to the correct term of International Building Code. These rule amendments were reviewed and approved on 02/13/2013 by the Health Facility Committee which has representation of the type of providers this rule would apply to.

SUMMARY OF THE RULE OR CHANGE: The changes are to clearly define when a building is a satellite operation and is not covered under the facilities license; and to update the wording of Uniform Building Code to the International Building Code.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Title 26, Chapter 21

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: This rule amendment will have no effect on state budgets since there will be no change in current practice.
♦ LOCAL GOVERNMENTS: This rule amendment will have no effect on local government budgets since there will be no change in current practice.
♦ SMALL BUSINESSES: This rule amendment will have no effect on small businesses since there will be no change in current practice.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: This rule amendment will have no effect on persons since there will be no change in current practice.

COMPLIANCE COSTS FOR AFFECTED PERSONS: This rule amendment will have no effect on persons since there will be no change in current practice.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This will have no effect on business.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HEALTH
FAMILY HEALTH AND PREPAREDNESS,
LICENSING

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:
♦ Carmen Richins by phone at 801-538-9087, by FAX at 801-538-6024, or by Internet E-mail at carmenrichins@utah.gov
♦ Joel Hoffman by phone at 801-538-6279, by FAX at 801-538-6024, or by Internet E-mail at jhoffman@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 12/23/2013

AUTHORIZED BY: David Patton, PhD, Executive Director

R432. Health, Family Health and Preparedness, Licensing.
R432-2. General Licensing Provisions.
R432-2-5. Requirements for a Satellite Service Operation.

(1) A "satellite operation" is a health care treatment service that:

(a) is administered by a parent facility within the scope of the parent facility's current license,

(b) is [~~in a location not contiguous with the parent facility~~]located further than 250 yards from the licensed facility or other areas determined by the department to be a part of the provider's campus,

(c) does not qualify for licensing under Section 26-21-2, and

(d) is approved by the Department for inclusion under the parent facility's license and identified as a remote service.

(2) A licensed health care facility that wishes to offer a satellite operation shall submit for Department review a program narrative and one set of construction drawings. The program narrative shall define at least the following:

(a) location of the remote facility (street address);

(b) capacity of the remote facility;

(c) license category of the parent facility;

(d) service to be provided at the remote facility (must be a service authorized under the parent facility license);

(e) ancillary administrative and support services to be provided at the remote facility; and

(f) International[~~Uniform~~] Building Code occupancy classification of the remote facility physical structure.

(3) Upon receipt of the satellite service program narrative and construction drawings, the Department shall make a determination of the applicable licensing requirements including the need for licensing the service. The Department shall verify at least the following items:

(a) There is only a single health care treatment service provided at the remote site and that it falls within the scope of the parent facility license;

(b) The remote facility physical structure complies with all construction codes appropriate for the service provided;

(c) All necessary administrative and support services for the specified treatment service are available, on a continuous basis during the hours of operation, to insure the health, safety, and welfare of the clients.

(4) If a facility qualifies as a single satellite service treatment center the Department shall issue a separate license identifying the facility as a "satellite service" of the licensed parent facility. This license shall be subject to all requirements set forth in R432-2 of the Health Facility Rules.

(5) A parent facility that wishes to offer more than one health care service at the same remote site shall either obtain a satellite service license for each service offered as described above or obtain a license for the remote complex as a free-standing health care facility.

(6) A satellite facility is not permitted within the confines of another licensed health care facility.

KEY: health care facilities
Date of Enactment or Last Substantive Amendment: [~~January 27, 2010~~]2013
Notice of Continuation: August 12, 2013
Authorizing, and Implemented or Interpreted Law: 26-21-9; 26-21-11; 26-21-12; 26-21-13

Human Resource Management, Administration
R477-4-4
Recruitment and Selection for Career Service Positions

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38077
FILED: 10/30/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The amendment redefines the three-calendar day requirement for job recruitment postings to three business days to provide better notice to applicants.

SUMMARY OF THE RULE OR CHANGE: In Subsection R477-4-4-2(b), "calendar" days is replaced with "business" days.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 67-19-6

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: These changes are administrative and do not directly impact state budgets.
♦ LOCAL GOVERNMENTS: This rule only affects the executive branch of state government and will have no impact on local government.
♦ SMALL BUSINESSES: This rule only affects the executive branch of state government and will have no impact on small businesses.

♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: This rule only affects the executive branch of state government and will have no impact on other persons. This rule has no financial impact on state employees.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There is no direct compliance cost for these amendments.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Rules published by the Department of Human Resource Management (DHRM) have no direct effect on businesses or any entity outside state government. DHRM has authority to write rules only to the extent allowed by the Utah Personnel Management Act, Title 67, Chapter 19. This act limits the provisions of career service and these rules to employees of the executive branch of state government. The only possible impact may be a very slight, indirect effect if an agency passes costs or savings on to business through fees. However, it is anticipated that the minimal costs associated with these changes will be absorbed by agency budgets and will have no effect on business.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HUMAN RESOURCE MANAGEMENT
ADMINISTRATION
ROOM 2120 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:
♦ J.J. Acker by phone at 801-538-4297, by FAX at 801-538-3081, or by Internet E-mail at jacker@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 01/01/2014

AUTHORIZED BY: Debbie Cragun, Executive Director

R477. Human Resource Management, Administration.
R477-4. Filling Positions.
R477-4-4. Recruitment and Selection for Career Service Positions.

(1) Prior to initiating recruitment, agencies may administer any of the following personnel actions:

(a) reemployment of a veteran eligible under USERRA;

(b) reassignment within an agency initiated by an employee's reasonable accommodation request under the ADA;

(c) fill a position as a result of return to work from long term disability or workers compensation at the same or lesser salary range;

(d) reassignment or transfer made in order to avoid a reduction in force, or for reorganization or bumping purposes;

(e) reassignment, transfer, or career mobility of qualified employees to better utilize skills or assist management in meeting the organization's mission;

(f) reclassification; or

(g) conversion from schedule A to schedule B as authorized by Subsection R477-5-1(3).

(2) Agencies shall use the DHRM approved recruitment and selection system for all career service position vacancies. This includes recruitments open within an agency, across agency lines, or to the general public. Recruitment shall comply with federal and state laws and DHRM rules and procedures.

(a) All recruitment announcements shall include the following:

(i) Information about the DHRM approved recruitment and selection system; and

(ii) opening and closing dates.

(b) Recruitments for career service positions shall be posted for a minimum of three [~~calendar~~]business days, excluding state holidays.

(3) Agencies may carry out all the following steps for recruitment and selection of vacant career service positions concurrently. Management may make appointments according to the following order:

(a) from the reappointment register created prior to March 2, 2009, provided the applicant applies for the position and meets minimum qualifications.

(b) from a hiring list of qualified applicants for the position, or from another process pre-approved by the Executive Director, DHRM.

KEY: employment, fair employment practices, hiring practices
Date of Enactment or Last Substantive Amendment: [~~July 1,~~] 2013
Notice of Continuation: February 2, 2012
Authorizing, and Implemented or Interpreted Law: 67-19-6; 67-20-8

Human Resource Management, Administration
R477-6-9
Severance Benefit

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38092
FILED: 11/01/2013

RULE ANALYSIS
PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this amendment is to minimize liability and associative administrative costs.

SUMMARY OF THE RULE OR CHANGE: The changes allow for greater agency discretion in administering severance.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 67-19-12 and Section 67-19-15 and Section 67-19-6

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: These changes are administrative and do not directly impact state budgets.
♦ LOCAL GOVERNMENTS: This rule only affects the executive branch of state government and will have no impact on local government.
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♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: This rule only affects the executive branch of state government and will have no impact on other persons. This rule has no financial impact on state employees.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There is no direct compliance cost for these amendments because the changes are administrative.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Rules published by the Department of Human Resource Management (DHRM) have no direct effect on businesses or any entity outside state government. DHRM has authority to write rules only to the extent allowed by the Utah Personnel Management Act, Title 67, Chapter 19. This act limits the provisions of career service and these rules to employees of the executive branch of state government. The only possible impact may be a very slight, indirect effect if an agency passes costs or savings on to business through fees. However, it is anticipated that the minimal costs associated with these changes will be absorbed by agency budgets and will have no effect on business.

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ROOM 2120 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:
♦ Katie Clayton by phone at 801-538-3080, by FAX at 801-538-3081, or by Internet E-mail at kclayton@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 01/01/2014

AUTHORIZED BY: Debbie Cragun, Executive Director

R477. Human Resource Management, Administration.
R477-6. Compensation.
R477-6-9. Severance Benefit.

(1) At the discretion of the appointing authority a[~~A~~] benefits eligible career service exempt employee on schedule AB, AC, AD, AR, AS or AT who is separated from state service through an action initiated by management, to include resignation in lieu of termination, may[~~shall~~] receive at the time of severance a benefit equal to:

(a) one week of salary, up to a maximum of 12 weeks, for each year of consecutive exempt service in the executive branch; and

(b) if eligible for COBRA, one month of health insurance coverage, up to a maximum of six months, for each year of consecutive exempt service, at the level of coverage the employee has at the time of severance, to be paid in a lump sum payment to the state's health care provider.

[~~(2) A severance benefit may not be paid to an employee:~~
~~(a) whose statutory term has expired without reappointment;~~
~~(b) who is retiring from state service; or~~
~~(c) who is dismissed for cause.~~

~~(3) A benefits eligible career service exempt employee on schedule AB, AD, AR or AT who accepts reassignment to a position with a lower salary range, without a break in service, shall receive a severance benefit equal to the difference between the current actual wage and the new actual wage multiplied by the number of accrued annual leave, converted sick leave, and excess hours on the date of reassignment.~~

~~(4) An employee on schedule AC or AS may be provided these same severance benefits at the discretion of the appointing authority.~~
]

KEY: salaries, employee benefit plans, insurance, personnel management
Date of Enactment or Last Substantive Amendment: [~~July 1, 2013~~]2014
Notice of Continuation: February 2, 2012
Authorizing, and Implemented or Interpreted Law: 63F-1-106; 67-19-6; 67-19-12; 67-19-12.5; 67-19-15.1(4)

Human Resource Management, Administration
R477-7
Leave

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38084
FILED: 10/31/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The statutes relating to converted sick leave and the unused sick leave retirement were amended during the 2013 General Legislative session in H.B. 194. The proposed amendments to affected rules reflect the new statutory mandates.

SUMMARY OF THE RULE OR CHANGE: The changes are: 1) caps the Unused Sick Leave Retirement Program II to only include an employee's unused accumulated sick leave and converted sick leave accrued between 01/01/2006 and 01/03/2014; 2) beginning on or after 01/04/2014 an employer shall make a biweekly matching contribution to a qualifying employee's defined contribution plan qualified under Section 401(k) of the Internal Revenue Service code; 3) provides that the matching contribution amount that an employer shall provide to each qualifying employee shall be determined on an annual basis by the Legislature; 4) there will be a new sick leave Program III; these hours accrue for eligible employees on or after 01/04/2013 but have no value at retirement; and 5) a converted sick end date was added to rule.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 67-19-14 and Section 67-19-43

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: Fiscal Note to H.B. 194 says, "Enactment of this bill will reduce expenditures under the Unused Sick Leave Retirement Program II by an estimated $1,084,000 from various sources beginning in FY 2015. Savings will increase each year until existing program liabilities. The cost of a new state employee defined contribution benefit created in this bill will depend upon amounts appropriated by the Legislature. Costs from all sources are capped at an estimated $6,000,000 in FY2014 and $13,000,000 annually beginning in FY 2015 assuming all eligible employees participate at $26 per pay period.
♦ LOCAL GOVERNMENTS: This rule only affects the executive branch of state government and will have no impact on local government.
♦ SMALL BUSINESSES: This rule only affects the executive branch of state government and will have no impact on small businesses.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: This rule only affects the executive branch of state government and will have no impact on other persons. This rule has no financial impact on state employees.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There is no direct compliance cost for these amendments. This rule only affects the executive branch of state government and will have no impact on other persons. This rule has no financial impact on state employees.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Rules published by the Department of Human Resource Management (DHRM) have no direct effect on businesses or any entity outside state government. DHRM has authority to write rules only to the extent allowed by the Utah Personnel Management Act, Title 67, Chapter 19. This act limits the provisions of career service and these rules to employees of the executive branch of state government. The only possible impact may be a very slight, indirect effect if an agency passes costs or savings on to business through fees. However, it is anticipated that the minimal costs associated with these changes will be absorbed by agency budgets and will have no effect on business.

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DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Katie Clayton by phone at 801-538-3080, by FAX at 801-538-3081, or by Internet E-mail at kclayton@utah.gov

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THIS RULE MAY BECOME EFFECTIVE ON: 01/01/2014

AUTHORIZED BY: Debbie Cragun, Executive Director

R477. Human Resource Management, Administration.
R477-7. Leave.
R477-7-4. Sick Leave.

(1) An eligible employee shall accrue sick leave, not to exceed four hours per pay period. Sick leave shall accrue without limit.

(2) Agency management may grant sick leave for preventive health and dental care, maternity, paternity, and adoption care, or for absence from duty because of illness, injury or disability of the employee, a spouse, children or parents living in the employee's home; or qualifying FMLA purposes.

(3) Agency management may grant exceptions for other unique medical situations.

(4) When management approves the use of sick leave, an employee may use any combination of Program I,[~~and~~] Program II, and Program III sick leave.

(5) An employee shall contact management prior to the beginning of the scheduled workday the employee is absent due to illness or injury.

(6) Any application for a grant of sick leave to cover an absence that exceeds three consecutive working days shall be supported by administratively acceptable evidence.

(7) If there is reason to believe that an employee is abusing sick leave, a supervisor may require an employee to produce evidence regardless of the number of sick hours used.

(8) Unless retiring, an employee separating from state employment shall forfeit any unused sick leave without compensation.

(a) An employee rehired into a benefited position within one year of separation due to a reduction in force shall have forfeited sick leave reinstated to Program I,[~~and~~] Program II, and Program III as accrued prior to the reduction in force.

(b) An employee rehired with benefits within one year of separation for reasons other than a reduction in force shall have forfeited sick leave reinstated as Program III sick leave.

(c) An employee who retires from state service and is rehired may not reinstate forfeited sick leave.

R477-7-5. Converted Sick Leave.

An employee may not accrue converted sick leave hours on or after January 3, 2014. [~~to converted sick leave after the end of the last pay period of the calendar year in which the employee is eligible.~~]Converted sick leave hours accrued before January 3, 2014 can be used for retirement per R477-7-5(6) or cashed out if the employee leaves employment.

(1)(a) Converted sick leave hours accrued prior to January 1, 2006 shall remain[~~be~~] Program I converted sick leave hours.

(b) Converted sick leave hours accrued after January 1, 2006 shall remain[~~be~~] Program II converted sick leave hours.

(2) To be eligible, an employee shall have accrued a total of 144 hours or more of sick leave in Program I and Program II combined at the beginning of the first pay period of the calendar year.

(a) At the end of the last pay period of a calendar year in which an employee is eligible, all unused sick leave hours accrued that year in excess of 64 shall be converted to Program II converted sick leave.

(b) The maximum hours of converted sick leave an employee may accrue in Program I and Program II combined is 320.

(c) If the employee has the maximum accrued in converted sick leave, these hours will be added to the annual leave account balance.

(d) In order to prevent or reverse the conversion, an employee shall:

(i) notify agency management no later than the last day of the last pay period of the calendar year in order to prevent the conversion; or

(ii) notify agency management no later than the end of February in order to reverse the conversion.

(e) Upon separation, an eligible employee may convert any unused sick leave hours accrued in the current calendar leave year in excess of 64 to converted sick leave hours in Program II.

(3) An employee may use converted sick leave as annual leave or as regular sick leave.

(4) When management approves the use of converted sick leave, an employee may use any combination of Program I and Program II converted sick leave.

(5) Employees retiring from LTD who have converted sick leave balances still intact may use these hours for the unused converted sick leave retirement program at the time they become eligible for retirement.

(6) Upon retirement, 25% of the value of the unused converted sick leave, but not to exceed Internal Revenue Service limitations, shall be placed in the employee's 401(k) account as an employer contribution.

(a) Converted sick leave hours from Program II shall be placed in the 401(k) account before hours from Program I.

(b) The remainder shall be used for:

(i) the purchase of health care insurance and life insurance under Subsection R477-7-6(3)(a) if the converted sick leave was accrued in Program I ; or

(ii) a contribution into the employees PEHP health reimbursement account under Subsection R477-7-6(6)(b) if the converted sick leave was accrued in Program II.

(7) Upon retirement, Program I converted sick leave hours may not be suspended or deferred for future use. This includes retired employees who reemploy with the state and choose to suspend their defined benefit payments.

(8) A retired employee who reemploys in a benefited position with the state after being separated for a continuous year after the retirement date, and who chooses to suspend pension, shall have a new benefit calculated on any new Program II converted sick leave hours accrued for the new period of employment, upon subsequent retirement. The employee shall be reemployed for at least two years before receiving this benefit.

R477-7-14. Furlough.

(1) Agency management may furlough employees as a means of saving salary costs in lieu of or in addition to a reduction in force. Furlough plans are subject to the approval of the agency head and the following conditions:

(a) Furlough hours shall be counted for purposes of annual, sick and holiday leave accrual.

(b) Payment of all state paid benefits shall continue at the agency's expense.

(i) Benefits that have fixed costs shall be paid at the full rate regardless of how many days an employee is furloughed.

(ii) Benefits that are paid as a percentage of actual wages shall continue to be paid as percentage of actual wages if the furlough is less than one pay period. Employees who are furloughed for a full pay period shall have no percentage based benefits paid.

(c) An employee who is furloughed shall continue to pay the employee portion of all benefits. Voluntary benefits shall remain enti[~~t~~]rely at the employee's expense.

(d) An employee shall return to the current position.

(e) Furlough is applied equitably; e.g., to all persons in a given class, all program staff, or all staff in an organization.

KEY: holidays, leave benefits, vacations
Date of Enactment or Last Substantive Amendment: [~~July 1, 2013~~]2014
Notice of Continuation: February 2, 2012
Authorizing, and Implemented or Interpreted Law: 34-43-103; 63G-1-301; 67-19-6; 67-19-12.9; 67-19-14; 67-19-14.2; 67-19-14.4; 67-19-14.5

Human Resource Management, Administration
R477-101
Administrative Law Judge Conduct Committee

NOTICE OF PROPOSED RULE
(New Rule)
DAR FILE NO.: 38091
FILED: 11/01/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Department of Human Resource Management (DHRM) was mandated in the 2013 Legislative General Session pursuant S.B. 191 to create rules regarding the Administrative Law Judge Standards of Conduct and an Administrative Law Judge Conduct Committee.

SUMMARY OF THE RULE OR CHANGE: This new rule governs Administrative Law Judge conduct and complaint procedures.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 67-19e-101 et seq.

MATERIALS INCORPORATED BY REFERENCES:
♦ Adds Model Code of Judicial Conduct for State Administrative Law Judges, published by National Association of Administrative Law Judiciary, November 1993

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: There are no costs or saving associated with this rule. Any costs or saving were considered in the fiscal note attached to the S.B. 191 (2013).
♦ LOCAL GOVERNMENTS: This rule only affects the executive branch of state government and will have no impact on local government.
♦ SMALL BUSINESSES: This rule only affects the executive branch of state government and will have no impact on small businesses.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: This rule only affects the executive branch of state government and will have no impact on other persons. This rule has no financial impact on state employees.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There is no direct compliance cost for this rule as it simply establishes a code of conduct and describes complaint procedures.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Rules published by DHRM have no direct effect on businesses or any entity outside state government. DHRM has authority to write rules only to the extent allowed by the Utah Personnel Management Act, Title 67, Chapter 19. This act limits the provisions of career service and these rules to employees of the executive branch of state government. The only possible impact may be a very slight, indirect effect if an agency passes costs or savings on to business through fees. However, it is anticipated that the minimal costs associated with these changes will be absorbed by agency budgets and will have no effect on business.

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DIRECT QUESTIONS REGARDING THIS RULE TO:
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THIS RULE MAY BECOME EFFECTIVE ON: 01/01/2014

AUTHORIZED BY: Debbie Cragun, Executive Director

R477. Human Resource Management, Administration.
R477-101. Administrative Law Judge Conduct Committee.
R477-101-1. Authority and Purpose.

This rule is enacted pursuant to Utah Code Section 67-19e-104, requiring the Department of Human Resource Management to establish rules governing minimum performance standards for administrative law judges, procedures for addressing and reviewing complaints against administrative law judges, standards for complaints, and standards of conduct for administrative law judges.

R477-101-2. Definitions.

In addition to the terms defined in Utah Code Section 67-19e-102:

(1) "Administrative Law Judge" (ALJ) includes Hearing Officers employed or contracted by a state agency that meet the criteria described in Utah Code Section 67-19e-102(1)(a).

(2) "Chair" means the Executive Director, Department of Human Resource Management, or designee.

(3) "Code of Conduct" means the Model Code of Judicial Conduct for State Administrative Law Judges, National Association of Administrative Law Judges (November 1993) incorporated by reference.

(4) "Committee" means the Administrative Law Judge Committee created in Utah Code Section 67-19e-108.

(5) "Committee Meeting" means a proceeding at which a Complaint is presented to the Committee by the investigator. Respondent ALJ shall also have the opportunity to appear and speak regarding the Complaint and its allegations.

(6) "Complaint" means a written document filed with the Department pursuant to Utah Administrative Code R477-101-401 alleging Misconduct by an ALJ.

(7) "Department" means the Department of Human Resource Management.

(8) "Final Agency Action" occurs when the substantive rights or obligations of litigants in an administrative proceeding have been determined or legal consequences flow from a determination and when the agency decision is not preliminary, preparatory, procedural or intermediate.

(9) "Full investigation" means that portion of an investigation where the Respondent ALJ may respond, in writing, to specific allegations identified in a Complaint. A Full Investigation may also include, but is not limited to: examination by the Investigator of documents, correspondence, hearing records, transcripts or tapes; interviews of the complainant, counsel, hearing staff, Respondent ALJ, interested parties, and other witnesses.

(10) "Good cause" means a cause or reason in law, equity or justice that provides responsible basis for action or a decision.

(11) "Interested Party" means an individual or entity who participated in an event or proceeding giving rise to a Complaint against the Respondent ALJ.

(12) "Investigator" means a person employed by the department to perform investigations mandated under Utah Code Section 67-19e-107 and present information at the Committee Meeting.

(13) "Misconduct" means a violation of the Code of Conduct or Utah Code Section 67-19e-101 et seq.

(14) "Preliminary Investigation" means that portion of an investigation conducted by the Department upon receipt of a Complaint. A Preliminary Investigation may include, but is not limited to: examination of documents, correspondence, interviews of the complainant, counsel, hearing staff, and other witnesses.

(15) "Respondent ALJ" means an ALJ against whom a Complaint is filed.

R477-101-3. Jurisdiction.

(1) Administrative Law Judges. The Committee has jurisdiction over ALJs to investigate, review, hear, and make recommendations regarding Complaints filed against ALJs.

(2) Former ALJs. The Committee has continuing jurisdiction over former ALJs regarding allegations that Misconduct occurred during service as an ALJ if a Complaint is received before the ALJ's appointment concludes.

R477-101-4. Records Classification and Retention.

(1) Records prepared by and for the Committee, including all Complaints, investigative reports, recommendations, and votes on recommended action against an ALJ are classified as protected under Utah Code Section 63G-2-305.

(2) Committee records shall be maintained by the department for a period of three years following the conclusion of any Committee activity.

R477-101-201. Committee.

(1) The Executive Director or designee shall serve as Chair of the Committee, and appoint four Executive Directors or their designees to serve on the Committee.

(2) Only Executive Directors of agencies that employ or contract with ALJs may serve on the Committee.

(3) If a Department investigation establishes a Complaint requires further action, the Executive Director and Chair shall convene the Committee.

(4) An Executive Director of the agency that employs or contracts with the Respondent ALJ may not participate in a Committee proceeding involving the Respondent ALJ.

(5) After convening the Committee, the Department shall provide a copy of the Complaint and its investigative results to the Committee and the Respondent ALJ.

(6) Within 30 days of the date the Committee is convened on a complaint the Committee shall schedule a Committee Meeting. At the Committee Meeting the Respondent ALJ shall be given the opportunity to appear, speak and present documents in response to a Complaint.

(7) Committee members may attend Committee meetings in person, by telephone, by videoconference, or by other means approved in advance by the Chair.

(8) After consideration of all information provided at the Committee Meeting, the Committee shall dispose of the Complaint by issuing a decision or report with a recommendation to the agency containing:

(a) a brief description of the Complaint and the investigative results;

(b) findings, and;

(c) recommendations.

(9) Committee members shall not, individually or collectively, engage in ex parte communications about proceedings with complainants, witnesses, or ALJs.

R477-101-202. Duties of the Chair.

(1) The Chair shall:

(a) receive, acknowledge receipt of and review Complaints;

(b) notify complainants about the status and disposition of their Complaints,

(c) make recommendations to the Committee regarding further proceedings or the disposition of a Complaint;

(d) stay investigation(s) or committee proceedings pending Final Agency Action of the matter giving rise to the Complaint against the Respondent ALJ;

(e) maintain records of the Committee's operations and actions;

(f) compile data to aid in the administration of the Committee's operations and actions;

(g) prepare and distribute an annual report of the Committee's operations and actions;

(h) direct the operations of the Committee's office, and supervise other members of the Committee's staff;

(i) make available to the public the laws, rules, and procedures of the Committee and its operations;

(j) consider requests for extension of time periods and, upon a showing of Good Cause, grant such requests for a period not to exceed 20 days for each request.

(2) Subject to the duty to direct and supervise, the Chair may delegate any of the foregoing duties to other members of the Committee's staff.

R477-101-301. Code of Conduct.

(1) ALJs shall comply with the Model Code of Judicial Conduct for State Administrative Law Judges, National Association of Administrative Law Judges.

(2) In order to suit a specific agency need, an agency may make an addendum or modification to the Code of Conduct. Any such addendum or modification shall be specific to their agency. In addition, any addendum or modification to the Code of Conduct must be reviewed and approved by the Committee before being implemented. The Committee may be convened for the purpose of reviewing any proposed addendum or modification.

R477-101-401. Filing Procedure.

(1) An individual who alleges a violation of the Code of Conduct or otherwise has a Complaint against an ALJ may file a timely Complaint with the Department. To be timely a Complaint must be in writing and filed with the Department within 20 working days of Final Administrative Action in the matter in which the individual is an Interested Party.

(2) Complaints filed with the Department are deemed filed on the date actually received by the Department. The Department shall date-stamp all Complaints on the date received. All filing and other time periods are based upon the Department's working days.

(3) Complaints must contain specific facts and allegations of Misconduct and must be signed by the person filing the Complaint or by the person's authorized representative. Complaints shall also contain the name, address, and telephone number of the complainant, and the name, business address, and telephone number of the representative, if a party or person is being represented.

(4) The Department will give written notice to both the complainant and Respondent ALJ when a Complaint is received.

R477-101-402. Investigation.

(1) Preliminary Investigation.

(a) The Department shall review all timely filed Complaints and shall, regardless of whether the allegations contained therein would constitute misconduct if true, conduct a Preliminary Investigation.

(b) If the Preliminary Investigation determines that the Complaint is untimely, frivolous, without merit of, or if the Complaint merely indicates disagreement with the Respondent ALJ's decision, without further alleged Misconduct, the Complaint may be similarly dismissed without further action.

(c) If, after a Preliminary Investigation is completed, there is a reasonable basis to find Misconduct occurred, the Investigator shall initiate a Full Investigation.

(2) Full Investigation.

Within ten days after a determination to conduct a Full Investigation is made, the Investigator shall notify the Respondent ALJ that a Full Investigation is being conducted. The notice shall:

(a) inform the Respondent ALJ of the specific facts and allegations being investigated and the canons or statutory provisions allegedly violated;

(b) inform the Respondent ALJ that the investigation may be expanded if appropriate;

(c) invite the Respondent ALJ to respond to the Complaint in writing within 10 working days;

(d) include a copy of the Complaint, the Preliminary Investigation report(s), and any other documentation reviewed in determining whether to authorize a Full Investigation; and

(e) unless continued by the Chair, Full Investigations shall be completed within three months of the determination to conduct a Full Investigation.

R477-101-403. Full Investigative Findings.

Results of the investigation shall be provided to the Chair, who shall determine whether to convene a Committee Meeting.

R477-101-501. Notice.

(1) If after review of the Full Investigative result and findings the Chair determines the Complaint is factually or legally insufficient to establish Misconduct, the Chair shall similarly dismiss the Complaint and take no further action.

(2) If after review of the Full Investigative result and findings the Chair determines the Complaint requires further action, the Chair shall convene the Committee and order a Committee Meeting be scheduled.

(3) After convening the Committee the Chair shall provide Respondent ALJ written notice of the ALJ's right to appear, speak, and present documents at the Committee Meeting. The Chair shall also provide the Respondent ALJ with a copy of the Complaint and the results of the Department's investigation.

(4) Notice that a Committee has been convened and a Committee Meeting ordered shall be made by personal service or certified mail upon the Respondent ALJ or the Respondent ALJ's representative. Service of all other notices or papers may be regular mail.

(5) Within 20 days after receiving written notice from the Chair that a Committee has been convened the Respondent ALJ may provide the Committee a written response to the Complaint.

(6) After receipt of the Respondent ALJ's response of after expiration of the time to respond the Committee shall, in consultation with the ALJ, schedule a Committee Meeting. The Committee shall notify the ALJ in writing of the date, time, and place of the Committee Meeting. Unless continued for Good Cause, Committee Meetings shall be held within four months of the date a Committee is convened on a Complaint.

(7) No later than 20 days before the scheduled Committee Meeting the Chair shall provide the Respondent ALJ with copies of all documents proposed for use at the Committee Meeting or to be relied upon in making its report and recommendation.

(8) Respondent ALJ shall be entitled to representation at every stage of the Committee proceedings or the Committee Meeting.

(9) Neither the Utah Rules of Evidence nor the Utah Rules of Civil Procedure apply in Committee proceedings.

R477-101-502. Effect of Respondent ALJ's Resignation or Retirement during Proceeding.

If the Respondent ALJ resigns or retires during the proceedings, the Committee shall determine whether to proceed or dismiss the proceedings.

R477-101-503. Committee Meetings.

(1) The Chair shall rule on all motions or objections raised during a Committee Meeting, set reasonable limits on the statements or documents presented, including any statements from the complainant. The Chair may limit the time allowed for the presentation of information, may bifurcate any and all issues to be considered, and may make any and all other rulings regarding any Committee proceeding or Committee Meeting.

(2) To hold a Committee Meeting there must be at least 3 members of the Committee present.

(3) The Respondent ALJ shall be permitted to present information to, make statements and produce witnesses for the Committee's consideration.

(4) Committee members may ask questions of any witness including the Respondent ALJ.

(5) Immediately following the conclusion of the Committee Meeting, the Committee shall deliberate and decide whether there is sufficient evidence the Respondent ALJ violated the Code of Conduct or otherwise engaged in Misconduct. Any such decision shall require a majority vote of the participating Committee members.

(6) Committee decisions shall be supported by a preponderance of the evidence.

(7) Within 30 days of the conclusion of the Committee Meeting, the Chair shall prepare a memorandum decision or report, with a recommendation for any proposed personnel action(s), and shall forward the decision and recommendation to the Respondent ALJ and the agency head of the Respondent ALJ.

(8) After deliberation, if the Committee finds insufficient evidence or reason to determine Misconduct occurred, the complaint shall be dismissed.

R477-101-504. Discipline.

(1) At any time after the commencement of a Full Investigation and before any Committee action, the ALJ may admit to any or all of the allegations in exchange for a stated sanction. The admission shall be submitted to the Committee for a recommendation.

(2) Any corrective and/or disciplinary action taken against a career service employee by the employing agency shall be implemented in accordance with applicable Department or state rule(s) governing discipline.

R477-101-505. Reinstatement of Proceedings.

(1) Reinstatement upon Request by Complainant.

(a) If a Complaint is dismissed, the complainant may, within 20 days of the date of the letter notifying the complainant of the dismissal, file a written request that the Committee reinstate the Complaint. The request shall include the specific grounds upon which reinstatement is sought.

(b) The request shall be presented to the Committee at the next available Meeting of the Committee, at which time the Committee shall determine whether to reinstate the Complaint.

(c) A determination not to reinstate the Complaint is not reviewable.

(2) Reinstatement by the Chair.

(a) If the Committee dismisses a Complaint, the Chair may, at any time upon the receipt of newly discovered evidence, request that the Committee reinstate the Complaint. The request shall include the specific grounds upon which the reinstatement is sought.

(b) The request shall be presented to the Committee at the next available Meeting of the Committee, at which time the Committee shall determine whether to reinstate the Complaint.

R477-101-601. Performance Standard.

(1) The following minimum performance standards shall apply to all ALJ's:

(a) The ALJ shall have no more than one agency disciplinary action or one Committee recommendation for disciplinary action during the ALJ's four-year evaluation cycle; and

(b) The ALJ shall receive an average score of no less than 65% on each survey category as provided in Utah Code 67-19e-106.

(2) For any question that does not use the numerical scale, the Committee shall establish the minimum performance standard. Any established performance standard shall be substantially equivalent to the standard required by Utah Code Section 67-19e-105.

R477-101-602. Performance Surveys.

(1) Initial performance surveys shall be conducted by the department beginning January 1, 2014, based on current ALJs' assignment effective date. Current ALJ's will be divided into four approximately equal groups based on length of tenure in the ALJ position. The most tenured group will be surveyed first, with the next tenured group being surveyed beginning January 1 of the following calendar year, until the four-year survey cycle is established.

(2) Survey results shall be maintained by the department and shall not be maintained in the ALJ's personnel file.

(3) Survey results shall be made available to the ALJ's supervisor for consideration in completing annual performance evaluations.

KEY: administrative law judges, conduct committee
Date of Enactment or Last Substantive Amendment: 2014
Authorizing and Implemented or Interpreted Law: 67-19e-101 through 67-19e-109

Human Services, Services for People with Disabilities
R539-4
Behavior Interventions

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38093
FILED: 11/01/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Division of Services for People with Disabilities (DSPD) has reviewed and approved two additional manual restraint programs. Subsection R539-4-

5(4)(c) outlines manual restraint programs that the Division allows. Any restraint program not listed there has to be reviewed by our State Behavior Review Committee. Since DSPD has reviewed and approved these two programs, our division would like to include them among the list of restraint programs that no longer need to be reviewed by our State Behavior Review Committee every time a family would like to participate.

SUMMARY OF THE RULE OR CHANGE: The changes add two additional approved manual restraint programs to the list in Subsection R539-4-5(4)(c).

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 62A-5-102 and Section 62A-5-103

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: No anticipated costs or savings to the state budget. The state budget is not affected at all by this rule. All this rule does is officially recognize Division approval of two manual restraint programs. It does not require any funds from the state budget to be used, nor does it require any additional added responsibility for state government.
♦ LOCAL GOVERNMENTS: No anticipated costs or savings to local governments. Local government is not affected by this rule. All this rule does is officially recognize Division approval of two manual restraint programs. It has no effect on the budget, nor does it require any spending or saving from local government.
♦ SMALL BUSINESSES: No anticipated costs or savings for small businesses. Small businesses are not affected by this rule. No business is required by this rule change to participate in manual restraint programs, or adopt those being added to the list. This rule allows certain businesses to use the additional manual restraint programs listed if they so choose, but is not mandatory and should not add or remove a cost from those businesses choosing to do so.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: No anticipated costs or savings for persons other than small businesses, businesses, or local governmental entities. Nothing in this rule change is imposing a mandatory responsibility on any person other than small businesses, businesses, or local governmental entities. It gives people an additional options should they choose, but does not require anything of them, nor should it impose any additional costs or savings on those persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There is no compliance cost affecting persons by adding these potential manual restraint programs. It just gives providers and families an additional approved manual restraint program, beyond what the Division has already approved. As such, it is not a rule change that has an effect on any costs for those who wish to use these approved manual restraint techniques and program.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There will be no costs or savings associated with this rule.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HUMAN SERVICES
SERVICES FOR PEOPLE WITH DISABILITIES
195 N 1950 W 3RD FLR
SALT LAKE CITY, UT 84116
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Julene Jones by phone at 801-538-4521, by FAX at 801-538-3942, or by Internet E-mail at jhjones@utah.gov
♦ Nathan Wolfley by phone at 801-538-4154, by FAX at 801-538-4279, or by Internet E-mail at nwolfley@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 12/23/2013

AUTHORIZED BY: Paul Smith, Director

R539. Human Services, Services for People with Disabilities.
R539-4. Behavior Interventions.
R539-4-2. Authority.

(1) This rule establishes procedures and standards for Persons' constitutional liberty interests as required by Subsection 62A-5-103[~~(4)(b)~~].

R539-4-5. Review and Approval Process.

(1) The Behavior Peer Review Committee shall review and approve the Behavior Support Plan annually. The plan may be implemented prior to the Behavior Peer Review Committee's review; however the review and approval must be completed within 60 calendar days of implementation.

(2) The Behavior Peer Review Committee's review and approval process shall include the following:

(a) A confirmation that appropriate Positive Behavior Supports, including Level I Interventions, were fully implemented and revised as needed prior to the implementation of Level II or Level III Interventions.

(b) Ensure the technical adequacy of the Functional Behavior Assessment and Behavior Support Plan based on principles from the fields of Positive Behavior Supports and applied behavior analysis.

(c) Ensure plans are in place to attempt reducing the use of intrusive interventions.

(d) Ensure that staff training and plan implementation are adequate.

(3) The Provider Human Rights Committee shall approve Behavior Support Plans with Level II and Level III Interventions annually. Review and approval shall focus on rights issues, including consent and justification for the use of intrusive interventions.

(4) The State Behavior Review Committee must consist of at least three members, including representatives from the Division, Provider, and an independent professional having a recognized expertise in Positive Behavior Supports. The Committee shall review and approve the following:

(a) Behavior Support Plans that include Time-out Rooms, Mechanical Restraints or Highly Noxious Stimuli.

(b) Behavior Support Plans that include forms of Manual Restraint or Exclusionary Time-out used for long-term behavior change and not used in response to an emergency situation.

(c) Behavior Support Plans that include manual restraint not outlined in Mandt, PART, [~~or~~] SOAR, Safety Care, or CPI training programs.

(5) The Committee shall determine the time-frame for follow-up review.

(6) Behavior Support Plans shall be submitted to the Division's state office for temporary approval prior to implementation pending the State Behavior Review Committee's review of the plan.

(7) Families participating in Self-Administered Services may seek State Behavior Review Committee recommendations, if desired.

KEY: people with disabilities, behavior
Date of Enactment or Last Substantive Amendment: [~~May 3, 2005~~]2013
Notice of Continuation: December 17, 2009
Authorizing, and Implemented or Interpreted Law: 62A-5-102; 62A-5-103

Human Services, Services for People with Disabilities
R539-10
Short-Term Limited Waiting List Services

NOTICE OF PROPOSED RULE

(New Rule)
DAR FILE NO.: 38094
FILED: 11/01/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this rule is to set forth procedures for how the Division of Services for People with Disabilities (DSPD) will determine the use of non-lapsing funds to provide short-term, limited services, as allowed by new legislation (S.B. 259 passed in the 2013 General Legislative Session) and codified in Subsections 62A-5-102(7)(c) and (d).

SUMMARY OF THE RULE OR CHANGE: The new rule sets forth eligibility, limitations, and selection rules for people on the waiting list hoping to receive short-term limited waiting list services such as: respite care, family skill building and preservation classes, and service brokering services.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 62A-5-102(7)

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: There are no anticipated costs or savings, to the state budget. Any funding for short-term limited waiting list services comes from funds that have already been appropriated to the Division, and become non-lapsing funds eligible for one-time expenditures as the Division deems appropriate.
♦ LOCAL GOVERNMENTS: There are no anticipated costs or savings to local government. Local government is not contracted to provide these services and the funding for these services come from funds that have already been appropriated to the Division.
♦ SMALL BUSINESSES: There are no anticipated costs or savings to small businesses. Any funding for short-term limited waiting list services comes from funds that have already been appropriated to the Division. This will not impact any small businesses; the rule only changes what current funding can be used for.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: There are no anticipated costs or savings to persons other than small businesses, businesses, or local government entities. Any funding for short-term limited waiting list services comes from funds that have already been appropriated to the Division. This will not impact any small businesses; the rule only changes what current funding can be used for.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs for affected persons. The rule change is giving the ability to provide services on the DSPD waiting list. Any funding for short-term limited waiting list services comes from funds that have already been appropriated to the Division, and become non-lapsing funds eligible for one-time expenditures as the Division deems appropriate.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There will be no costs or savings associated with this rule.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HUMAN SERVICES
SERVICES FOR PEOPLE WITH DISABILITIES
195 N 1950 W 3RD FLR
SALT LAKE CITY, UT 84116
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Julene Jones by phone at 801-538-4521, by FAX at 801-538-3942, or by Internet E-mail at jhjones@utah.gov
♦ Nathan Wolfley by phone at 801-538-4154, by FAX at 801-538-4279, or by Internet E-mail at nwolfley@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 12/23/2013

AUTHORIZED BY: Paul Smith, Director

R539. Human Services, Services for People with Disabilities.
R539-10. Short-Term Limited Waiting List Services.
R539-10-1. Purpose and Authority.

(1) The purpose of this rule is to provide:

(a) procedures and standards for the determination of eligibility for persons on the waiting list to receive short-term, limited services from the Division.

(2) This rule is authorized by Subsections 62A-5-102(2); 62A-5-102(7)(c).

R539-10-2. Definitions.

(1) Terms used in this rule are defined in Section 62A-5-101 and R539-1-2.

(2) In addition:

(a) "Active Status" means a person has a current needs assessment score and is on the Division's waiting list.

(b) "Respite" is a service provided in a person's residence or other approved residential setting, designed to give relief to or during the absence of a person's primary caregiver.

R539-10-3. Eligibility.

(1) A person is eligible for short-term limited waiting list services if:

(a) the person has met eligibility criteria for non-waiver services as set forth in R539-1;

(b) the person is not receiving ongoing services with the Division; and

(c) the person is currently in active status on the Division's waiting list.

R539-10-4. Limitations.

(1) Funds granted must be used during the fiscal year in which they are granted, beginning July 1st of the year granted and ending June 30th of the following year.

(a) If there is no plan to use the funds or if the funds are unused, those funds will return to the Division and may be reallocated to another eligible person.

(b) In the case of short-term limited family skill building and preservation classes, openings that become available due to families dropping out of the program or other circumstances, shall be filled if possible by additional families from the same geographical area that meet all eligibility criteria.

R539-10-5. Selection for Short-Term Limited Respite Care Services.

(1) Nonlapsing Funds may be available to provide short-term limited respite care services for persons determined eligible who are on the Division's waiting list.

(2) When the Division determines that sufficient funds are available to provide short-term limited respite care services, persons will be selected to receive short-term limited respite care according to the following method:

(a) The Division shall identify all persons on the waiting list who have indicated that they are in need of respite services;

(b) Persons identified by the Division as needing respite services shall be grouped together, from which the Division shall use a random selection process to select persons to receive short-term limited respite services.

R539-10-6. Short-Term Limited Respite Care Provider Options.

(1) Short-term limited respite care services may be provided through either the Self-Administered Services Model or the traditional Agency-Based Provider Model or a combination of both.

(2) If the person elects the Self-Administered Services Model to provide short-term limited respite care, the following requirements must be met:

(a) the person must select a fiscal agent, through which all payments to employees must be made;

(b) the person must adhere to all additional requirements set forth in Section R539-5.

R539-10-7. Additional Participation Requirements for Short-Term Limited Family Skill Building and Preservation Classes.

(1) In order to be eligible for participation in short-term family skill building and preservation classes the family of the eligible person must agree to the following additional requirements:

(a) To sign a participation agreement stating that the family will participate fully in the offered short-term family skill building and preservation classes;

(b) To have the person's waiting list needs assessment re-evaluated within six months of completing participation in the short-term family skill building and preservation classes;

R539-10-8. Selection and Enrollment for Short-Term Limited Family Skill Building and Preservation Classes.

(1) Nonlapsing Funds may be available to provide short-term limited family skill building and preservation classes for persons determined eligible who are on the Division's waiting list.

(2) When the Division determines that sufficient funds are available to provide short-term limited family skill building and preservation classes, persons will be selected to participate in the family skill building and preservation classes according to the following parameters:

(a) The Division shall advertise an open enrollment period to all persons with an active status on the Division's waiting list;

(b) During the open enrollment period, the Division will accept applications for a two week period from persons or their families wishing to participate;

(i) Additional enrollment periods may be offered as the Division deems necessary;

(c) Applications will be reviewed to determine an applicant's eligibility;

(d) Eligible applicants will be admitted into the program in the order in which they have applied to participate, in the respective geographical area in which they live;

(i) If the number of applications for the respective geographical area exceeds 300 during the open enrollment period, all eligible program applicants will be grouped together from which participants will be selected to participate using a random selection process;

R539-10-9. Short-Term Limited Service Brokering Services.

(1) Nonlapsing Funds may be available to provide short-term limited service brokering services for persons determined eligible who are on the Division's waiting list.

(2) When the Division determines that sufficient funds are available to provide short-term limited service brokering services, persons will be selected to receive short-term limited service brokering services according to need as determined from information supplied to the Division.

KEY: waiting lists, family preservation, respite, service brokering
Date of Enactment or Last Substantive Amendment: 2013
Authorizing, and Implemented or Interpreted Law: 62A-5-102(7)

Human Services, Services for People with Disabilities
R539-11
Family Preservation Pilot Program

NOTICE OF PROPOSED RULE
(Repeal)
DAR FILE NO.: 38095
FILED: 11/01/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule no longer has relevance, as the Division of Services for People with Disabilities (DSPD) is no longer running a "Family Preservation Pilot Program", but instead has been authorized by new legislation to provide "family skill building and preservation classes" on an ongoing basis, which will be governed by recently proposed new Rule R539-10. (DAR NOTE: The proposed new Rule R539-10 is under DAR No. 38094 in this issue, November 15, 2013, of the Bulletin.)

SUMMARY OF THE RULE OR CHANGE: This rule is repealed in its entirety because it is obsolete.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 62A-5-102(7)

ANTICIPATED COST OR SAVINGS TO:

♦ THE STATE BUDGET: There are no anticipated cost or savings to state budget because the program no longer exists.

♦ LOCAL GOVERNMENTS: There are no anticipated cost or savings to local government because the program no longer exists.

♦ SMALL BUSINESSES: There are no anticipated cost or savings to small businesses because the program no longer exists.

♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: There are no anticipated cost or savings to persons other than small businesses, businesses, or local government entities because the program no longer exists.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There is no compliance cost for persons affected by this rule repeal because the program no longer exists.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There will be no fiscal impact associated with this rule.

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

HUMAN SERVICES
SERVICES FOR PEOPLE WITH DISABILITIES
195 N 1950 W 3RD FLR
SALT LAKE CITY, UT 84116
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

♦ Julene Jones by phone at 801-538-4521, by FAX at 801-538-3942, or by Internet E-mail at jhjones@utah.gov

♦ Nathan Wolfley by phone at 801-538-4154, by FAX at 801-538-4279, or by Internet E-mail at nwolfley@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 12/23/2013

AUTHORIZED BY: Paul Smith, Director

R539. Human Services, Services for People with Disabilities.
[~~R539-11. Family Preservation Pilot Program.~~
~~R539-11-1. Purpose and Authority.~~

~~(1) The purpose of this rule is to provide:~~

~~(a) procedures and standards for the determination of eligibility for the Division's pilot program to provide Family Preservation Services for Persons on the Division's Waiting List as specified in R539-2-4.~~

~~(2) This rule is authorized by Section 62A-5-103.2~~

~~R539-11-2. Definitions.~~

~~Terms used in this rule are defined in Section 62A-5-101, and~~

~~"Person": Individual who meets eligibility requirements in Rule R539-1.~~

~~"Active Status": Has a current Needs Assessment Score on Division wait list.~~

~~"Participate fully": Follow through with assignments and accept guidance and clinical judgment regarding treatment issues of Professional and clinical team. Also to complete Self Inventory Assessments.~~

~~"Time-limited": Workshops run for six weeks. Follow up services will not exceed six weeks following the end of the workshops. Total time of participation for any one family is three months.~~

~~**R539-11-3. Person's Eligibility.**~~

~~(1) A person who meets the eligibility requirements listed in Section 62A-5-103.2 may participate in the Family Preservation Pilot Program provided that:~~

~~the person agrees to enter services under the conditions listed in Section 62A-5-103.2,~~

~~the person agrees to use an approved provider.~~

~~The person is currently in active status on the Division wait list.~~

~~**R539-11-4. Family's Eligibility.**~~

~~(1) A family who has a person who meets the eligibility requirements listed in Rule R539-1 living in their home, may participate in the Family Preservation Pilot Program provided:~~

~~The family agrees to have their wait list needs assessment re-evaluated approximately six months after completing participation in pilot program.~~

~~The family agrees to sign a participation agreement agreeing to participate fully in pilot program.~~

~~The family agrees to time-limited services.~~

~~The family agrees to access services that can be purchased from providers, through Division contracted providers.~~

~~**R539-11-5. Priority.**~~

~~People will be served in the order in which they apply to participate in the pilot program in the respective geographical area in which they live and as space becomes available in workshops.~~

~~**R539-11-6. Service Brokering.**~~

~~(1) Persons eligible for the Supported Employment Pilot Program may also use Service Brokering services.~~

~~**KEY: disabilities**~~
~~**Date of Enactment or Last Substantive Amendment: November 14, 2007**~~
~~**Notice of Continuation: November 5, 2012**~~
~~**Authorizing, and Implemented or Interpreted Law: 62A-5-103.2]**~~

Insurance, Administration
R590-96
Rule to Recognize New Annuity Mortality Tables for Use in Determining Reserve Liabilities for Annuities

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38069
FILED: 10/18/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: A new individual annuity reserving table is being added to the rule. The rule will enhance solvency of insurers selling individual annuities.

SUMMARY OF THE RULE OR CHANGE: The 2012 Individual Annuity Reserving (2012 IAR) Table is being added to the rule for use in determining the minimum standard of valuation for annuity and pure endowment contracts. The following terms are being added to the rule's Definition Section: Period Table, 1994 GAM Table, Projection Scale AA, 2012 IAM Period Table, Projection Scale G2, and 2012 IAR Table; publication information about several of the tables already noted in the rule, is being updated. Subsection R590-96-4(D) sets the date that the new 2012 IAR Table will begin to be used as after 01/01/2015. Section R590-96-5 outlines how the new table will be applied and mortality rates calculated. Section R590-96-7 of the rule is amended to read consistently with Section R590-96-5.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 31A-17-505

MATERIALS INCORPORATED BY REFERENCES:

- Adds 2012 Individual Annuity Reserving (IAR) Table, published by National Association of Insurance Commission, December 2012

ANTICIPATED COST OR SAVINGS TO:

- THE STATE BUDGET: The changes to this rule will have no impact on the department's budget, expenditures or revenues. The rule directs insurance companies offering annuity products to the mortality tables they are to use in determining the minimum standard of valuation for annuity and pure endowment contracts. The adoption of a new table does not change the filings, fees or any other duties the insurer has to the department that would affect the insurer or department's costs or savings.
- LOCAL GOVERNMENTS: This rule only affects licensees of the department. It has no impact on local governments.
- SMALL BUSINESSES: The changes to this rule affect insurance companies, which are large employers, not small businesses.
- PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: The rule change will have a direct impact on insurance companies issuing individual annuities and may have an indirect impact on the public. Insurers selling individual annuities will be required to hold higher reserves. They will

also have to modify their systems to accommodate the new table. The increase in reserves may cause increase in annuity prices to the consumers.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The rule change will have a direct impact on insurance companies issuing individual annuities and may have an indirect impact on the public. Insurers selling individual annuities will be required to hold higher reserves. They will also have to modify their systems to accommodate the new table. The increase in reserves may cause increase in annuity prices to the consumers.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Insurance companies will have to modify their reserving systems to accommodate new table. How this is accomplished will vary from company to company. The expense, if any, is not expected to be significant.

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 AT 5:00 PM ON 12/31/2013

THIS RULE MAY BECOME EFFECTIVE ON: 01/07/2014

AUTHORIZED BY: Jilene Whitby, Information Specialist

R590. Insurance, Administration.
R590-96. Rule to Recognize New Annuity Mortality Tables for Use in Determining Reserve Liabilities for Annuities.
R590-96-1. Authority.

This rule is promulgated by the Insurance Commissioner pursuant to Sections 31A-2-201, and 31A-17-505.

R590-96-2. Purpose.

The purpose of this rule is to recognize the following mortality tables for use in determining the minimum standard of valuation for annuity and pure endowment contracts: the 1983 Table [~~"a"~~](a), the 1983 Group Annuity Mortality (1983 GAM) Table, the Annuity 2000 Mortality Table, the 2012 Individual Annuity Reserving (2012 IAR) Table, and the 1994 Group Annuity Reserving (1994 GAR) Table.

R590-96-3. Definitions.

A. As used in this rule "Period Table" means a table of mortality rates applicable to a given calendar year.

B. As used in this rule "Generational Mortality Table" means a mortality table containing a set of mortality rates that decrease for a given age from one year to the next based on a combination of a period table and a projection scale containing mortality improvement factors.

[~~A~~]C. As used in this rule "1983 Table [~~"a"~~](a)" means that mortality table developed by the Society of Actuaries Committee to Recommend a New Mortality Basis for Individual Annuity Valuation[~~ and~~], adopted by the NAIC in June 1982 as a recognized mortality table for annuities, and published in the 1982 Proceedings of the NAIC II, page 454[~~ in June 1982 by the National Association of Insurance Commissioners~~].

[~~B~~]D. As used in this rule "1983 GAM Table" means that mortality table developed by the Society of Actuaries Committee on Annuities[~~ and~~], adopted by the NAIC in December 1983 as a recognized mortality table for annuities, and published in 1984 Proceedings of the NAIC I, pages 414-415[~~ in December 1983 by the National Association of Insurance Commissioners~~].

E. As used in this rule "1994 GAM Table" means the 1994 Group Annuity Mortality Static Table, a period table containing loaded mortality rates for calendar year 1994, developed by the Society of Actuaries Group Annuity Valuation Table Task Force, and published in the Transactions of the Society of Actuaries, Vol. XLVII (1995), pages 898-899.

F. As used in this rule "Projection Scale AA" means that table of annual mortality improvement factors for projecting future mortality rates beyond calendar year 1994, developed by the Society of Actuaries Group Annuity Valuation Table Task Force, and published in the Transactions of the Society of Actuaries, Vol. XLVII (1995), 824-826.

[~~C~~]G. As used in this rule "1994 GAR Table" means the 1994 Group Annuity Reserving Table, a generational mortality[~~that mortality~~] table developed by the Society of Actuaries Group Annuity Valuation Table Task Force, derived from a combination of 1994 GAM Table and the Projection Scale AA as described in Subsection R590-96-7,[~~ and shown on pages 866-867 of Volume XLVII of the Transactions of the Society of Actuaries, 1995, and~~] adopted by the NAIC in December 1996 as a recognized mortality table for annuities, and published in the Transactions of the Society of Actuaries, Vol. XLVII (1995), pages 866-867[~~ in December 1996 by the National Association of Insurance Commissioners~~].

[~~D~~]H. As used in this rule "Annuity 2000 Mortality Table" means that mortality table developed by the Society of Actuaries Committee on Life Insurance Research[~~ and shown on page 240 of Volume XLVII of the Transactions of the Society of Actuaries (1995) and~~] adopted by the NAIC in December 1996 as a recognized mortality table for annuities, and published in the Transactions of the Society of Actuaries, Vol. XLVII (1995), page 240[~~ in December 1996 by the National Association of Insurance Commissioners~~].

I. As used in this rule "2012 IAM Period Table" means that period table containing loaded mortality rates for calendar year 2012, developed by the Society of Actuaries Committee on Life Insurance Research, and published in the 2012 Proceedings of the NAIC, Fall Volume I, pages 149-150.

J. As used in this rule "Projection Scale G2" means that table of annuity mortality improvement factors for projecting future mortality rates beyond calendar year 2012, developed by the Society of Actuaries Committee on Life Insurance Research, and published in the 2012 Proceedings of the NAIC, Fall Volume I, pages 151-152.

K. As used in this rule "2012 IAR Table" means that generational mortality table developed by Society of Actuaries Committee on Life Insurance Research, derived from a combination of the 2012 IAM Period Table and the Projection Scale G2 as described in Subsection R590-96-5, adopted by the NAIC in December 2012,and published in the 2012 Proceedings of the NAIC, Fall Volume I, pages 149-152.

[~~E~~]L. The tables identified in R590-96-3.C[~~-~~] [~~and~~]through [~~D.~~]K, are hereby incorporated by reference within this rule and are available at the department's website https://insurance.utah.gov/legal-resources/rules/current-rules.php[~~for public inspection at the Insurance Department during normal business hours~~].

R590-96-4. Individual Annuity or Pure Endowment Contracts.

A. Except as provided in Subsections [~~B. and C.~~]R590-96-4.B through E[~~- of this section~~], the 1983 Table [~~"a"~~](a) is recognized and approved as an individual annuity mortality table for valuation and, at the option of the company, may be used for purposes of determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after April 2, 1980.

B. Except as provided in Subsections [~~C.~~]R590-96-4.C through E[~~- of this section~~], either the 1983 Table [~~"a"~~](a) or the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after July 1, 1985.

C. Except as provided in Subsections [~~D~~]R590-96-4.D and E[~~- of this section~~], the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after July 1, 1999.

D. Except as provided in Subsection R590-96-4.E, the 2012 IAR Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 2015.

[~~D~~]E. The 1983 Table [~~"a"~~](a) without projection is to be used for determining the minimum standards of valuation for an individual annuity or pure endowment contract issued on or after July 1, 1999, solely when the contract is based on life contingencies and is issued to fund periodic benefits arising from:

(1) Settlements of various forms of claims pertaining to court settlements or out of court settlements from tort actions;

(2) Settlements involving similar actions such as worker's compensation claims; or

(3) Settlements of long term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments.

R590-96-5. Application of the 2012 IAR Table.

A. In using the 2012 IAR Table, the mortality rate for a person age x in year (2012 + n) is calculated as follows: $q_x^{2012+n} = q_x^{2012}(1 - G2_x)^n$; where q_x^{2012} is a mortality rate applicable to a person age x in the 2012 IAM Period Table and $G2_x$ is an annual mortality improvement factor applicable to a person age x in the Projection Scale G2.

B. The resulting mortality rate q_x^{2012+n} shall be rounded to six decimal places.

R590-96-[5]6. Group Annuity or Pure Endowment Contracts.

A. Except as provided in Subsections R590-96-6.B[~~-~~] and C[~~- of this section~~], the 1983 GAM Table, the 1983 Table [~~"a"~~](a) and the 1994 GAR Table are recognized and approved as group annuity mortality tables for valuation and, at the option of the company, any one of these tables may be used for purposes of valuation for an annuity or pure endowment purchased on or after April 2, 1980 under a group annuity or pure endowment contract.

B. Except as provided in Subsection R590-96-6.C[~~- of this section~~], either the 1983 GAM Table or the 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after July 1, 1985 under a group annuity or pure endowment contract.

C. The 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after July 1, 1999 under a group annuity or pure endowment contract.

R590-96-[6]7. Application of the 1994 GAR Table.

In using the 1994 GAR Table, the mortality rate for a person age x in year (1994 + n) is calculated as follows: $q_x^{1994+n} = q_x^{1994}(1 - AA_x)^n$; where the q_x^{1994} is a mortality rate applicable to a person age x in the 1994 GAM Table and AA_xs is an annual mortality improvement factor applicable to a person age x in the Projection scale AA[~~are as specified in the 1994 GAR Table~~].

R590-96-[7]8. Separability.

If any provision of this rule or its application to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances may not be affected by it.

KEY: insurance law
Date of Enactment or Last Substantive Amendment: [~~March 16, 1999~~]2014
Notice of Continuation: August 22, 2012
Authorizing, and Implemented or Interpreted Law: 31A-2-201; 31A-17-505

Insurance, Administration
R590-229
Annuity Disclosure

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38090
FILED: 11/01/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule is being amended to update the incorporated National Association of Insurance Commissioners (NAIC) annuity buyer's guides to the 2013 versions.

SUMMARY OF THE RULE OR CHANGE: In 2013, the buyer's guides were updated from the 2007 version. There are now three versions: annuities in general, fixed annuities, and variable annuities.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 31A-22-425

MATERIALS INCORPORATED BY REFERENCES:

- ♦ Updates Buyer's Guide for Deferred Annuities, published by National Association of Insurance Commissioners (NAIC), 2013
- ♦ Adds Buyer's Guide for deferred Annuities - Fixed, published by National Association of Insurance Commissioners (NAIC), 2013
- ♦ Adds Buyer's Guide for Deferred Annuities - Variable, published by National Association of Insurance Commissioners (NAIC), 2013

ANTICIPATED COST OR SAVINGS TO:

♦ THE STATE BUDGET: Companies will not be required to make any filings with the department so there will be no additional workload for the department, nor will there be any costs or savings to the department. The amendments simply note the change from one buyer's guide to three with their names and publication information.

♦ LOCAL GOVERNMENTS: The changes to this rule do not affect local government. They deal solely with the relationship between the department and its licensees.

♦ SMALL BUSINESSES: The changes to this rule will have no cost or savings for small businesses. They will affect insurance companies selling annuity coverage.

♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: With the change of the annuity buyer's guide to the new versions, insurance companies can either continue to purchase hard copies from the National Association of Insurance Commissioners (NAIC) for $0.75 to $0.80 each, or they can purchase an electronic version by paying a license fee of $500 for each version, as well as royalty fees of from $250 to $25,600, depending on quantity. Individuals purchasing this coverage will not be affected financially by this change.

COMPLIANCE COSTS FOR AFFECTED PERSONS: With the change of the annuity buyer's guide to the new versions, insurance companies can either continue to purchase hard copies from the NAIC for $0.75 to $0.80 each, or they can purchase an electronic version by paying a license fee of $500 for each version, as well as royalty fees of from $250 to $25,600, depending on quantity. Individuals purchasing this coverage will not be affected financially by this change.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Insurance companies will need to replace the annuity booklets they have on hand with new hard copies or electronic versions.

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 AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 12/23/2013

AUTHORIZED BY: Todd Kiser, Commissioner

R590. Insurance, Administration.
R590-229. Annuity Disclosure.
R590-229-4. Incorporation by reference.

The following Buyer's Guides are hereby incorporated by reference within this rule:

(1) "Buyer's Guide for Deferred Annuities" dated 2013, as adopted by and available from the National Association of Insurance Commissioners;

(2) "Buyer's Guide for Deferred Annuities - Fixed" dated 2013, as adopted by and available from the National Association of Insurance Commissioners; and

(3) "Buyer's Guide for Deferred Annuities - Variable" dated 2013 as adopted by and available from the National Association of Insurance Commissioners.

R590-229-5. Definitions.

In addition to the definitions in Section 31A-1-301, the following definitions shall apply for the purpose of this rule:

(1) "Buyer's Guide" means a document which contains, and is limited to, the language contained in the "Buyer's Guide [~~to~~]for Fixed Deferred Annuities,"[~~ and its "Appendix I Equity-Indexed Annuities,"~~] dated [~~1998~~]2013, the Buyer's Guide for Fixed Deferred Annuities - Fixed" dated 2013, and the "Buyer's Guide for Fixed Deferred Annuities - Variable" dated 2013[~~as adopted by, and available from the National Association of Insurance Commissioners, which are incorporated in this rule by reference or go to the department's website~~].

(2) "Contract owner" means the owner named in the annuity contract or certificate holder in the case of a group annuity contract.

(3) "Determinable elements" means elements that are derived from processes or methods that are guaranteed at issue and not

subject to company discretion, but where the values or amounts cannot be determined until some point after issue. These elements include the premiums, credited interest rates with any applicable bonus, benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these. These elements may be described as guaranteed but not determined at issue. An element is considered determinable if all of the underlying elements that go into its calculation are either guaranteed or determinable.

(4) "Disclosure document" means the document described in Subsection 6(2) of this rule.

(5) "Funding agreement" means an agreement for an insurer to accept and accumulate funds and to make one or more payments at future dates in amounts that are not based on mortality or morbidity contingencies.

(6) "Generic name" means a short title descriptive of the annuity contract being applied for such as "single premium deferred annuity".

(7) "Guaranteed elements" means premiums, credited interest rates with any applicable bonus, benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are guaranteed and determined at issue. An element is considered guaranteed if all of the underlying elements that go into its calculation are guaranteed.

(8) "Non-guaranteed elements" means the premiums, credited interest rates with any applicable bonus, benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these that are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying elements that go into its calculation are non-guaranteed.

(9) "Structured settlement annuity" means a "qualified funding asset" as defined in IRC Section 130(d) or an annuity that would be a qualified funding asset under IRC Section 130(d) but for the fact that it is not owned by an assignee under a qualified assignment.

R590-229-[5]6. Appropriate Buyer's Guide.

(1) [~~Where an application for an equity-indexed annuity is taken, t~~]The "Buyer's Guide [~~to~~]for Fixed Deferred Annuities" [~~with "Appendix I for Equity-Indexed Annuities" ~~]shall be [~~the Buyer's Guide given to the applicant and will be ~~]considered the appropriate Buyer's Guide for[~~ the~~]an annuity product.

(2) [~~For all other annuity products,~~]Notwithstanding Subsection (1):

(a) for a fixed non-variable annuity product, the "Buyer's Guide to Fixed Deferred Annuities - Fixed" [~~with or without "Appendix I Equity-Indexed Annuities" will be considered the appropriate Buyer's Guide~~]may be used as the appropriate Buyer's Guide; and

(b) for a variable annuity product, the "Buyer's Guide for Fixed Deferred Annuities - Variable" may be used as the appropriate Buyer's Guide.

R590-229-[6]7. Standards for the Disclosure Document and Buyer's Guide.

(1)(a) Where the application for an annuity contract is taken in a face-to-face meeting, the applicant shall, at or before the time of application, be given both the disclosure document described in Subsection [~~6~~]7(2) of this section and the appropriate Buyer's Guide, as described in Section [~~5~~]6.

(b) Where the application for an annuity contract is taken by means other than in a face-to-face meeting, the applicant shall be sent both the disclosure document and the appropriate Buyer's Guide no later than five business days after the completed application is received by the insurer.

(i) With respect to an application received as a result of a direct solicitation through the mail:

(A) providing a Buyer's Guide in a mailing inviting prospective applicants to apply for an annuity contract shall be deemed to satisfy the requirement that the appropriate Buyer's Guide be provided no later than five business days after receipt of the application; and

(B) providing a disclosure document in a mailing inviting a prospective applicant to apply for an annuity contract shall be deemed to satisfy the requirement that the disclosure document be provided no later than five business days after receipt of the application.

(ii) With respect to an application received via the Internet:

(A) taking reasonable steps to make the appropriate Buyer's Guide available for viewing and printing on the insurer's website shall be deemed to satisfy the requirement that the appropriate Buyer's Guide be provided no later than five business days of receipt of the application; and

(B) taking reasonable steps to make the disclosure document available for viewing and printing on the insurer's website shall be deemed to satisfy the requirement that the disclosure document be provided no later than five business days after receipt of the application.

(c) A solicitation for an annuity contract provided in other than a face-to-face meeting shall include a statement that the prospective applicant can obtain from the insurer a free annuity Buyer's Guide upon request.

(2) At a minimum, the following information shall be included in the disclosure document required to be provided under this rule:

(a) the generic name of the contract, the company product name, if different, the form number, and the fact that it is an annuity;

(b) the insurer's name and address;

(c) a description of the contract and its benefits, emphasizing its long-term nature, including examples where appropriate of:

(i) the guaranteed, non-guaranteed and determinable elements of the contract, and their limitations, if any, and an explanation of how they operate;

(ii) an explanation of the initial crediting rate, specifying any bonus or introductory portion, the duration of the rate and the fact that rates may change from time to time and are not guaranteed;

(iii) periodic income options, both on a guaranteed and non-guaranteed basis;

(iv) any value reductions caused by withdrawals from or surrender of the contract;

(v) how values in the contract can be accessed;

(vi) the death benefit, if available, and how it will be calculated;

(vii) a summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; and

(viii) impact of any rider, such as a long-term care rider;

(d) specific dollar amount or percentage charges and fees shall be listed with an explanation of how they apply; and

(e) information about the current guaranteed rate for a new contract that contains a clear notice that the rate is subject to change.

(3) An insurer shall define terms used in the disclosure statement in language that facilitates the understanding by a typical person within the segment of the public to which the disclosure statement is directed.

R590-229-[~~7~~]8. Report to Contract Owners.

For an annuity in the payout period with changes in non-guaranteed elements and for the accumulation period of a deferred annuity, the insurer shall provide the contract owner with a report, at least annually, on the status of the contract that contains at least the following information:

(1) the beginning and end date of the current report period;

(2) the accumulation and cash surrender value, if any, at the end of the previous report period and at the end of the current report period;

(3) the total amounts, if any, that have been credited, charged to the contract value, or paid during the current report period; and

(4) the amount of outstanding loans, if any, as of the end of the current report period.

R590-229-[8]9. Enforcement Date.

The commissioner will begin enforcing the provisions of this rule 45 days after the effective[~~on the~~] date [~~this rule goes into effect~~].

R590-229-[9]10. Severability.

If any provision or clause of this rule or its application to any person or situation is held invalid, such 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.

KEY: insurance, annuity disclosure
Date of Enactment or Last Substantive Amendment: [~~October 7, 2004~~]2013
Notice of Continuation: September 22, 2009
Authorizing, and Implemented or Interpreted Law: 31A-2-201; 31A-22-425

Insurance, Administration
R590-268
Small Employer Stop-Loss Insurance

NOTICE OF PROPOSED RULE
(New Rule)
DAR FILE NO.: 38087
FILED: 11/01/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Implement new rulemaking requirements in Sections 31A-43-301, 31A-43-302, and 31A-43-303 as a result of passage of H.B. 160 passed during the 2013 General Legislative Session.

SUMMARY OF THE RULE OR CHANGE: As a result of passage of H.B. 160 (2013), Sections 31A-43-301, 31A-43-302, and 31A-43-303 were added to the Insurance Code requiring the department to develop a rule to provide a universal application form, the content of the stop-loss insurance disclosure, prohibit lasering, and establish the form and manner of form and rate filings and of the annual actuarial certification and report on stop-loss experience.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 31A-43-304 and Title 31A, Chapter 43

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: Health insurance companies will be required to file with the department small employer forms and rates that department staff will need to review. It is anticipated that currently 10-12 insurers may be affected by this rule. Work load on department staff will be minimal, and no costs or savings will be incurred.
♦ LOCAL GOVERNMENTS: There will be no impact on local governments. This rule only affects a few licensees of the department.
♦ SMALL BUSINESSES: The rule establishes uniform coverage requirements for the stop-loss market that did not exist before. There will be no cost or savings to them.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: Costs will be minimal--Insurers selling stop-loss insurance will need to print applications and disclosure forms for small employers enrolled in this product.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Costs will be minimal--Insurers selling stop-loss insurance will need to print applications and disclosure forms for small employers enrolled in this product.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Compliance costs will be negligible.

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 AT 5:00 PM ON 12/16/2013

INTERESTED PERSONS MAY ATTEND A PUBLIC HEARING REGARDING THIS RULE:
♦ 12/10/2013 09:00 AM, State Office Bldg, 450 N State St, Room 3112, Salt Lake City, UT

THIS RULE MAY BECOME EFFECTIVE ON: 12/23/2013

AUTHORIZED BY: Todd Kiser, Commissioner

R590. Insurance Administration.
R590-268. Small Employer Stop-Loss Insurance.
R590-268-1. Authority.

This rule is promulgated pursuant to Section 31A-43-304 wherein the commissioner may make rules to implement Title 31A, Chapter 43.

R590-268-2. Scope.

This rule applies to all small employer stop-loss contracts issued or renewed on or after July 1, 2013.

R590-268-3. Purpose.

The purpose of this rule is to provide a universal application form, provide the content of the stop-loss insurance disclosure, prohibit lasering, and establish the form and manner of form and rate filings and of the annual actuarial certification and report on stop-loss experience.

R590-268-4. Definitions.

For the purposes of this rule, the commissioner adopts the definitions of Sections 31A-1-301 and 31A-43-102.

R590-268-5. Standard Application.

(1) Stop-loss insurers marketing to small employers shall use the Utah Small Employer Stop-loss Universal Application.

(2) The Small Employer Stop-loss Universal Application shall not display the insurer's name, identifying logo or address.

(3) The Utah Small Employer Stop-loss Universal Application, published November 15, 2013, is hereby incorporated by reference and is available on the Department's website at https://insurance.utah.gov/legal-resources/rules/current-rules.php.

(4) The Utah Small Employer Stop-loss Universal Application may be altered for:

(a) purposes of electronic application and submission, including electronic signature disclaimers;

(b) languages other than English; and

(c) reasons specifically approved by the commissioner.

R590-268-6. Stop-Loss Insurance Disclosure.

(1) Stop-loss insurers marketing to small employers shall use the Utah Small Employer Stop-loss Disclosure.

(2) The stop-loss insurer may display the insurer's name, identifying logo, and address on the disclosure.

(3) The Utah Small Employer Stop-loss Disclosure, published November 15, 2013, is hereby incorporated by reference and is available on the Department's website at https://insurance.utah.gov/legal-resources/rules/current-rules.php.

(4) The disclosure may be altered for reasons specifically approved by the commissioner.

R590-268-7. Lasering.

(1) Subsection 31A-43-301(2)(a) prohibits lasering. For the purpose of this rule lasering includes:

(a) assigning a different attachment point for an individuals based on their expected claims or a given diagnosis;

(b) assigning a deductible to an individual that must be met before stop loss coverage applies;

(c) denying stop loss coverage to an individual who is otherwise covered by the small employer's medical plan; and

(d) applying an actively at work exclusion to stop loss coverage.

R590-268-8. Form and Rate Filings.

(1) A contract filing consists of one contract form, the application, any related documents, disclosure, rate manual, and actuarial memorandum.

(2) A new or revised rate manual shall:

(a) include a summary of how the rate is calculated;

(b) contain specific area factors applicable in Utah;

(c) be filed 30 days prior to use;

(d) be applied in the same manner for all small employer stop-loss contracts;

(e) describe how the overall rate is reviewed for compliance; and

(f) include an actuarial certification signed by a qualified actuary.

(3) All filings shall be submitted using SERFF.

R590-268-9. Annual Actuarial Memorandum and Certification.

(1) The insurer shall submit annually on or before April 1 using SERFF:

(a) stop-loss experience for the previous year for Utah;

(b) certification of compliance with requirements of section 31A-43-301; and

(c) an actuarial memorandum describing the review done in preparation of the certification.

(2) The insurer's stop-loss experience shall be presented by small employer and shall include:

(a) employer size including both covered lives count and employee count as of the beginning of the contract;

(b) covered lives exposure years and employee exposure years for the experience time period;

(c) specific attachment point;

(d) expected claims in the absence of stop loss insurance;

(e) expected claims under the specific attachment point;

(f) aggregate attachment point;

(g) earned premium; and

(h) claims paid by the stop loss insurance broken out by specific losses and aggregate losses.

R590-268-10. Penalties.

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

R590-268-11. Enforcement Date.

The commissioner shall begin enforcing the provisions of this rule 30 days from the effective date.

R590-268-12. Severability.

If any provision of this rule or its application to any person or situation is 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.

KEY: small employer stop-loss
Date of Enactment or Last Substantive Amendment: 2013
Authorizing, and Implemented or Interpreted Law: 31A-43-304, Title 31A, Chapter 43

Insurance, Administration
R590-269
Individual Open Enrollment Period

NOTICE OF PROPOSED RULE

(New Rule)
DAR FILE NO.: 38088
FILED: 11/01/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: As a result of passage of H.B. 160 during the 2013 General Legislative Session, Subsection 31A-30-117(1)(c) was added to the Insurance code requiring a rule to establish a statewide open enrollment period that applies to the individual insurance market that is not on the Patient Protection and Affordable Care Act (PPACA) certified individual exchange.

SUMMARY OF THE RULE OR CHANGE: The rule sets the time period and conditions for the open enrollment period.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 31A-30-117(1)(c)

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: No company filings are required that department personnel would need to review. There are no provisions that would create a cost or saving for the department.
♦ LOCAL GOVERNMENTS: The new law requiring that the department establish a statewide open enrollment period that applies to those individuals that do not purchase coverage on the PPACA certified individual exchange will provide a way for more individuals within the state to be covered for health insurance. This could alleviate impact on local services provided for the uninsured.
♦ SMALL BUSINESSES: This rule provides an open enrollment period for individuals. It does not deal with small businesses.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: The rule allows individuals to apply for a health benefit plan with guaranteed issue of health coverage. This will be available once every year. The cost impact will be felt by insurers providing coverage to individuals that previously they would have denied. These costs cannot be calculated at this time.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The rule allows individuals to apply for a health benefit plan with guaranteed issue of health coverage. This will be available once every year. The cost impact will be felt by insurers providing coverage to individuals that previously they would have denied. These costs cannot be calculated at this time.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Health insurers who provide coverage to individuals during the open enrollment period will be required to accept all applicants without the requirement that they first pass a physical examination. This will likely result in an increase in claims for these insurers.

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 AT 5:00 PM ON 12/16/2013

INTERESTED PERSONS MAY ATTEND A PUBLIC HEARING REGARDING THIS RULE:
♦ 12/10/2013 09:00 AM, State Office Bldg, 450 N State St, Room 3112, Salt Lake City, UT

THIS RULE MAY BECOME EFFECTIVE ON: 12/23/2013

AUTHORIZED BY: Todd Kiser, Commissioner

R590. Insurance, Administration.
R590-269. Individual Open Enrollment Period.
R590-269-1. Authority.

This rule is promulgated pursuant to Subsection 31A-30-117(1)(c) wherein the commissioner is directed to adopt a rule to establish one statewide open enrollment period for the individual insurance market that is not part of the Federally Facilitated Marketplace.

R590-269-2. Purpose and Scope.

(1) The purpose of this rule is to establish an open enrollment period for a carrier that offers an individual health benefit plan outside the Federally Facilitated Marketplace.

(2) This rule applies to a carrier that offers an individual health benefit plan outside the Federally Facilitated Marketplace with an effective date on or after January 1, 2014.

R590-269-3. Definitions.

In addition to the definitions in Sections 31A-1-301 and 31A-30-103, the following definitions apply for the purpose of this rule.

(1) "Federally Facilitated Marketplace" means an exchange set up by the federal government to facilitate the purchase of individual health insurance in accordance with the Patient Protection and Affordability Care Act (PPACA).

(2) "Qualifying life event" means an event that triggers a special enrollment period because an individual or dependent:

(a) loses minimum essential coverage;

(b) gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;

(c) enrollment or non-enrollment is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee or agent of an exchange or the United States Department of Health and Human Services, or its instrumentalities as evaluated and determined by an exchange;

(d) adequately demonstrates to the individual carrier that the health benefit plan in which he or she is previously enrolled substantially violated a material provision of its contract in relation to the enrollee;

(e) is newly ineligible for advance payment of premium tax credits; or

(f) permanently moves into a new service area.

(2)(a) "Loss of minimum essential coverage" means those circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii).

(b) Loss of minimum essential coverage does not include termination or loss due to:

(i) failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; or

(ii) situations allowing for a rescission as specified in 45 CFR 147.128.

R590-269-4. Open and Special Enrollment Periods.

(1)(a)(i) Except as otherwise provided herein, the initial open enrollment period for an individual health benefit plan outside the Federally Facilitated Marketplace is October 1, 2013 through March 31, 2014.

(ii) The open enrollment period in Subsection (a)(i) shall be extended to be consistent with the open enrollment period for the Federally Facilitated Marketplace if the United States Department of Health and Human Services extends the open enrollment period for the Federally Facilitated Marketplace beyond March 31, 2014.

(iii)(A) Coverage begins on January 1, 2014 for individuals who enroll on or before December 15, 2013.

(B) After December 15, 2013, if an individual enrollment occurs between the first and the fifteenth of the month, coverage is effective the first day of the following month. If enrollment occurs between the sixteen and the last day of the month, then coverage is effective the first day of the second following month.

(b) After the initial enrollment period in Subsection (a), the open enrollment period is annually from October 15 through December 7 for a coverage effective date of January 1 the immediately following year.

(2)(a) An individual carrier shall offer to an individual experiencing a qualifying life event, a special enrollment period for at least 60 days.

(b) In the case of birth, adoption or placement for adoption, the coverage is effective on the date of:

(i) birth;

(ii) adoption; or

(iii) placement for adoption

(c) Coverage is effective the first day of the month following the date the insurer receives the request for special enrollment in the case of:

(i) marriage;

(ii) an individual or dependent loses minimum essential coverage;

(iii) an individual or dependent's enrollment or non-enrollment is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee or agent of an exchange or the United States Department of Health and Human Services, or its instrumentalities as evaluated and determined by an exchange ;

(iv) an individual adequately demonstrates to the individual carrier that the health benefit plan in which he or she is previously enrolled substantially violated a material provision of its contract in relation to the enrollee; or

(v) an individual permanently moves into a new service area.

(3) Nothing in this rule prohibits an insurer from offering open or special enrollment periods in addition to the open and special enrollment periods required by this rule.

R590-269-5. Penalties.

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

R590-269-6. Enforcement Date.

The commissioner will begin enforcing this rule 30 days from the rule's effective date.

R590-269-7. Severability.

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

KEY: individual open enrollment period
Date of Enactment or Last Substantive Amendment: 2013
Authorizing, and Implemented or Interpreted Law: 31A-30-117

Labor Commission, Industrial Accidents
R612-400-5
Premium Rates for the Uninsured Employers' Fund and the Employers' Reinsurance Fund

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38072
FILED: 10/23/2013

RULE ANALYSIS
PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Workers' Compensation insurance premiums in Utah include an assessment to fund the Employers' Reinsurance Fund (ERF) and the Uninsured Employers Fund (UEF). Employers that self-insure their workers' compensation liabilities are required to pay an equivalent assessment. These assessment rates are reviewed annually and amended as appropriate in order to ensure the funds remain viable and are fully funded. The proposed change establishes these assessment rates for the 2014 calendar year.

SUMMARY OF THE RULE OR CHANGE: For 2014, the proposed amendment maintains the ERF's premium assessment rate at 2.9% and increases the UEF's premium assessment rate from 0.15% to 0.35%.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 59-9-101(2)

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: The proposed amendment will impose no additional administrative or enforcement costs on the Labor Commission, which is the state agency charged with administering and enforcing Utah's workers' compensation system. This increase, however, may marginally affect the state's budget in that it may be passed on in the form of an increase in the state's workers' compensation insurance premiums.
♦ LOCAL GOVERNMENTS: This increase may marginally affect local governments in that it may be passed on in the form of increased workers' compensation insurance premiums.
♦ SMALL BUSINESSES: This increase may marginally affect small businesses in that it may be passed on in the form of increased workers' compensation insurance premiums.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: This increase will not impact persons who do not own a business, have no employees, and have no workers' compensation insurance policy.

COMPLIANCE COSTS FOR AFFECTED PERSONS: This increase may affect the workers' compensation insurance premiums paid by the state of Utah, local governments, and businesses. The total cost cannot be determined at this time.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This increase may affect the workers' compensation insurance premiums paid by the state of Utah, local governments, and businesses. The total cost cannot be determined at this time.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
LABOR COMMISSION
INDUSTRIAL ACCIDENTS
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:
♦ Ron Dressler by phone at 801-530-6841, by FAX at 801-530-6804, or by Internet E-mail at rdressler@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 12/23/2013

AUTHORIZED BY: Sherrie Hayashi, Commissioner

R612. Labor Commission, Industrial Accidents.
R612-400. Workers' Compensation Insurance, Self-Insurance and Waivers.
R612-400-5. Premium Rates for the Uninsured Employers' Fund and the Employers' Reinsurance Fund.

A. Pursuant to Section 59-9-101(2), Section 59-9-101.3 and 34A-2-202 the workers' compensation premium rates effective January 1, 201[~~3~~]4, as established by the Labor Commission, shall be:

1. 0.[~~15~~]35% for the Uninsured Employers' Fund;
2. 2.9% for the Employers' Reinsurance Fund;

B. The premium rates are a percentage of the total workers' compensation insurance premium income as detailed in Section 59-9-101(2)(a).

KEY: workers' compensation, insurance, rates, waivers
Date of Enactment or Last Substantive Amendment: [~~February 25,~~]2013
Authorizing, and Implemented or Interpreted Law: 59-9-101(2)

Natural Resources, Parks and Recreation
R651-634
Nonresident OHV User Permits and Fees

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 38085
FILED: 10/31/2013

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: During the 2013 General Legislative Session, the legislature passed H.B. 126, which became effective on 05/14/2013. This bill allows unregistered off-highway vehicles (OHV) at demonstration events, or for publicity photo shoots. Many times these vehicles are prototypes and do not have the necessary credentials to qualify for the issuing of a registration or nonresident permit. This change is designed to alleviate this problem.

SUMMARY OF THE RULE OR CHANGE: This bill allows unregistered OHVs at demonstration events, or for publicity photos shoots. Many times these vehicles are prototypes and do not have the necessary credentials to qualify for the issuing of a registration or nonresident permit. This change is designed to alleviate this problem.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 41-22-35 and Section 79-4-304

ANTICIPATED COST OR SAVINGS TO:
♦ THE STATE BUDGET: There will be no costs or savings from the implementation of this rule to the OHV program budget or state budget. This rule will only affect out-of-state OHV manufacturers.
♦ LOCAL GOVERNMENTS: There will be no costs or savings to local governments, from the implementation of this rule. In fact, this rule may generate additional revenue for local governments. This rule will only affect out-of-state OHV manufacturers.
♦ SMALL BUSINESSES: This rule will not cost or save money for small businesses. In fact, the implementation of this rule may create revenue for small businesses. This rule will only affect out-of-state OHV manufacturers.
♦ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: No other person/s will be affected by the implementation of this rule. This rule will only affect out-of-state OHV manufacturers.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There will be minimal costs from OHV manufactures, from outside of Utah. The minimal costs should not exceed more than $3 per occurrence. This minimal cost is associated with paper and/or labor associated with producing a letter.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule should have a positive impact on business.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
NATURAL RESOURCES
PARKS AND RECREATION
ROOM 116
1594 W NORTH TEMPLE
SALT LAKE CITY, UT 84116-3154
or at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
♦ Tammy Wright by phone at 801-538-7359, by FAX at 801-538-7378, or by Internet E-mail at tammywright@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 12/16/2013

THIS RULE MAY BECOME EFFECTIVE ON: 12/23/2013

AUTHORIZED BY: Fred Hayes, Director

R651. Natural Resources, Parks and Recreation.
R651-634. Nonresident OHV User Permits and Fees.
R651-634-1. User Permits and Fees.

Except as provided below, any nonresident owning an off-highway vehicle, who operates or gives another person permission to operate the off-highway vehicle on any public land, trail, street or highway in this state, shall pay an annual off-highway vehicle user fee.

1. A decal will be issued which proves payment has been made. The decal will then be displayed on the off-highway vehicle as follows: On snowmobiles, the decal shall be mounted on the left side of the hood, pan or tunnel. On motorcycles, the decal shall be mounted on the left fork, or on the left side body plastic. On all-terrain vehicles, the decal shall be mounted on the rear of the vehicle. Vehicle types are defined in 41-22-2 UCA. In all instances, the decal shall be mounted in a visible location. The decal shall be non-transferable.

2. A receipt will be issued with the decal indicating the fee paid, the Vehicle Identification Number (VIN) of the off-highway vehicle, and the off-highway vehicle owner's name and address. This receipt shall remain with the off-highway vehicle at all times.

3. Fees charged will be in accordance with S.B. 14 (1999 Utah Laws 1, effective July 1, 1999), and H.B. 51 (2004 Utah Laws, Chapter 314, effective July 1, 2004) which state that the off-highway vehicle user annual fee will be $30 per year.

4. Nonresident OHV user permits shall continue in effect for a period of 12 months beginning with the first day of the calendar month of purchase, and shall not expire until the last day of the same month in the following year.

Applicants for a nonresident OHV user permit shall provide evidence that the applicant is the owner of the off-highway vehicle, and is not a resident of Utah. Such evidence shall include:

a. A government issued identification card showing the state of residency of the off-highway vehicle owner, and one of the following:

(1) A title or certificate of registration from a state other than Utah.

(2) An original bill of sale; or

b. A sworn affidavit stating that the off-highway vehicle is owned by a nonresident of the State of Utah. The affidavit must state the name and address of the vehicle owner, and a description of the off-highway vehicle, including the Vehicle Identification Number (VIN).

Off-highway vehicles currently registered in a state offering reciprocal operating privileges to Utah residents shall be exempt from the nonresident user fee requirements of this rule. The Division shall maintain a list of states offering reciprocal operating privileges to Utah residents. This list shall be updated at least annually.

Provisions of this rule shall not apply to off-highway vehicles exempt under 41-22-35(1)(b)(i), or to off-highway vehicles participating in scheduled competitive events sponsored by a public or private entity, or in noncompetitive events sponsored in whole or in part by any governmental entity; or to Street Legal All-terrain Vehicles as defined in 41-6a-102(61), and registered for highway use in a state that offers reciprocal highway operating privileges to Utah residents operating Street Legal All-Terrain vehicles.

Provisions of this rule shall not apply to off-highway vehicles owned by an off-highway vehicle manufacturer and being operated exclusively for the purpose of an off-highway vehicle manufacturer sponsored event; provided that the operator of the vehicle has in his or her possession a letter or certificate issued by the manufacturer which contains the following information:

(1) The name, address and contact information of the off-highway vehicle manufacturer; and

(2) A physical description of the vehicle, including the vehicle identification number or another number assigned by the manufacturer for identification purposes; and

(3) A brief description of the manufacturer sponsored event, including the dates thereof; and

(4) The name of the authorized operator(s) and

(5) An authorized signature of a manufacturer's representative.

KEY: parks
Date of Enactment or Last Substantive Amendment: [~~December 22, 2008~~]December 23, 2013
Notice of Continuation: June 29, 2010
Authorizing, and Implemented or Interpreted Law: 41-22-35; 79-4-304

End of the Notices of Proposed Rules Section

NOTICES OF
RULE EFFECTIVE DATES

State law provides for agencies to make their rules effective and enforceable after publication in the Utah State Bulletin. In the case of Proposed Rules or Changes in Proposed Rules with a designated comment period, the law permits an agency to file a notice of effective date any time after the close of comment plus seven days. In the case of Changes in Proposed Rules with no designated comment period, the law permits an agency to file a notice of effective date on any date including or after the thirtieth day after the rule's publication date. If an agency fails to file a Notice of Effective Date within 120 days from the publication of a Proposed Rule or a related Change in Proposed Rule the rule lapses and the agency must start the rulemaking process over.

Notices of Effective Date are governed by Subsection 63G-3-301(12), 63G-3-303, and Sections R15-4-5a and 5b.

Abbreviations
AMD = Amendment
CPR = Change in Proposed Rule
NEW = New Rule
R&R = Repeal & Reenact
REP = Repeal

Administrative Services
Purchasing and General Services
No. 37837 (AMD): R33-3-3. Small Purchases
Published: 08/01/2013
Effective: 10/24/2013

No. 37938 (AMD): R33-11. Surplus Property
Published: 09/15/2013
Effective: 10/24/2013

Alcoholic Beverage Control
Administration
No. 37962 (AMD): R81-1-9. Liquor Dispensing Systems
Published: 09/15/2013
Effective: 10/30/2013

Commerce
Occupational and Professional Licensing
No. 37943 (AMD): R156-55d. Burglar Alarm Licensing Rule
Published: 09/15/2013
Effective: 10/29/2013

No. 37948 (AMD): R156-60. Mental Health Professional Practice Act Rule
Published: 09/15/2013
Effective: 10/22/2013

No. 37944 (AMD): R156-63a-102. Definitions
Published: 09/15/2013
Effective: 10/29/2013

No. 37945 (AMD): R156-63b-102. Definitions
Published: 09/15/2013
Effective: 10/29/2013

No. 37942 (AMD): R156-83. Online Prescribing, Dispensing, and Facilitation Licensing Act Rule
Published: 09/15/2013
Effective: 10/22/2013

Real Estate
No. 37950 (AMD): R162-2g-307d. Instructor Certification for Pre-licensing Education
Published: 09/15/2013
Effective: 10/23/2013

Environmental Quality
Air Quality
No. 37704 (NEW): R307-361. Architectural Coatings
Published: 07/01/2013
Effective: 10/31/2013

No. 37704 (CPR): R307-361. Architectural Coatings
Published: 10/01/2013
Effective: 10/31/2013

Water Quality
No. 37961 (AMD): R317-6-6. Implementation
Published: 09/15/2013
Effective: 10/24/2013

Health
Family Health and Preparedness, Emergency Medical Services
No. 37681 (NEW): R426-1. General Definitions
Published: 07/01/2013
Effective: 10/18/2013

No. 37682 (NEW): R426-2. Emergency Medical Services Provider Designations, Critical Incident Stress Management and Quality Assurance Reviews
Published: 07/01/2013
Effective: 10/18/2013

No. 37683 (NEW): R426-3. Licensure
Published: 07/01/2013
Effective: 10/18/2013

No. 37684 (NEW): R426-4. Operations
Published: 07/01/2013
Effective: 10/18/2013

No. 37685 (R&R): R426-5. Statewide Trauma System Standards
Published: 07/01/2013
Effective: 10/18/2013

No. 37686 (R&R): R426-6. Emergency Medical Services Competitive Grants Program Rules
Published: 07/01/2013
Effective: 10/18/2013

No. 37687 (R&R): R426-7. Emergency Medical Services Prehospital Data System Rules
Published: 07/01/2013
Effective: 10/18/2013

No. 37688 (R&R): R426-8. Emergency Medical Services Per Capita Grants Program Rules
Published: 07/01/2013
Effective: 10/18/2013

No. 37689 (NEW): R426-9. Statewide Trauma System Standards
Published: 07/01/2013
Effective: 10/18/2013

No. 37690 (REP): R426-11. General Provisions
Published: 07/01/2013
Effective: 10/18/2013

No. 37691 (REP): R426-12. Emergency Medical Services Training and Certification Standards
Published: 07/01/2013
Effective: 10/18/2013

No. 37692 (REP): R426-13. Emergency Medical Services Provider Designations
Published: 07/01/2013
Effective: 10/18/2013

No. 37693 (REP): R426-14. Ambulance Service and Paramedic Service Licensure
Published: 07/01/2013
Effective: 10/18/2013

No. 37694 (REP): R426-15. Licensed and Designated Provider Operations
Published: 07/01/2013
Effective: 10/18/2013

No. 37695 (REP): R426-16. Emergency Medical Services Ambulance Rates and Charges
Published: 07/01/2013
Effective: 10/18/2013

Insurance
Administration
No. 37861 (AMD): R590-226. Submission of Life Insurance Filings
Published: 08/15/2013
Effective: 10/16/2013

No. 37862 (AMD): R590-227. Submission of Annuity Filings
Published: 08/15/2013
Effective: 10/16/2013

Public Safety
Driver License
No. 37933 (R&R): R708-10. Classified License System
Published: 09/15/2013
Effective: 10/22/2013

Public Service Commission
Administration
No. 37508 (AMD): R746-200. Residential Utility Service Rules for Electric, Gas, Water, and Sewer Utilities
Published: 05/01/2013
Effective: 11/01/2013

No. 37508 (CPR): R746-200. Residential Utility Service Rules for Electric, Gas, Water, and Sewer Utilities
Published: 08/15/2013
Effective: 11/01/2013

School and Institutional Trust Lands
Administration
No. 37934 (AMD): R850-5-200. Payments
Published: 09/15/2013
Effective: 10/22/2013

Tax Commission
Administration
No. 37935 (AMD): R861-1A-29. Decisions, Orders, and Reconsideration Pursuant to Utah Code Ann. Sections 59-1-205 and 63G-4-302
Published: 09/15/2013
Effective: 10/24/2013

Property Tax
No. 37936 (AMD): R884-24P-33. 2013 Personal Property Valuation Guides and Schedules Pursuant to Utah Code Ann. Section 59-2-301
Published: 09/15/2013
Effective: 10/24/2013

Workforce Services
Employment Development
No. 37947 (AMD): R986-400. General Assistance
Published: 09/15/2013
Effective: 11/01/2013

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, 2013 through November 01, 2013. The Rules Index is published in the Utah State Bulletin and in the annual Utah Administrative Rules 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: Due to space constraints, the Keyword Index is not included in this issue of the Utah State Bulletin.

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 (5110 State Office Building, Salt Lake City, UT), or may be viewed online at the Division’s web site (http://www.rules.utah.gov/).

RULES INDEX - BY AGENCY (CODE NUMBER)

ABBREVIATIONS

AMD = Amendment
CPR = Change in proposed rule
EMR = Emergency rule (120 day)
NEW = New rule
EXD = Expired
NSC = Nonsubstantive rule change
REP = Repeal
R&R = Repeal and reenact
5YR = Five-Year Review

CODE REFERENCE	TITLE	FILE NUMBER	ACTION	EFFECTIVE DATE	BULLETIN ISSUE/PAGE
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Archives					
R17-5	Definitions for Rules in Title R17	37653	5YR	05/17/2013	2013-12/49
R17-6	Records Storage and Disposal at the State Records Center	37654	5YR	05/17/2013	2013-12/49
R17-7	Archival Records Care and Access at the State Archives	37659	5YR	05/28/2013	2013-12/50
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R25-5	Payment of Per Diem to Boards	37558	AMD	06/21/2013	2013-10/6
R25-6	Relocation Reimbursement	37522	5YR	04/15/2013	2013-9/29
R25-7	Travel-Related Reimbursements for State Employees	37523	5YR	04/15/2013	2013-9/30
R25-7	Travel-Related Reimbursements for State Employees	37556	AMD	06/21/2013	2013-10/7
R25-8	Overtime Meal Allowance	37524	5YR	04/15/2013	2013-9/30
R25-8	Overtime Meal Allowance	37557	AMD	06/21/2013	2013-10/12
Fleet Operations					
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R33-3-3	Small Purchases	37837	AMD	10/24/2013	2013-15/12
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R33-11	Surplus Property	37938	AMD	10/24/2013	2013-18/6
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AGRICULTURE AND FOOD

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R58-18	Elk Farming	37850	AMD	09/10/2013	2013-15/15
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Horse Racing Commission (Utah)					
R52-7	Horse Racing	37420	EMR	03/20/2013	2013-8/47
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R68-2	Utah Commercial Feed Act Governing Feed.	37632	NSC	06/07/2013	Not Printed
R68-5	Grain Inspection	37249	5YR	02/05/2013	2013-5/189
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R70-320-18	Transport Tanks, Operators	36915	AMD	01/29/2013	2012-21/8
R70-330	Raw Milk for Retail	36914	AMD	01/29/2013	2012-21/9
R70-330	Raw Milk for Retail	37620	EMR	05/14/2013	2013-11/84

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R81-1-31	Duties of Commission Subcommittees	37363	AMD	06/25/2013	2013-6/4
R81-1-31	Duties of Commission Subcommittees	37363	CPR	06/25/2013	2013-10/206
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R81-4D-2	Application	37370	AMD	04/30/2013	2013-6/8
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R81-4F-2	Application	37372	AMD	04/30/2013	2013-6/10
R81-5-1	Licensing	37617	AMD	09/24/2013	2013-11/8
R81-5-1	Licensing	37617	CPR	09/24/2013	2013-16/54
R81-5-2	Application	37373	AMD	04/30/2013	2013-6/11
R81-5-5	Advertising	37618	AMD	07/30/2013	2013-11/9
R81-5-18	Age Verification - Dining and Social Clubs	37619	NSC	06/07/2013	Not Printed
R81-9-1	Application	37377	AMD	04/30/2013	2013-6/12
R81-10	Off-Premise Beer Retailers	37673	5YR	05/31/2013	2013-12/51
R81-10A-3	Application	37374	AMD	04/30/2013	2013-6/13
R81-10B	Temporary Beer Event Permits	37836	5YR	07/11/2013	2013-15/125

R81-10C-2	Application	37375	AMD	04/30/2013	2013-6/14
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R137-2	Government Records Access and Management Act	37535	5YR	04/23/2013	2013-10/213
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R156-1	General Rule of the Division of Occupational and Professional Licensing	37754	AMD	08/22/2013	2013-14/21
R156-1-102	Definitions	37199	AMD	03/11/2013	2013-3/2
R156-3a-102	Definitions	37073	AMD	01/24/2013	2012-24/6
R156-5a	Podiatric Physician Licensing Act Rule	37997	5YR	09/16/2013	2013-19/147
R156-11a	Barber, Cosmetologist/Barber, Esthetician, Electrologist, and Nail Technician Licensing Act Rule	37697	AMD	08/08/2013	2013-13/3
R156-17b	Pharmacy Practice Act Rule	37707	AMD	08/08/2013	2013-13/7
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R156-24b-503	Physical Therapist Supervisory Authority and Responsibility	37526	AMD	06/10/2013	2013-9/2
R156-31b	Nurse Practice Act Rule	37417	5YR	03/18/2013	2013-8/53
R156-37	Utah Controlled Substances Act Rule	37040	AMD	01/08/2013	2012-23/18
R156-37-502	Unprofessional Conduct	37175	NSC	01/30/2013	Not Printed
R156-37c	Utah Controlled Substance Precursor Act Rule	37959	5YR	09/03/2013	2013-18/61
R156-37f	Controlled Substance Database Act Rule	37039	NEW	01/08/2013	2012-23/21
R156-44a	Nurse Midwife Practice Act Rules	37071	AMD	01/22/2013	2012-24/11
R156-49	Dietitian Certification Act Rule	37273	5YR	02/07/2013	2013-5/189
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R156-55a	Utah Construction Trades Licensing Act Rule	37364	AMD	04/22/2013	2013-6/17
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R156-56-403	Factory Built Housing Dispute Resolution Program	37753	AMD	08/22/2013	2013-14/27
R156-60	Mental Health Professional Practice Act Rule	37948	AMD	10/22/2013	2013-18/16
R156-63a	Security Personnel Licensing Act Contract Security Rule	37974	5YR	09/09/2013	2013-19/147
R156-63a-102	Definitions	37944	AMD	10/29/2013	2013-18/18
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R156-63b-102	Definitions	37945	AMD	10/29/2013	2013-18/19
R156-67-306	Exemptions from Licensure	37270	AMD	04/08/2013	2013-5/10
R156-68	Utah Osteopathic Medical Practice Act Rule	37272	5YR	02/07/2013	2013-5/191
R156-68-306	Exemptions from Licensure	37271	AMD	04/08/2013	2013-5/11
R156-69-302b	Qualifications for Licensure - Examination Requirements - Dentist	37706	AMD	08/08/2013	2013-13/24

R156-70a-304	Continuing Education	37705	AMD	08/08/2013	2013-13/25
R156-74	Certified Court Reporters Licensing Act Rule	37958	5YR	09/03/2013	2013-18/61
R156-75	Genetic Counselors Licensing Act Rule	37533	AMD	06/24/2013	2013-10/15
R156-82	Electronic Prescribing Act Rule	37202	NEW	03/11/2013	2013-3/5
R156-82	Electronic Prescribing Act Rule	37396	NSC	04/01/2013	Not Printed
R156-83	Online Prescribing, Dispensing, and Facilitation Licensing Act Rule	37942	AMD	10/22/2013	2013-18/21
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R162-2c	Utah Residential Mortgage Practices and Licensing Rules	37678	AMD	08/07/2013	2013-12/9
R162-2e	Appraisal Management Company Administrative Rules	37677	AMD	08/28/2013	2013-12/19
R162-2f	Real Estate Licensing and Practices Rules	37393	AMD	05/08/2013	2013-7/8
R162-2f	Real Estate Licensing and Practices Rules	37530	AMD	06/21/2013	2013-10/17
R162-2f-403	Trust Accounts	37394	AMD	05/08/2013	2013-7/16
R162-2f-403a	Trust Accounts	37664	NSC	06/24/2013	Not Printed
R162-2g	Real Estate Appraiser Licensing and Certification Administrative Rules	36973	AMD	01/02/2013	2012-22/19
R162-2g	Real Estate Appraiser Licensing and Certification Administrative Rules	37750	AMD	08/21/2013	2013-14/28
R162-2g	Real Estate Appraiser Licensing and Certification Administrative Rules	37865	AMD	10/09/2013	2013-16/4
R162-2g-307d	Instructor Certification for Pre-licensing Education	37950	AMD	10/23/2013	2013-18/25
R162-57a	Timeshare and Camp Resort Rules	37076	AMD	04/02/2013	2012-24/14
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R164-31-1	Guidelines for the Assessment of Administrative Fines	37042	AMD	01/08/2013	2012-23/26
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R251-105	Applicant Qualifications for Employment with Department of Corrections	38030	5YR	09/30/2013	2013-20/50
R251-111	Government Records Access and Management	37828	EXD	07/09/2013	2013-15/137
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R270-1	Award and Reparation Standards	37061	AMD	01/07/2013	2012-23/27
R270-1	Award and Reparation Standards	37166	NSC	01/30/2013	Not Printed
R270-1	Award and Reparation Standards	37380	AMD	04/22/2013	2013-6/25
R270-2	Crime Victim Reparations Adjudicative Proceedings	37063	AMD	01/07/2013	2012-23/33
R270-2	Crime Victim Reparations Adjudicative Proceedings	37167	NSC	01/30/2013	Not Printed
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R277-113	LEA Fiscal Policies and Accountability	37356	NEW	04/22/2013	2013-6/28
R277-113-5	Required LEA Fiscal Policies	37538	NSC	05/17/2013	Not Printed
R277-403	Student Reading Proficiency and Notice to Parents	37708	5YR	06/10/2013	2013-13/230
R277-404	Requirements for Assessments of Student Achievement	37993	5YR	09/13/2013	2013-19/149
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R277-406	K-3 Reading Improvement Program and the State Reading Goal	37734	AMD	08/07/2013	2013-13/26
R277-407-2	Authority and Purpose	37755	NSC	07/19/2013	Not Printed
R277-407-3	Classes and Activities During the Regular School Day	37735	AMD	08/07/2013	2013-13/28
R277-410-3	Accreditation of Public Schools	37920	AMD	10/08/2013	2013-17/4
R277-411	School District Sponsored School Seminars on Youth Protection-Related Issues	37634	NEW	07/08/2013	2013-11/16
R277-412	State Capitol Visit Program	37921	NEW	10/08/2013	2013-17/4
R277-412-1	Definitions	38045	NSC	10/30/2013	Not Printed
R277-422-3	Requirements and Timelines for State-Supported Voted Local Levy	37736	AMD	08/07/2013	2013-13/29
R277-425	Budgeting, Accounting, and Auditing for Utah Local Education Agencies (LEAs)	37884	5YR	08/02/2013	2013-17/45
R277-425	Budgeting, Accounting, and Auditing for Utah Local Education Agencies (LEAs)	37922	AMD	10/08/2013	2013-17/6
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R277-445-2	Authority and Purpose	37756	NSC	07/19/2013	Not Printed
R277-445-3	Standards	37278	AMD	04/08/2013	2013-5/13
R277-445-3	Standards	37737	AMD	08/07/2013	2013-13/30
R277-460	Distribution of Substance Abuse Prevention Account	37628	5YR	05/15/2013	2013-11/98
R277-460-6	Evaluation and Reports	37419	NSC	04/15/2013	Not Printed
R277-469	Instructional Materials Commission Operating Procedures	37494	5YR	04/08/2013	2013-9/31
R277-469	Instructional Materials Commission Operating Procedures	37509	AMD	06/07/2013	2013-9/3
R277-470	Charter Schools - General Provisions	37885	5YR	08/02/2013	2013-17/46
R277-470	Charter Schools - General Provisions	37923	AMD	10/08/2013	2013-17/7
R277-477	Distribution of Funds from the Interest and Dividend Account (School LAND Trust Funds) and Administration of the School LAND Trust Program	37710	5YR	06/10/2013	2013-13/231
R277-477	Distribution of Funds from the Interest and Dividend Account (School LAND Trust Funds) and Administration of the School LAND Trust Program	37738	R&R	08/07/2013	2013-13/32
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R277-481	Charter School Oversight, Monitoring and Appeals	37924	AMD	10/08/2013	2013-17/10
R277-482	Charter School Timelines and Approval Processes	37887	5YR	08/02/2013	2013-17/47
R277-482	Charter School Timelines and Approval Processes	37925	AMD	10/08/2013	2013-17/13
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R277-484	Data Standards	37739	AMD	08/07/2013	2013-13/39
R277-485	Loss of Enrollment	37496	5YR	04/08/2013	2013-9/32
R277-487	Public School Student Confidentiality	37144	AMD	02/21/2013	2013-2/7
R277-487	Public School Data Confidentiality and Disclosure	37740	AMD	08/07/2013	2013-13/43
R277-489	Early Intervention Program	37741	AMD	08/07/2013	2013-13/46
R277-490	Beverley Taylor Sorenson Elementary Arts Learning Program	37711	5YR	06/10/2013	2013-13/231
R277-490	Beverley Taylor Sorenson Elementary Arts Learning Program	37742	AMD	08/07/2013	2013-13/48
R277-491	School Community Councils	37629	5YR	05/15/2013	2013-11/98
R277-491	School Community Councils	37636	R&R	07/08/2013	2013-11/17
R277-492	Utah Science Technology and Research Initiative (USTAR) Centers Program	37888	5YR	08/02/2013	2013-17/47
R277-492	Utah Science Technology and Research Initiative (USTAR) Centers Program	37926	AMD	10/08/2013	2013-17/17
R277-494	Charter School and Online Student Participation in Extracurricular or Co-curricular School Activities	38041	5YR	10/04/2013	2013-21/71

R277-498	Grant for Math Teaching Training	37279	NEW	04/08/2013	2013-5/14
R277-498-4	Criteria for Awarding Grants	37507	NSC	04/29/2013	Not Printed
R277-502	Educator Licensing and Data Retention	37058	AMD	01/07/2013	2012-23/34
R277-502	Educator Licensing and Data Retention	37146	AMD	02/21/2013	2013-2/10
R277-508	Employment of Substitute Teachers	37497	5YR	04/08/2013	2013-9/32
R277-508	Employment of Substitute Teachers	37510	AMD	06/07/2013	2013-9/8
R277-509	Licensure of Student Teachers and Interns	37059	AMD	01/07/2013	2012-23/39
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R277-517-5	Board Disciplinary Actions	37359	NSC	03/15/2013	Not Printed
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R277-525	Special Educator Stipends	37712	5YR	06/10/2013	2013-13/232
R277-526	Paraeducator to Teacher Scholarship Program	37889	5YR	08/02/2013	2013-17/48
R277-531-3	Public Educator Evaluation Framework	37537	AMD	06/24/2013	2013-10/26
R277-532	Local Board Policies for Evaluation of Non-Licensed Public Education Employees (Classified Employees)	37280	NEW	04/08/2013	2013-5/16
R277-600	Student Transportation Standards and Procedures	37400	5YR	03/12/2013	2013-7/62
R277-600	Student Transportation Standards and Procedures	37413	AMD	05/16/2013	2013-7/20
R277-602	Special Needs Scholarships - Funding and Procedures	37713	5YR	06/10/2013	2013-13/232
R277-602	Special Needs Scholarships - Funding and Procedures	37743	AMD	08/07/2013	2013-13/51
R277-605	Coaching Standards and Athletic Clinics	37401	5YR	03/12/2013	2013-7/62
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R277-609	Standards for School District, School and Charter School Discipline Plans	37890	5YR	08/02/2013	2013-17/48
R277-609	Standards for School District, School and Charter School Discipline Plans	37927	AMD	10/08/2013	2013-17/20
R277-609-3	LEA Responsibility to Develop Plans	38046	NSC	10/30/2013	Not Printed
R277-610	Released-Time Classes	37402	5YR	03/12/2013	2013-7/63
R277-610	Released-Time Classes	37414	AMD	05/16/2013	2013-7/24
R277-613	School District and Charter School Bullying and Hazing Policies and Training	37891	5YR	08/02/2013	2013-17/49
R277-613	School District and Charter School Bullying and Hazing Policies and Training	37928	AMD	10/08/2013	2013-17/23
R277-614	Athletes and Students with Head Injuries	37630	5YR	05/15/2013	2013-11/99
R277-614	Athletes and Students with Head Injuries	37635	AMD	07/08/2013	2013-11/23
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R277-617	Smart School Technology Program	37745	AMD	08/07/2013	2013-13/56
R277-619	Student Leadership Skills Development	37746	NEW	08/07/2013	2013-13/58
R277-620	Suicide Prevention Programs	37929	NEW	10/08/2013	2013-17/26
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R277-702	Procedures for the Utah High School Completion Diploma (Effective on July 1, 2009)	37415	AMD	05/16/2013	2013-7/26
R277-705	Secondary School Completion and Diplomas	37994	5YR	09/13/2013	2013-19/150
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R277-709-3	Student Evaluation, Education Plans, and LEA Programs	37244	NSC	02/15/2013	Not Printed
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R277-719	Standards for Selling Foods Outside of the Reimbursable Meal in Schools	37406	5YR	03/12/2013	2013-7/65
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R277-750-3	Standards and Procedures	37930	AMD	10/08/2013	2013-17/28
R277-751	Special Education Extended School Year (ESY)	37499	5YR	04/08/2013	2013-9/33
R277-751	Special Education Extended School Year (ESY)	37511	AMD	06/07/2013	2013-9/10

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R280-200	Rehabilitation	37500	5YR	04/08/2013	2013-9/34
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R305-4	Clean Fuels and Vehicle Technology Fund Grant and Loan Program	37847	5YR	07/15/2013	2013-15/126
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R305-6	Administrative Procedures	36554	CPR	01/31/2013	2013-1/32
R305-7	Administrative Procedures	36553	NEW	01/31/2013	2012-16/45
R305-7	Administrative Procedures	36553	CPR	01/31/2013	2013-1/32
R305-9	Recusal of a Board Member for Conflict of Interest	36776	NEW	02/22/2013	2012-19/28
R305-9	Recusal of a Board Member for Conflict of Interest	36776	CPR	02/22/2013	2013-2/94
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R307-101-2	Definitions	36723	AMD	02/01/2013	2012-19/29
R307-101-2	Definitions	36723	CPR	02/01/2013	2013-1/38
R307-101-2	Definitions	37702	NSC	07/09/2013	Not Printed
R307-101-3	Version of Code of Federal Regulations Incorporated by Reference	37582	AMD	08/08/2013	2013-11/24
R307-102	General Requirements: Broadly Applicable Requirements	37261	5YR	02/06/2013	2013-5/191
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R307-170	Continuous Emission Monitoring Program	37259	5YR	02/06/2013	2013-5/192
R307-208	Outdoor Wood Boiler Prohibition	36481	NEW	04/10/2013	2012-15/12
R307-208	Outdoor Wood Boiler Prohibition	36481	CPR	04/10/2013	2012-23/56
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R307-307	Davis, Salt Lake, and Utah Counties: Road Salting and Sanding	36741	CPR	02/01/2013	2013-1/45
R307-307	Road Salting and Sanding	37234	NSC	02/15/2013	Not Printed
R307-312	Aggregate Processing Operations for PM2.5 Nonattainment Areas	36740	NEW	02/01/2013	2012-19/45
R307-312	Aggregate Processing Operations for PM2.5 Nonattainment Areas	36740	CPR	02/01/2013	2013-1/47
R307-340	Ozone Nonattainment and Maintenance Areas: Surface Coating Processes	36725	REP	02/01/2013	2012-19/49
R307-340	Ozone Nonattainment and Maintenance Areas: Surface Coating Processes	36725	CPR	02/01/2013	2013-1/48
R307-342	Adhesives and Sealants	37275	NEW	08/01/2013	2013-5/17
R307-342	Adhesives and Sealants	37275	CPR	08/01/2013	2013-13/208

R307-343	Ozone Nonattainment and Maintenance Areas: Emissions Standards for Wood Furniture Manufacturing Operations	36738	AMD	05/01/2013	2012-19/56
R307-343	Ozone Nonattainment and Maintenance Areas: Emissions Standards for Wood Furniture Manufacturing Operations	36738	CPR	05/01/2013	2013-1/49
R307-343	Emissions Standards for Wood Furniture Manufacturing Operations	36738	CPR	05/01/2013	2013-7/44
R307-344	Paper, Film, and Foil Coatings	36726	NEW	02/01/2013	2012-19/65
R307-344	Paper, Film, and Foil Coatings	36726	CPR	02/01/2013	2013-1/52
R307-345	Fabric and Vinyl Coatings	36727	NEW	02/01/2013	2012-19/67
R307-345	Fabric and Vinyl Coatings	36727	CPR	02/01/2013	2013-1/54
R307-346	Metal Furniture Surface Coatings	36728	NEW	02/01/2013	2012-19/69
R307-346	Metal Furniture Surface Coatings	36728	CPR	02/01/2013	2013-1/57
R307-347	Large Appliance Surface Coatings	36729	NEW	02/01/2013	2012-19/71
R307-347	Large Appliance Surface Coatings	36729	CPR	02/01/2013	2013-1/59
R307-348	Magnet Wire Coatings	36730	NEW	02/01/2013	2012-19/73
R307-348	Magnet Wire Coatings	36730	CPR	02/01/2013	2013-1/61
R307-349	Flat Wood Panel Coatings	36731	NEW	02/01/2013	2012-19/74
R307-349	Flat Wood Panel Coatings	36731	CPR	02/01/2013	2013-1/63
R307-350	Miscellaneous Metal Parts and Products Coatings	36732	NEW	02/01/2013	2012-19/76
R307-350	Miscellaneous Metal Parts and Products Coatings	36732	CPR	02/01/2013	2013-1/65
R307-351	Graphic Arts	36733	NEW	02/01/2013	2012-19/80
R307-351	Graphic Arts	36733	CPR	02/01/2013	2013-1/69
R307-351-2	Applicability	38015	NSC	10/08/2013	Not Printed
R307-351-4	Standards for Rotogravure, Flexographic, and Specialty Printing Operations	37235	NSC	02/15/2013	Not Printed
R307-352	Metal Container, Closure, and Coil Coatings	36734	NEW	02/01/2013	2012-19/84
R307-352	Metal Container, Closure, and Coil Coatings	36734	CPR	02/01/2013	2013-1/73
R307-353	Plastic Part Coatings	36735	NEW	05/01/2013	2012-19/86
R307-353	Plastic Parts Coatings	36735	CPR	05/01/2013	2013-1/75
R307-353	Plastic Parts Coatings	36735	CPR	05/01/2013	2013-7/46
R307-354	Automotive Refinishing Coatings	36736	NEW	02/01/2013	2012-19/88
R307-354	Automotive Refinishing Coatings	36736	CPR	02/01/2013	2013-1/79
R307-355	Control of Emissions from Aerospace Manufacture and Rework Facilities	36737	NEW	02/01/2013	2012-19/91
R307-355	Control of Emissions from Aerospace Manufacture and Rework Facilities	36737	CPR	02/01/2013	2013-1/82
R307-355-5	Emission Standards	37237	NSC	02/15/2013	Not Printed
R307-357	Consumer Products	37276	NEW	08/01/2013	2013-5/22
R307-357	Consumer Products	37276	CPR	08/01/2013	2013-13/213
R307-361	Architectural Coatings	37704	NEW	10/31/2013	2013-13/64
R307-361	Architectural Coatings	37704	CPR	10/31/2013	2013-19/138
R307-401-7	Public Notice	37831	AMD	10/03/2013	2013-15/27
R307-401-15	Air Strippers and Soil Venting Projects	37037	AMD	02/07/2013	2012-23/40
R307-401-15	Air Strippers and Soil Venting Projects	37236	NSC	02/15/2013	Not Printed
R307-401-19	Analysis of Alternatives	37268	AMD	07/01/2013	2013-5/36
R307-401-19	Analysis of Alternatives	37268	CPR	07/01/2013	2013-11/72
R307-401-20	Relaxation of Limitations	37269	AMD	07/01/2013	2013-5/36
R307-401-20	Relaxation of Limitations	37269	CPR	07/01/2013	2013-11/72
R307-403-1	Definitions	37263	AMD	07/01/2013	2013-5/37
R307-403-1	Purpose and Definitions	37263	CPR	07/01/2013	2013-11/73
R307-403-2	Emission Limitations	37264	AMD	07/01/2013	2013-5/39
R307-403-2	Applicability	37264	CPR	07/01/2013	2013-11/74
R307-403-10	Analysis of Alternatives	37266	AMD	07/01/2013	2013-5/42
R307-403-10	Analysis of Alternatives	37266	CPR	07/01/2013	2013-11/77
R307-403-11	Actuals PALs	37267	AMD	07/01/2013	2013-5/43
R307-403-11	Actuals PALs	37267	CPR	07/01/2013	2013-11/77
R307-420	Permits: Ozone Offset Requirements in Davis and Salt Lake Counties	37265	AMD	07/01/2013	2013-5/43
R307-420	Permits: Ozone Offset Requirements in Davis and Salt Lake Counties	37265	CPR	07/01/2013	2013-11/78
R307-801	Utah Asbestos Rule	37252	5YR	02/06/2013	2013-5/197

R311-207	Accessing the Petroleum Storage Tank Trust Fund for Leaking Petroleum Storage Tanks	37579	NSC	05/17/2013	Not Printed
R311-208	Underground Storage Tank Penalty Guidance	37488	NSC	04/29/2013	Not Printed
R311-209	Petroleum Storage Tank Cleanup Fund and State Cleanup Appropriation	37489	NSC	04/29/2013	Not Printed
R311-211	Corrective Action Cleanup Standards Policy - UST and CERCLA Sites	37490	NSC	04/29/2013	Not Printed
R311-212	Administration of the Petroleum Storage Tank Loan Fund	37491	NSC	04/29/2013	Not Printed
R311-500	Illegal Drug Operations Site Reporting and Decontamination Act, Decontamination Specialist Certification Program	37513	NSC	04/29/2013	Not Printed
Radiation Control					
R313-12	General Provisions	37189	AMD	03/19/2013	2013-3/6
R313-12-3	Definitions	37597	NSC	06/07/2013	Not Printed
R313-14	Violations and Escalated Enforcement	37190	AMD	03/19/2013	2013-3/14
R313-15	Standards for Protection Against Radiation	37191	AMD	03/19/2013	2013-3/18
R313-16	General Requirements Applicable to the Installation, Registration, Inspection, and Use of Radiation Machines	37179	NSC	01/31/2013	Not Printed
R313-17	Administrative Procedures	37192	AMD	03/19/2013	2013-3/40
R313-18	Notices, Instructions and Reports to Workers by Licensees or Registrants--Inspections	37193	AMD	03/19/2013	2013-3/42
R313-19	Requirements of General Applicability to Licensing of Radioactive Material	37194	AMD	03/19/2013	2013-3/45
R313-21	General Licenses	37181	NSC	01/31/2013	Not Printed
R313-21	General Licenses	38039	5YR	10/04/2013	2013-21/71
R313-22	Specific Licenses	37195	AMD	03/19/2013	2013-3/56
R313-24	Uranium Mills and Source Material Mill Tailings Disposal Facility Requirements	37196	AMD	03/19/2013	2013-3/74
R313-25	License Requirements for Land Disposal of Radioactive Waste - General Provisions	37180	NSC	01/31/2013	Not Printed
R313-26	Generator Site Access Permit Requirements for Accessing Utah Radioactive Waste Disposal Facilities	37182	NSC	01/31/2013	Not Printed
R313-28	Use of X-Rays in the Healing Arts	37183	NSC	01/31/2013	Not Printed
R313-28-80	Intraoral Dental Radiographic Systems	37867	AMD	10/15/2013	2013-16/6
R313-30	Therapeutic Radiation Machines	37197	AMD	03/19/2013	2013-3/76
R313-30	Therapeutic Radiation Machines	38040	5YR	10/04/2013	2013-21/72
R313-32	Medical Use of Radioactive Material	37184	NSC	01/31/2013	Not Printed
R313-34	Requirements for Irradiators	37185	NSC	01/31/2013	Not Printed
R313-35	Requirements for X-Ray Equipment Used for Non-Medical Applications	37198	AMD	03/19/2013	2013-3/91
R313-36	Special Requirements for Industrial Radiographic Operations	37186	NSC	01/31/2013	Not Printed
R313-38	Licenses and Radiation Safety Requirements for Well Logging	37187	NSC	01/31/2013	Not Printed
R313-38	Licenses and Radiation Safety Requirements for Well Logging	38043	5YR	10/07/2013	2013-21/72
R313-70	Payments, Categories and Types of Fees	37188	NSC	01/31/2013	Not Printed
Solid and Hazardous Waste					
R315-1	Utah Hazardous Waste Definitions and References	37305	AMD	04/25/2013	2013-5/45
R315-2	General Requirements - Identification and Listing of Hazardous Waste	37306	AMD	04/25/2013	2013-5/48
R315-3	Application and Permit Procedures for Hazardous Waste Treatment, Storage, and Disposal Facilities	37307	AMD	04/25/2013	2013-5/63
R315-4	Procedures for Decisionmaking	37308	AMD	04/25/2013	2013-5/64
R315-5	Hazardous Waste Generator Requirements	37309	AMD	04/25/2013	2013-5/69
R315-6	Hazardous Waste Transporter Requirements	37310	AMD	04/25/2013	2013-5/73
R315-7	Interim Status Requirements for Hazardous Waste Treatment, Storage, and Disposal Facilities	37311	AMD	04/25/2013	2013-5/76

R315-8	Standards for Owners and Operators of Hazardous Waste Treatment, Storage, and Disposal Facilities	37312	AMD	04/25/2013	2013-5/99
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R315-12	Administrative Procedures	37314	AMD	04/25/2013	2013-5/101
R315-13	Land Disposal Restrictions	37315	AMD	04/25/2013	2013-5/102
R315-16	Standards for Universal Waste Management	37317	AMD	04/25/2013	2013-5/103
R315-17	End of Life Automotive Mercury Switch Removal Standards	37318	AMD	04/25/2013	2013-5/107
R315-50-6	Representative Sampling Methods	37319	AMD	04/25/2013	2013-5/109
R315-101	Cleanup Action and Risk-Based Closure Standards	37320	AMD	04/25/2013	2013-5/110
R315-102	Penalty Policy	37321	AMD	04/25/2013	2013-5/113
R315-301	Solid Waste Authority, Definitions, and General Requirements	37282	5YR	02/13/2013	2013-5/198
R315-301	Solid Waste Authority, Definitions, and General Requirements	37322	AMD	04/25/2013	2013-5/116
R315-302	Solid Waste Facility Location Standards, General Facility Requirements, and Closure Requirements	37283	5YR	02/13/2013	2013-5/198
R315-302	Solid Waste Facility Location Standards, General Facility Requirements, and Closure Requirements	37323	AMD	04/25/2013	2013-5/122
R315-303	Landfilling Standards	37284	5YR	02/13/2013	2013-5/199
R315-303	Landfilling Standards	37324	AMD	04/25/2013	2013-5/127
R315-304	Industrial Solid Waste Landfill Requirements	37285	5YR	02/13/2013	2013-5/200
R315-304	Industrial Solid Waste Landfill Requirements	37325	AMD	04/25/2013	2013-5/132
R315-305	Class IV and VI Landfill Requirements	37286	5YR	02/13/2013	2013-5/200
R315-305	Class IV and VI Landfill Requirements	37326	AMD	04/25/2013	2013-5/134
R315-306	Incinerator Standards	37287	5YR	02/13/2013	2013-5/201
R315-306	Incinerator Standards	37327	AMD	04/25/2013	2013-5/136
R315-307	Landtreatment Disposal Standards	37288	5YR	02/13/2013	2013-5/201
R315-307-3	Standards for Maintenance and Operation	37328	AMD	04/25/2013	2013-5/138
R315-308	Ground Water Monitoring Requirements	37289	5YR	02/13/2013	2013-5/202
R315-308	Ground Water Monitoring Requirements	37329	AMD	04/25/2013	2013-5/139
R315-309	Financial Assurance	37290	5YR	02/13/2013	2013-5/202
R315-309	Financial Assurance	37330	AMD	04/25/2013	2013-5/144
R315-310	Permit Requirements for Solid Waste Facilities	37291	5YR	02/13/2013	2013-5/203
R315-310	Permit Requirements for Solid Waste Facilities	37331	AMD	04/25/2013	2013-5/151
R315-311	Permit Approval For Solid Waste Disposal, Waste Tire Storage, Energy Recovery and Incinerator Facilities	37292	5YR	02/13/2013	2013-5/204
R315-311	Permit Approval For Solid Waste Disposal, Waste Tire Storage, Energy Recovery, And Incinerator Facilities	37332	AMD	04/25/2013	2013-5/155
R315-312	Recycling and Composting Facility Standards	37293	5YR	02/13/2013	2013-5/204
R315-312	Recycling and Composting Facility Standards	37333	AMD	04/25/2013	2013-5/157
R315-313	Transfer Stations and Drop Box Facilities	37294	5YR	02/13/2013	2013-5/205
R315-313-2	Transfer Station Standards	37334	AMD	04/25/2013	2013-5/159
R315-314	Facility Standards for Piles Used for Storage and Treatment	37295	5YR	02/13/2013	2013-5/205
R315-314	Facility Standards for Piles Used for Storage and Treatment	37335	AMD	04/25/2013	2013-5/160
R315-315	Special Waste Requirements	37296	5YR	02/13/2013	2013-5/206
R315-315	Special Waste Requirements	37336	AMD	04/25/2013	2013-5/163
R315-316	Infectious Waste Requirements	37297	5YR	02/13/2013	2013-5/206
R315-316	Infectious Waste Requirements	37337	AMD	04/25/2013	2013-5/165
R315-317	Other Processes, Variances, Violations, and Petition for Rule Change	37298	5YR	02/13/2013	2013-5/207
R315-317	Other Processes, Variances, Violations, and Petition for Rule Change	37338	AMD	04/25/2013	2013-5/167
R315-317	Other Processes, Variances, Violations, and Petition for Rule Change	37480	NSC	04/29/2013	Not Printed
R315-318	Permit by Rule	37299	5YR	02/13/2013	2013-5/208
R315-318	Permit by Rule	37339	AMD	04/25/2013	2013-5/168
R315-320	Waste Tire Transporter and Recycler Requirements	37300	5YR	02/13/2013	2013-5/208

R315-320	Waste Tire Transporter and Recycler Requirements	37340	AMD	04/25/2013	2013-5/169
Water Quality					
R317-1	Definitions and General Requirements	37851	AMD	09/24/2013	2013-15/41
R317-1-1	Definitions	37366	AMD	08/19/2013	2013-6/32
R317-1-1	Definitions	37366	CPR	08/19/2013	2013-14/92
R317-2	Standards of Quality for Waters of the State	37361	AMD	08/19/2013	2013-6/34
R317-2	Standards of Quality for the Waters of the State	37361	CPR	08/19/2013	2013-14/94
R317-3	Design Requirements for Wastewater Collection, Treatment and Disposal Systems	37852	AMD	09/24/2013	2013-15/45
R317-4	Onsite Wastewater Systems	37575	R&R	09/01/2013	2013-10/27
R317-5	Large Underground Wastewater Disposal Systems	37853	AMD	09/24/2013	2013-15/80
R317-6	Ground Water Quality Protection	37854	AMD	09/24/2013	2013-15/85
R317-6-6	Implementation	37961	AMD	10/24/2013	2013-18/26
R317-7	Underground Injection Control (UIC) Program	37855	AMD	09/24/2013	2013-15/96
R317-8	Utah Pollutant Discharge Elimination System (UPDES)	37581	AMD	07/01/2013	2013-10/59
R317-9	Administrative Procedures	37239	5YR	01/31/2013	2013-4/51
R317-11	Certification Required to Design, Inspect and Maintain Underground Wastewater Disposal Systems, or Conduct Soil Evaluations or Percolation Tests for Underground Wastewater Disposal Systems	37812	AMD	09/01/2013	2013-14/54
R317-12	General Requirements: Tax Exemption for Water Pollution Control Equipment	37856	AMD	09/24/2013	2013-15/107
R317-13	Approvals and Permits for a Water Reuse Project	37240	5YR	01/31/2013	2013-4/51
R317-14	Approval in Change in Point of Discharge of POTW	37241	5YR	01/31/2013	2013-4/52
R317-15	Water Quality Certification	37362	NEW	08/19/2013	2013-6/44
R317-15	Water Quality Certification	37362	CPR	08/19/2013	2013-14/101
R317-101	Utah Wastewater Project Assistance Program	37448	5YR	03/28/2013	2013-8/54
R317-401	Graywater Systems	37857	AMD	09/24/2013	2013-15/108
FINANCIAL INSTITUTIONS					
Administration					
R331-14	Rule Governing Parties Who Engage in the Business of Issuing and Selling Money Orders, Traveler's Checks, and Other Instruments for the Purpose of Effecting Third-Party Payments	38023	NSC	10/08/2013	Not Printed
R331-20	Designation of Adjudicative Proceedings as Informal	37939	5YR	08/23/2013	2013-18/62
R331-21	Rule Governing Establishment of and Participation in Collective Investment Funds by Trust Companies	37940	5YR	08/23/2013	2013-18/63
R331-24	Accounting for Accrued Uncollected Income by Banks and Industrial Loan Corporations	37941	5YR	08/23/2013	2013-18/63
R331-25	Rule Governing Debt Cancellation and Debt Suspension Agreements Issued by Depository Institutions, Who Are Under the Jurisdiction of the Department of Financial Institutions	38060	5YR	10/11/2013	2013-21/73
Nondepository Lenders					
R343-9	Deferred Deposit Lenders Registration with the Nationwide Database	37864	NEW	09/23/2013	2013-16/8
GOVERNOR					
Economic Development					
R357-2	Rural Broadband Service Fund	37206	EXT	01/16/2013	2013-4/63
R357-2	Rural Broadband Service Fund	37204	REP	05/01/2013	2013-3/96
R357-3	Refundable Economic Development Tax Credit	37666	5YR	05/30/2013	2013-12/52
R357-6	Technology and Life Science Economic Development and Related Tax Credits	37208	AMD	05/01/2013	2013-4/15

R357-9	Alternative Energy Development Tax Incentives	37207	AMD	05/01/2013	2013-4/16
Economic Development, Pete Suazo Utah Athletic Commission					
R359-1	Pete Suazo Utah Athletic Commission Act Rule	37672	AMD	09/13/2013	2013-12/21
Planning and Budget, Inspector General of Medicaid Services (Office of)					
R367-1	Office of Inspector General of Medicaid Services	37536	R&R	06/21/2013	2013-10/135
HEALTH					
Administration					
R380-250	HIPAA Privacy Rule Implementation	37596	5YR	05/06/2013	2013-11/99
R380-250	HIPAA Privacy Rule Implementation	37679	AMD	08/07/2013	2013-13/122
Center for Health Data, Vital Records and Statistics					
R436-1	Duties of the Department of Health	37418	5YR	03/19/2013	2013-8/55
R436-2	Infants of Unknown Parentage; Foundling Registration	37423	5YR	03/21/2013	2013-8/56
R436-3	Amendment of Vital Records	37424	5YR	03/21/2013	2013-8/57
R436-4	Delayed Registration of Birth	37425	5YR	03/21/2013	2013-8/57
R436-7	Death Registration	37426	5YR	03/21/2013	2013-8/58
R436-8	Authorization for Final Disposition of Deceased Persons	37427	5YR	03/21/2013	2013-8/58
R436-9	Persons and Institutions Required to Keep Monthly Listings of Vital Statistics Events	37428	5YR	03/21/2013	2013-8/59
R436-10	Birth and Death Certificates	37429	5YR	03/21/2013	2013-8/60
R436-12	Certified Copies of Vital Statistics Records	37430	5YR	03/21/2013	2013-8/60
R436-13	Disclosure of Records	37431	5YR	03/21/2013	2013-8/61
R436-14	Copies of Data from Vital Records	37432	5YR	03/21/2013	2013-8/61
R436-15	Fees	37433	5YR	03/21/2013	2013-8/62
R436-16	Violation of Rules	37434	5YR	03/21/2013	2013-8/62
R436-17	Review and Approval of Research Requests	37435	5YR	03/21/2013	2013-8/63
Children's Health Insurance Program					
R382-1	Benefits and Administration	37608	5YR	05/08/2013	2013-11/100
R382-10	Eligibility	37610	5YR	05/09/2013	2013-11/100
R382-10	Eligibility	37879	AMD	10/01/2013	2013-16/10
Disease Control and Prevention, Environmental Services					
R392-103	Food Handler Training and Certificate	37589	NEW	08/01/2013	2013-11/28
R392-200	Design, Construction, Operation, Sanitation, and Safety of Schools	37763	AMD	08/26/2013	2013-14/57
R392-302-3	General Requirements	37072	AMD	02/28/2013	2012-24/26
R392-510-6	Requirements for Smoking Permitted Areas	37454	AMD	07/01/2013	2013-8/8
R392-700	Indoor Tanning Bed Sanitation	37251	5YR	02/06/2013	2013-5/209
Disease Control and Prevention, Epidemiology					
R386-702	Communicable Disease Rule	37345	AMD	05/15/2013	2013-5/173
Disease Control and Prevention, Health Promotion					
R384-201	School-Based Vision Screening for Students in Public Schools	37028	NEW	02/20/2013	2012-23/42
R384-201	School-Based Vision Screening for Students in Public Schools	37453	AMD	07/01/2013	2013-8/6
Disease Control and Prevention, Immunization					
R396-100	Immunization Rule for Students	37806	5YR	06/28/2013	2013-14/105
Disease Control and Prevention, Laboratory Services					
R438-13	Rules for the Certification of Institutions to Obtain Impounded Animals in the State of Utah	37842	5YR	07/12/2013	2013-15/126
Family Health and Preparedness, Child Care Licensing					
R430-6-3	Submission of Background Screening Information	37774	AMD	09/01/2013	2013-14/71
R430-50	Residential Certificate Child Care	37661	5YR	05/29/2013	2013-12/53

R430-50-7	Personnel	37775	AMD	09/01/2013	2013-14/73
R430-60	Hourly Child Care Centers	37662	5YR	05/29/2013	2013-12/54
R430-60-7	Personnel	37777	AMD	09/01/2013	2013-14/74
R430-70-7	Personnel	37778	AMD	09/01/2013	2013-14/76
R430-90	Licensed Family Child Care	37663	5YR	05/29/2013	2013-12/54
R430-90-7	Personnel	37779	AMD	09/01/2013	2013-14/77
R430-100-7	Personnel	37780	AMD	09/01/2013	2013-14/79
Family Health and Preparedness, Children with Special Health Care Needs					
R398-1	Newborn Screening	37381	AMD	07/01/2013	2013-7/28
R398-2	Newborn Hearing Screening	37810	5YR	07/01/2013	2013-14/105
R398-3	Children's Hearing Aid Pilot Program	37899	NEW	10/15/2013	2013-17/31
R398-15	Autism Treatment Account	37809	AMD	08/27/2013	2013-14/70
R398-20	Early Intervention	37827	EXT	07/09/2013	2013-15/135
R398-20	Early Intervention	37892	5YR	08/02/2013	2013-17/50
Family Health and Preparedness, Emergency Medical Services					
R426-1	General Definitions	37681	NEW	10/18/2013	2013-13/130
R426-2	Air Medical Service Rules	37397	EXD	02/24/2013	2013-7/71
R426-2	Air Medical Service Rules	37409	EMR	03/14/2013	2013-7/55
R426-2	Air Medical Service Rules	37411	NEW	05/30/2013	2013-7/32
R426-2	Emergency Medical Services Provider Designations, Critical Incident Stress Management and Quality Assurance Reviews	37682	NEW	10/18/2013	2013-13/133
R426-2 (Changed to R426-100)	Air Medical Service Rules	38078	NSC	11/01/2013	Not Printed
R426-3	Licensure	37683	NEW	10/18/2013	2013-13/137
R426-4	Operations	37684	NEW	10/18/2013	2013-13/141
R426-5	Statewide Trauma System Standards	37685	R&R	10/18/2013	2013-13/155
R426-6	Emergency Medical Services Competitive Grants Program Rules	37398	EXD	03/01/2013	2013-7/71
R426-6	Emergency Medical Services Competitive Grants Program Rules	37408	EMR	03/14/2013	2013-7/59
R426-6	Emergency Medical Services Competitive Grants Program Rules	37410	NEW	05/30/2013	2013-7/36
R426-6	Emergency Medical Services Competitive Grants Program Rules	37686	R&R	10/18/2013	2013-13/165
R426-7	Emergency Medical Services Prehospital Data System Rules	37687	R&R	10/18/2013	2013-13/168
R426-8	Emergency Medical Services Per Capita Grants Program Rules	37688	R&R	10/18/2013	2013-13/176
R426-9	Statewide Trauma System Standards	37689	NEW	10/18/2013	2013-13/178
R426-11	General Provisions	37690	REP	10/18/2013	2013-13/182
R426-12	Emergency Medical Services Training and Certification Standards	37691	REP	10/18/2013	2013-13/184
R426-13	Emergency Medical Services Provider Designations	37692	REP	10/18/2013	2013-13/185
R426-14	Ambulance Service and Paramedic Service Licensure	37693	REP	10/18/2013	2013-13/187
R426-15	Licensed and Designated Provider Operations	37694	REP	10/18/2013	2013-13/191
R426-16	Emergency Medical Services Ambulance Rates and Charges	37695	REP	10/18/2013	2013-13/191
Family Health and Preparedness, Licensing					
R432-1	General Health Care Facility Rules	37912	5YR	08/12/2013	2013-17/51
R432-2	General Licensing Provisions	37913	5YR	08/12/2013	2013-17/52
R432-3	General Health Care Facility Rules Inspection and Enforcement	37209	AMD	04/24/2013	2013-4/17
R432-3	General Health Care Facility Rules Inspection and Enforcement	37914	5YR	08/12/2013	2013-17/52
R432-4	General Construction	37915	5YR	08/12/2013	2013-17/53
R432-5	Nursing Facility Construction	37916	5YR	08/12/2013	2013-17/53
R432-6	Assisted Living Facility General Construction	37917	5YR	08/12/2013	2013-17/54
R432-16	Hospice Inpatient Facility Construction	37281	5YR	02/11/2013	2013-5/209
R432-31	Life with Dignity Order	37442	AMD	06/07/2013	2013-8/12
R432-35	Background Screening -- Health Facilities	37441	5YR	03/25/2013	2013-8/55

Health Care Financing					
R410-14	Administrative Hearing Procedures	37045	AMD	01/09/2013	2012-23/44
R410-14	Administrative Hearing Procedures	37906	AMD	10/08/2013	2013-17/32
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R414-1-5	Incorporations by Reference	37122	AMD	03/01/2013	2013-2/18
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R414-1-5	Incorporations by Reference	37715	AMD	08/07/2013	2013-13/123
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R512-302	Out-of-Home Services, Responsibilities Pertaining to an Out-of-Home Caregiver	37646	AMD	07/22/2013	2013-12/27
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R539-15	Time-Limited Respite Care Program	37919	REP	10/10/2013	2013-17/36
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R525-3	Medication Treatment of Patients	37968	NSC	09/30/2013	Not Printed
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R525-7	Complaints/Suggestions/Concerns	37972	NSC	09/30/2013	Not Printed
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R590-171	Surplus Lines Procedures Rule	36846	CPR	01/22/2013	2012-24/32
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R590-222-3	Incorporation by Reference	37838	AMD	09/23/2013	2013-15/110
R590-222-3	Incorporation by Reference	38050	NSC	10/30/2013	Not Printed
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R651-614	Fishing, Hunting and Trapping	37585	AMD	07/08/2013	2013-11/45
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R657-34	Procedures for Confirmation of Ordinances on Hunting Closures	37592	5YR	05/06/2013	2013-11/103
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R657-37	Cooperative Wildlife Management Units for Big Game or Turkey	37593	5YR	05/06/2013	2013-11/104
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R657-59	Private Fish Ponds	37895	5YR	08/05/2013	2013-17/59
R657-60	Aquatic Invasive Species Interdiction	37896	5YR	08/05/2013	2013-17/59
R657-64	Predator Control Incentives	37609	AMD	07/08/2013	2013-11/48
R657-65	Urban Deer Control	37716	NEW	08/08/2013	2013-13/195

PARDONS (BOARD OF)

Administration					
R671-312	Commutation Hearings for Death Penalty Cases	37341	5YR	02/15/2013	2013-5/212
R671-312	Commutation Hearings for Death Penalty Cases	37438	AMD	05/22/2013	2013-8/15
R671-312A	Commutation Procedures Applicable to Persons Sentenced to Death Before April 26, 1992	37439	NEW	05/22/2013	2013-8/18
R671-312B	Commutation Procedures Applicable to Persons Sentenced to Death After April 26, 1992	37440	NEW	05/22/2013	2013-8/20
R671-315	Pardons	37455	AMD	05/22/2013	2013-8/23
R671-509	Parole Progress / Violation Reports	37342	5YR	02/15/2013	2013-5/212
R671-509	Parole Progress / Violation Reports	37456	AMD	05/22/2013	2013-8/25
R671-510	Evidence for Issuance of Warrants	37343	5YR	02/15/2013	2013-5/212
R671-510	Evidence for Issuance of Warrants	37457	AMD	05/22/2013	2013-8/26
R671-512	Execution of the Warrant	37344	5YR	02/15/2013	2013-5/213
R671-512	Execution of the Warrant	37458	AMD	05/22/2013	2013-8/27
R671-513	Expedited Determination on Parolee Challenge to Probable Cause	37346	5YR	02/15/2013	2013-5/214
R671-513	Expedited Determination of Parolee Challenge to Probable Cause	37459	AMD	05/22/2013	2013-8/28
R671-514	Waiver and Pleas of Guilt	37347	5YR	02/15/2013	2013-5/214
R671-514	Waiver and Pleas of Guilt	37460	AMD	05/22/2013	2013-8/29
R671-515	Timeliness of Parole Revocation Hearings	37348	5YR	02/15/2013	2013-5/215
R671-515	Timeliness of Parole Revocation Hearings	37461	AMD	05/22/2013	2013-8/31
R671-516	Parole Revocation Hearings	37349	5YR	02/15/2013	2013-5/215
R671-516	Parole Revocation Hearings	37462	AMD	05/22/2013	2013-8/32
R671-517	Evidentiary Hearings and Proceedings	37350	5YR	02/15/2013	2013-5/216
R671-517	Evidentiary Hearings and Proceedings	37463	AMD	05/22/2013	2013-8/33
R671-518	Conduct of Proceedings When a Criminal Charge Results in Conviction	37351	5YR	02/15/2013	2013-5/216
R671-519	Proceedings When Criminal Charges Result in Acquittal	37352	5YR	02/15/2013	2013-5/217
R671-519	Proceedings When Criminal Charges Result in Acquittal	37464	AMD	05/22/2013	2013-8/35
R671-520	Treatment of Confidential Testimony	37353	5YR	02/15/2013	2013-5/217
R671-520	Treatment of Confidential Testimony	37465	AMD	05/22/2013	2013-8/36
R671-522	Continuances Due to Pending Criminal Charges	37354	5YR	02/15/2013	2013-5/218

PROFESSIONAL PRACTICES ADVISORY COMMISSION

Administration					
R686-100	Professional Practices Advisory Commission, Rules of Procedure: Complaints and Hearings	37243	5YR	02/01/2013	2013-4/60
R686-101	Alcohol Related Offenses	37637	5YR	05/16/2013	2013-12/57
R686-101 (Changed to R686-104)	Alcohol Related Offenses	37674	AMD	09/10/2013	2013-12/33
R686-102	Drug Related Offenses	37638	5YR	05/16/2013	2013-12/58
R686-102 (Changed to R686-105)	Drug Related Offenses	37675	AMD	09/10/2013	2013-12/34
R686-104 (Changed to R686-103)	Utah Professional Practices Advisory Commission Review of License Due to Background Check Offenses	37863	NSC	09/10/2013	Not Printed

PUBLIC SAFETY

Criminal Investigations and Technical Services, Criminal Identification					
R722-300	Concealed Firearm Permit and Instructor Rule	37606	AMD	07/08/2013	2013-11/50
R722-310	Regulation of Bail Bond Recovery and Enforcement Agents	37605	AMD	07/08/2013	2013-11/55
R722-320	Undercover Identification	37226	5YR	01/24/2013	2013-4/61
R722-320	Undercover Identification	37227	NSC	02/15/2013	Not Printed
R722-330	Licensing of Private Investigators	37604	AMD	07/08/2013	2013-11/58

R722-340	Emergency Vehicles	37532	5YR	04/22/2013	2013-10/215
R722-340 (Changed to R698-7)	Emergency Vehicles	37590	NSC	05/31/2013	Not Printed
R722-360	Certificate of Removal from the Sex Offender and Kidnap Offender Registry	37232	NEW	03/25/2013	2013-4/46
R722-900	Review and Challenge of Criminal Record	37514	5YR	04/10/2013	2013-9/44
R722-900	Review and Challenge of Criminal Record	37769	R&R	08/21/2013	2013-14/81
Driver License					
R708-10	Classified License System	37933	R&R	10/22/2013	2013-18/36
R708-21	Third Party Testing	37614	EMR	05/14/2013	2013-11/89
R708-21	Third-Party Testing	37717	AMD	08/08/2013	2013-13/198
R708-30	Motorcycle Rider Training Schools	37613	5YR	05/13/2013	2013-11/105
R708-32	Uninsured Motorist Database	37554	R&R	06/30/2013	2013-10/192
R708-33	Electric Assisted Bicycle Headgear	37612	REP	07/08/2013	2013-11/49
R708-45	Renewal or Duplicate License for a Utah Resident Temporarily Residing Out of State	37657	EMR	05/23/2013	2013-12/45
R708-45	Renewal or Duplicate License for a Utah Resident Temporarily Residing Out of State	37718	R&R	08/08/2013	2013-13/202
R708-49	Temporary Identification Card	37555	NEW	06/30/2013	2013-10/194
R708-49	Temporary Identification Card	38037	NSC	10/08/2013	Not Printed
Fire Marshal					
R710-5	Automatic Fire Sprinkler System Inspecting and Testing	37443	5YR	03/25/2013	2013-8/67
R710-12	Hazardous Materials Training and Certification	37390	5YR	03/08/2013	2013-7/67
Homeland Security					
R704-1	Search and Rescue Financial Assistance Program	37170	NSC	01/23/2013	Not Printed
R704-2	Statewide Mutual Aid Act Activation	37117	NEW	02/25/2013	2013-2/83
Peace Officer Standards and Training					
R728-501	Career Development Courses	37805	5YR	06/28/2013	2013-14/118
PUBLIC SERVICE COMMISSION					
Administration					
R746-110	Uncontested Matters to be Adjudicated Informally	37757	5YR	06/24/2013	2013-14/119
R746-200	Residential Utility Service Rules for Electric, Gas, Water, and Sewer Utilities	37508	AMD	11/01/2013	2013-9/18
R746-200	Residential Utility Service Rules for Electric, Gas, Water, and Sewer Utilities	37508	CPR	11/01/2013	2013-16/55
R746-200-7	Termination of Service	37932	NSC	11/01/2013	Not Printed
R746-210	Utility Service Rules Applicable Only to Electric Utilities	37759	5YR	06/24/2013	2013-14/119
R746-240	Telecommunication Service Rules	37760	5YR	06/24/2013	2013-14/120
R746-313	Electric Service Reliability	37116	AMD	02/21/2013	2013-2/87
R746-320	Uniform Rules Governing Natural Gas Service	37041	AMD	01/07/2013	2012-23/48
R746-330	Rules for Water and Sewer Utilities Operating in Utah	37385	5YR	03/05/2013	2013-7/68
R746-332	Depreciation Rates for Water Utilities	37451	5YR	03/28/2013	2013-8/68
R746-340	Service Quality for Telecommunications Corporations	37758	5YR	06/24/2013	2013-14/120
R746-343-15	Surcharge	37449	AMD	07/01/2013	2013-8/37
R746-344	Filing Requirements for Telephone Corporations with Less than 5,000 Access Line Subscribers	37869	5YR	07/31/2013	2013-16/67
R746-345	Pole Attachments	37870	5YR	07/31/2013	2013-16/67
R746-347	Extended Area Service (EAS)	37386	5YR	03/05/2013	2013-7/68
R746-402	Rules Governing Reports of Accidents by Electric, Gas, Telephone, and Water Utilities	37452	5YR	03/28/2013	2013-8/68
R746-404	Regulation of Promotional Programs of Electric and Gas Public Utilities	37872	5YR	07/31/2013	2013-16/68
R746-405	Filing of Tariffs for Gas, Electric, Telephone, and Water Utilities	37450	5YR	03/28/2013	2013-8/69

R746-405	Filing of Tariffs for Gas, Electric, Telephone, and Water Utilities	37447	AMD	06/20/2013	2013-8/38
R746-406	Advertising by Electric and Gas Utilities	37871	5YR	07/31/2013	2013-16/68
R746-500	Americans with Disabilities Act Complaint Procedure	37868	5YR	07/31/2013	2013-16/69
R746-600	Postretirement Benefits other than Pensions	37985	5YR	09/11/2013	2013-19/151
REGENTS (BOARD OF)					
Administration					
R765-136	Language Proficiency in the Utah System of Higher Education	37551	5YR	04/29/2013	2013-10/216
R765-254	Secure Area Hearing Rooms	37552	5YR	04/29/2013	2013-10/216
R765-555	Policy on Colleges and Universities Providing Facilities, Goods and Services in Competition with Private Enterprise	37553	5YR	04/29/2013	2013-10/217
R765-604	New Century Scholarship	37586	AMD	07/08/2013	2013-11/61
R765-605	Utah Centennial Opportunity Program for Education	37539	5YR	04/24/2013	2013-10/217
R765-605	Utah Centennial Opportunity Program for Education	37547	AMD	06/24/2013	2013-10/195
R765-606	Utah Leveraging Educational Assistance Partnership Program	37540	5YR	04/24/2013	2013-10/218
R765-609	Regents' Scholarship	37587	AMD	07/08/2013	2013-11/65
University of Utah, Administration					
R805-1	Operating Regulations for Bicycles, Skateboards and Scooters	37407	5YR	03/12/2013	2013-7/69
R805-1	Operating Regulations for Bicycles, Skateboards and Scooters	37770	AMD	08/21/2013	2013-14/85
R805-2	Government Records Access and Management Act Procedures	37824	5YR	07/08/2013	2013-15/134
University of Utah, Commuter Services					
R810-1-8	University Vehicle Parking	37096	AMD	03/21/2013	2013-1/12
R810-1-14	Living In A Motor Vehicle On Campus	37098	AMD	03/21/2013	2013-1/13
R810-2-1	Parking Meters	37092	AMD	03/21/2013	2013-1/14
R810-12	Bicycles, Skateboards and Other Toy Vehicles	37387	EXD	03/07/2013	2013-7/71
SCHOOL AND INSTITUTIONAL TRUST LANDS					
Administration					
R850-5-200	Payments	37934	AMD	10/22/2013	2013-18/38
SCIENCE TECHNOLOGY AND RESEARCH GOVERNING AUTHORITY					
Administration					
R856-1	Formation and Funding of Utah Science Technology and Research Innovation Teams	37963	NSC	09/30/2013	Not Printed
R856-2	Distribution of Utah Science Technology and Research Commercialization Revenues	37964	NSC	09/30/2013	Not Printed
TAX COMMISSION					
Administration					
R861-1A-9	State Board of Equalization Procedures Pursuant to Utah Code Ann. Sections 59-2-212, 59-2-1004, and 59-2-1006	38016	NSC	10/08/2013	Not Printed
R861-1A-12	Policies and Procedures Regarding Public Disclosure Pursuant to Utah Code Ann. Sections 41-3-209, 59-1-210, 59-1-403, and 59-1-405	36991	AMD	01/10/2013	2012-22/144
R861-1A-26	Procedures for Formal Adjudicative Proceedings Pursuant to Utah Code Ann. Sections 59-1-501 and 63G-4-204 through 63G-4-209	37104	AMD	02/21/2013	2013-1/15

R861-1A-29	Decisions, Orders, and Reconsideration Pursuant to Utah Code Ann. Sections 59-1-205 and 63G-4-302	37935	AMD	10/24/2013	2013-18/40
R861-1A-37	Provisions Relating to Disclosure of Commercial Information Pursuant to Utah Code Ann. Section 59-1-404	37106	AMD	02/21/2013	2013-1/17
R861-1A-46	Procedures for Purchaser Refund Requests Pursuant to Utah Code Ann. Sections 59-1-1410 and 59-12-110	37107	AMD	02/21/2013	2013-1/18
Auditing					
R865-9I-13	Pass-Through Entity Withholding Pursuant to Utah Code Ann. Sections 59-10-116, 59-10-117, 59-10-118, 59-10-1403.2, and 59-10-1405	37108	AMD	02/21/2013	2013-1/20
R865-9I-46	Medical Savings Account Administration Pursuant to Utah Code Ann. Sections 31A-32a-106, 59-10-114, and 59-10-1021	37178	NSC	01/31/2013	Not Printed
Motor Vehicle Enforcement					
R877-23V-21	Automated License Plate Recognition System Pursuant to Utah Code Ann. Section 41-3-105	37699	AMD	08/22/2013	2013-13/205
Property Tax					
R884-24P-33	2013 Personal Property Valuation Guides and Schedules Pursuant to Utah Code Ann. Section 59-2-301	37936	AMD	10/24/2013	2013-18/41
R884-24P-67	Information Required for Valuation of Low-Income Housing Pursuant to Utah Code Ann. Sections 59-2-102 and 59-2-301.3	37109	AMD	02/21/2013	2013-1/22
TRANSPORTATION					
Administration					
R907-64	Longitudinal and Wireless Access to Interstate Highway Rights-of-Way for Installation of Telecommunications Facilities	37094	R&R	02/07/2013	2013-1/23
R907-64	Longitudinal and Wireless Access to Interstate System Rights-of-Way for Installation of Telecommunication Facilities	37951	5YR	09/03/2013	2013-18/64
R907-65	Compensation Schedule for Longitudinal Access to Interstate Highway Rights-of-Way for Installation of Telecommunications Facilities	37952	5YR	09/03/2013	2013-18/64
R907-66-5	Small Purchase Cap	38035	NSC	10/07/2013	Not Printed
R907-67	Debarment of Contractors from Work on Department Projects -- Reasons	37953	5YR	09/03/2013	2013-18/65
Motor Carrier					
R909-19	Safety Regulations for Tow Truck Operations - Tow Truck Requirements for Equipment, Operation and Certification	37844	AMD	09/10/2013	2013-15/115
R909-19-7	Towing Notice Requirements	37624	EMR	05/14/2013	2013-11/93
R909-75	Safety Regulations for Motor Carriers Transporting Hazardous Materials and/or Hazardous Wastes	37875	AMD	09/23/2013	2013-16/38
Operations, Maintenance					
R918-4	Using Volunteer Groups and Third Party Contractors for the Adopt-a-Highway and Sponsor-a-Highway Litter Pickup Programs	37874	5YR	08/01/2013	2013-16/70
Preconstruction					
R930-7-5	Application	37957	NSC	09/13/2013	Not Printed
Program Development					
R926-10	Tollway Development Agreements	37954	5YR	09/03/2013	2013-18/65

TRANSPORTATION COMMISSION

Administration					
R940-2	Approval of Tollway Development Agreements	37955	5YR	09/03/2013	2013-18/66
R940-4	Airports of Regional Significance	37956	5YR	09/03/2013	2013-18/66

WORKFORCE SERVICES

Employment Development					
R986-100-117	Disqualification For Fraud (Intentional Program Violations or IPVs)	37644	AMD	09/10/2013	2013-12/36
R986-100-118a	Improper Access of Public Assistance Benefits	37541	AMD	06/27/2013	2013-10/200
R986-400	General Assistance	37947	AMD	11/01/2013	2013-18/49
R986-600	Workforce Investment Act	37878	AMD	10/07/2013	2013-16/40
R986-700-710	Income Limits for ES CC	37025	AMD	01/02/2013	2012-22/146
R986-900-902	Options and Waivers	37067	AMD	01/08/2013	2012-23/50
Housing and Community Development					
R990-101	Qualified Emergency Food Agencies Fund (QEFAF)	37542	AMD	07/01/2013	2013-10/201
Unemployment Insurance					
R994-201	Definition of Terms in Employment Security Act	37518	5YR	04/11/2013	2013-9/44
R994-202	Employing Units	37543	5YR	04/25/2013	2013-10/218
R994-208	Wages	37544	5YR	04/25/2013	2013-10/219
R994-305	Collection of Contributions	37066	AMD	01/08/2013	2012-23/52
R994-305-1201	Offer in Compromise	37023	AMD	01/02/2013	2012-22/147
R994-306	Charging Benefit Costs to Employers	37652	5YR	05/16/2013	2013-12/58
R994-307	Social Costs -- Relief of Charges	37651	5YR	05/16/2013	2013-12/59
R994-315	Centralized New Hire Registry Reporting	37650	5YR	05/16/2013	2013-12/59
R994-403	Claim for Benefits	37647	5YR	05/16/2013	2013-12/60
R994-403	Claim for Benefits	37517	AMD	06/12/2013	2013-9/23
R994-403-108b	Deferral of Work Registration and Work Search	37877	AMD	09/25/2013	2013-16/50
R994-403-115c	Period of Ineligibility	37671	AMD	08/01/2013	2013-12/38
R994-405	Ineligibility for Benefits	37648	5YR	05/16/2013	2013-12/60
R994-406	Fraud, Fault and Nonfault Overpayments	37024	AMD	01/02/2013	2012-22/148
R994-406-301	Claimant Fault	37238	AMD	04/02/2013	2013-4/48
R994-406-403	Fraud Disqualification and Penalty	37516	AMD	06/12/2013	2013-9/26
R994-508	Appeal Procedures	37649	5YR	05/16/2013	2013-12/61
R994-508-102	Time Limits for Filing an Appeal from an Initial Department Determination	37670	AMD	08/01/2013	2013-12/39
R994-508-307	Withdrawal of Appeal to the Board	37876	AMD	09/25/2013	2013-16/51