Appendix 1: Regulatory Impact Summary Table*

Fiscal Costs	FY 2020	FY 2021	FY 2022
State Government	$435,800,000	$0	$0
Local Government	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Person	$0	$0	$0
Total Fiscal Costs:	**$435,800,000**	**$0**	**$0**
Fiscal Benefits			
State Government	$0	$0	$0
Local Government	$0	$0	$0
Small Businesses	$145,300,000	$0	$0
Non-Small Businesses	$145,200,000	$0	$0
Other Persons	$145,300,000	$0	$0
Total Fiscal Benefits:	**$435,800,000**	**$0**	**$0**
Net Fiscal Benefits:	**$0**	**$0**	**$0**

***This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts for State Government, Local Government, Small Businesses and Other Persons are described in the narrative. Inestimable impacts for Non-Small Businesses are described in Appendix 2.**

Appendix 2: Regulatory Impact to Non-Small Businesses

About 25,200 non-small business providers of Medicaid services may see a portion of annual revenue that totals $435,800,000, based on expansion to the Adult Medicaid population. Additionally, up to 90,000 individuals will see a share of out-of-pocket savings based on that amount.

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-303. Coverage Groups.
R414-303-4. Medicaid for Parents and Caretaker Relatives, Pregnant Women, Children, Adults, and Individuals Infected with Tuberculosis Using MAGI Methodology.

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

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

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

$62 to the income standard for each family member. The income standards are as follows:[~~55% of the Federal Poverty Level (FPL).~~]

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

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

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

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

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

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

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

(8) The Department provides Medicaid coverage to an individual who is infected with tuberculosis and who does not qualify for a mandatory Medicaid coverage group. The individual's income cannot exceed the amount of earned income an individual, or if married, a couple, can have to qualify for Supplemental Security Income.

R414-303-11. Presumptive Eligibility for Medicaid.

(1) [~~The Department adopts and incorporates by reference, t~~]The definitions found [~~at~~]in 42

CFR 435.1101, and the provisions for presumptive eligibility found [~~at~~]in 42 CFR 435.1103[~~,~~] and 42 CFR 435.1110[~~, October 1, 2013 ed., in relation to determinations of presumptive eligibility~~], apply to Section R414-303-11.

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

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

(b) "presumptive eligibility" means a period of eligibility for medical services based on self-declaration that the individual meets the eligibility criteria.

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

(a) is pregnant;

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

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

(d) is not already covered by Medicaid or CHIP.

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

(5) A child born to a woman who is only presumptively eligible at the time of the infant's birth is not eligible for the one year of continued coverage defined in 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) A child determined presumptively eligible who is under 19 years of age may receive presumptive eligibility only through the end of the month after the presumptive determination date or until the end of the month in which the child turns 19, whichever occurs first.

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

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

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

(b) Through the end of the month in which the individual turns 65 years old; or

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

([~~8~~]9) The Department shall limit the coverage groups for which a hospital may make a presumptive eligibility decision to the groups described in 42 CFR 435.110, 435.116, 435.118, 435.150, and Rule R414-312.[~~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.~~]

([~~9~~]10) A hospital must enter into a memorandum of agreement with the Department to be a qualified entity and receive training on policy and procedures.

(1[~~0~~]1) 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.

(1[~~1~~]2) The covered provider may not count as income the following:

(a) Veteran's Administration (VA) payments;

(b) Child support payments; or

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

(1[~~2~~]3) An individual found presumptively eligible for one of the following coverage groups may only receive one presumptive eligibility period in a calendar year:

(a) Parents or caretaker relatives;

(b) Children under 19 years of age;

(c) Former foster care children; [~~and~~]

(d) Individuals with breast or cervical cancer[~~.~~]; and

(e) Adult expansion.

KEY: MAGI-based, coverage groups, former foster care youth, presumptive eligibility
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