NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ARIZONA LONG-TERM CARE SYSTEM

PREAMBLE

1.	**Sections Affected**	**Rulemaking Action**
	R9-28-206	Amend

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. 36-2907

Implementing statute: A.R.S. 36-2907, amended by HB2010, Forty-ninth Legislature, Seventh Special Session 2010

3. The proposed effective date of the rules:

October 1, 2010

4. A list of all previous notices appearing in the *Register* addressing the proposed exempt rule:

None

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

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6. An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from regular rulemaking procedures:

The AHCCCS Administration is proposing rule changes to delineate the service limitations/ exclusions as described in HB2010, Forty-ninth Legislature Seventh Special Session of 2010.

The AHCCCS Administration is exempt from the rule making requirements of Title 41, Chapter 6, A.R.S., as described in HB2010, Forty-ninth Legislature Seventh Special Session of 2010, Section 34.

7. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

No studies were relied upon for the implementation of this rulemaking, but analysis of the outpatient physical therapy services reported through claims and encounters as having provided these services during CY 2009, has assisted the AHCCCS Administration in arriving at the limitation amount of covered outpatient physical therapy services of 15 visits, which represents that the limitation does not affect 85% of members receiving outpatient physical therapy services.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable.

9. The summary of the economic, small business, and consumer impact:

The Administration estimates that approximately 183,380 members may be impacted by the proposed limitations/ exclusions of services as described in HB2010, Forty-ninth Legislature Seventh Special Session of 2010.

Based on the utilization of each type of service during the contract year (CY) 2009 the Administration foresees an approximate savings of $24,024,650 per CY. In addition, the limitation applied to outpatient physical therapy services the Administration foresees an approximate savings of $2,900,000 per CY for members 21 years of age and over.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

Not applicable.

11. A summary of the comments made regarding the rule and the agency response to them:

The following matrix outlines the comments received as of June 22, 2010 in regards to the Adult Benefit limitations and eliminations as described in A.R.S. 36-2907, amended by HB2010, Forty-ninth Legislature, Seventh Special Session 2010.

There were 30 attendees at a public hearing held simultaneously at three locations in Arizona. Of the 30 attendees, 14 attendees commented on the proposed rulemaking and some submitted their comments in writing as well. One commenter did not attend the hearing but submitted written comments only.

The general consensus was that all commenters where against one or more aspects of the rulemaking changes and expressed concerns in regards to how the specific services were selected for elimination or limitation. Many urged that data be reviewed by the agency to ensure that the legislature used current and sound information. Studies were identified and articles provided as information to be reviewed.

Item #	Rule Cite Line #	Comment From	Comment	Response
1.		Bruce Reeser Hanger Prosthetics and Orthotics	Is there a final ruling on whether there is a cap on prosthetics or where the microprocessor will be disallowed?	The AHCCCS Administration is not imposing a dollar limit on prosthetics. The only limitation regarding prosthetics is the exclusion of microprocessor-controlled lower limbs and microprocessor-controlled joints for lower limbs. No limitations have been applied to prosthetics for the upper extremities.
2.		Bruce Reeser Hanger Prosthetics and Orthotics	For the individuals who have existing prosthetics, will they be allowed to get them fixed?	Yes, if the prosthetic is one that is no longer covered under the rule, the reasonable cost of repair will be permitted when necessary for continued use. A socket joint or non-microprocessor control joint can be replaced to allow the entire prosthetic to be used. We will not be able to replace the microprocessor, but the reasonable costs of repair of the prosthetic will be covered.
3.		Bruce Reeser Hanger Prosthetics and Orthotics	Children under 21, is there anything that would not be covered that is presently covered?	The limitation in this rule does not apply to individuals under 21 years old.

4.		Bruce Reeser Hanger Prosthetics and Orthotics	For those 21 and older, can you clarify orthotics; does this include everything under the orthotic umbrella?	The statutory language included all orthotics; this will include everything that is under the "L0100 to L4999" codes. There are a few exceptions in that range of codes which are considered supplies which will be covered.
5.		Bruce Reeser Hanger Prosthetics and Orthotics	Do you realize that there is a possibility of higher utilization in other areas to off set the money that you saved by not allowing these patients to have these prosthetics or orthotics.	These issues were considered, along with many others, when making the coverage decisions.
6.		Michael Brewer Maricopa County Medical Center	Written statement provided and articles referenced. (see attachments) The patient's options for referrals are limited very limited for the various problems. Because dermatologists rarely address diabetic foot issues, we the podiatrist are the premier practitioners in this are, some orthopedic surgeons have obtained 6 months of lower extremity training but the vast majority of foot and ankle care is provided by highly specialized physicians of podiatric medicine. The changes you propose could potentially result in the loss of our residency program as we serve a majority of AHCCCS patients at the County Hospital. This program is considered one of the best in the country as DPM's, MDs and DOS all commiserate in a surgical intern year with identical responsibilities and expectations from attending physicians. The general surgery program relies on our residents to serve in all of these areas and not just in foot and ankle surgery. However you eliminating all services provided by podiatrists jeopardize our position to assist AHCCCS patients in the other capacities. Please take this into consideration.	Federal law allows AHCCCS to eliminate optional services. Podiatrists' services are among the optional services which the Legislature eliminated in HB2010 during the latest legislative session.
7.		Dr. Bryan Roth Maricopa County Medical Center	I am an attending physician for the group of residents. Pulling AHCCCS is a very real thing for the loss of the program, we have had multiple meetings discussing the implications and what this means to our program. We recently had a site survey at the beginning of May; we were recognized as one of the premier teaching facilities and programs in the country. How was the determination made to drop services covered by podiatrists but not limiting or allowing another physician to do that? We are a cheaper service, and we provide services that others do not have time to do, or want to do, or do not deem important.	Federal law allows AHCCCS to eliminate optional services. Podiatrists' services are among the optional services which the Legislature eliminated in HB2010 during the latest legislative session.

			If we vanish from our institution, the rates of amputations, major amputations, below knee amputations will sky rocket. Our concern is that everyone will be flipping the bill for prosthesis, long term disability. We are overall doing a disservice to our patient population. This should be reconsidered.	
8.		Cynthia Driscoll AZ Physical Therapy Association	Statement read (see attachment) The Physical Therapy Association objects to the utilization of an arbitrary cap on outpatient physical therapy services per calendar year. The cap without regard to the diagnosis discriminates to the most vulnerable of patients. A 15 visit cap will not be adequate for a meaningful rehabilitation and positive outcome. The AHCCCS Administration suggests that a 15 visit cap would not affect 85% of members who receive outpatient physical therapy based on their analysis of claims in 2009. It is unclear if this analysis adequately reflects the rehabilitative needs of AHCCCS members or merely reflects the use of PT services that is influenced by many other factors, such as copays, travel expenses, etc. Without useful outcome data it is unclear that the historical rate of utilization is adequate to meet the rehabilitative needs of AHCCCS members. AHCCCS does not address the significant needs of the minority of patients who have needed and used PT services in excess of 15 visits per calendar year. The cap without regard to clinical appropriateness of care fails to meet a reasonable standard of care of these complex patients. This could lead to rationing of care to avoid exhausting benefits too early in a calendar year. And could push members to greater cost of care and seeking uncovered services, such as inpatient settings. We urge you to consider the need of PT members and allow for additional services above the 15 visit limit based on diagnosis, individual evaluation and clinic judgment.	Federal law allows Medicaid Programs to place limits on services which meet the needs of 85% of the population. These limitations have been determined to be permissible. The AHCCCS Administration evaluated program information and data to determine that the 15 PT visit limit meets the needs of 85% of the population.
9.		Kay Wing President AZ Physical	Provided picture and described physical condition of patient. This type of patient is the type of person that will be affected by the 15 visit limit and would inadequately meet his medical needs.	Federal law allows Medicaid Programs to place limits on services which meet the needs of 85% of the population. These limitations have been determined to be permissible.

		Therapy Association		The AHCCCS Administration evaluated program information and data to determine that the 15 PT visit limit meets the needs of 85% of the population.
10.		Patty Telgener Hillrom Manufacturer of Percussive Vests	The population that uses the percussive vests are those with sistic fybrosis, cp, muscular dystrophy, and als. These patients have progressive lung disease, frequently leading to pneumonia and hospitalizations. Our concern is that the percussive vests are inadvertently classified as a prosthetic and were eliminated as a benefit, because if considered a prosthetic they did not meet the definition of medically necessary for rehab. The vests are not a prosthetic, they do not replace a body system, and they are clearly listed with Medicare as DME. We would like clarification on how they were classified as a prosthetic. We believe they should be under DME. The Luensa assessment that was done when the savings was reviewed for percussive vests was under $10,000, One of these patients with systic fybrosis or cp with an ICU stay will be over $30,000. Can we get clarification on the benefit categorization and how can we work together to make sure that some of these patients still have access to the percussive vest assuming that they meet your coverage criteria, because after this they will not have any other options. Written comment received 6/22/10: State Plan Amendment (SPA) #10-006 (attachment 3.1-A Limitations) listed percussive vests as a prosthetic. Percussive vests do NOT meet the definition of prosthesis (**replaces** missing, deformed or malfunctioning portions of the body"). At the public hearing on June 22nd, 2010, the panel stated that percussive vests are actually considered an Orthotic. However, the vest is classified as medical equipment and supplies, not orthotic. Medicare has a national coverage decision for percussive vests and the HCPCS codes are A0483 and E7025 and E7026. These HCPCS codes do NOT fall under the L-group of HCPCS codes which are considered orthotic. The Arizona House Bill 2010 states that "durable medical equipment is limited to items covered by Medicare" Percussive vests are considered DME and covered by Medicare; therefore coverage should not be eliminated. The panel stated that	The agency does not have the discretion to override the legislative decision to exclude percussive vests.

			Medicaid does not follow Medicare's definition of DME. However, per Arizona OMD Policy Manual, ' 310.16, at 3-31 (effective October 1, 1994) they list the definition of DME to be the following: **"Durable medical equipment means sturdy, long lasting items and appliances that can withstand repeated use, are designed primarily to serve a medical purpose and are not generally useful to a person in the absence of a medical condition, illness or injury."** So clearly, AZ Medicaid does recognize the definition of medical equipment and supplies outside of orthotics. Percussive vests do meet this definition of medical equipment. In addition, percussive vests have "A" and "E" HCPCS codes that are considered medical equipment and supplies (NOT orthotic "L" codes). We formally request that AHCCCS correctly classify percussive vests as medical equipment/ supplies and NOT orthotics. As stated earlier, the Arizona House Bill 2010 states that "durable medical equipment is limited to items covered by Medicare". Therefore, AHCCCS should continue to provide coverage of percussive vests for patients over the age of 21 years.	
11.		Kathleen Crout Member	With the upcoming orthotics benefits being eliminated as proposed would be detrimental to my health. I have spin bifida, tethered spinal cord, neuropathy, also drop foot on the right foot and a prosthetic below the left knee and multiple other health issues. If I have to pay for orthotic repair supplies and braces along with what I currently pay for, it would be impossible. I need to stay mobile to maintain muscle tone to my lower extremities, if these coverage's are taken away I will be in a wheelchair when something uncovered goes wrong and I cannot afford the necessary supplies I need. Being in a wheel chair for a prolonged time with my expensive health issues will cause a quicker deterioration in my condition. Spina bifida itself can and usually paralyze you from the waist down and put you on kidney dialysis. This concerns me as to which expense would be greater. As a non-emergency medical transportation for childless adults, or non ALTCS members. The time has come and I may need to utilize this benefit. Do these decisions need to be made at the expense of people's	Repairs will continue to be covered. See the Frequently Asked Questions at: http://www.azahcccs.gov/reporting/Downloads/Legislation/2010seventh/BenefitChanges_FAQs.pdf In regard to non-emergency transportation, the Administration is awaiting approval from the Federal government. Once additional information is received from the Center for Medicare and Medicaid Services, AHCCCS will notify the public, and the information will be posted on the AHCCCS website.

			quality of life and livelihood? Each one of us in our case is unique, but we all have in common is our health. I hope what I have touched will be carefully considered for all AHCCCS recipients.	
12.		Jena Freischmidt Member	I am concerned about why it says that specified transplants per HB2010, pancreas, ……..liver for diagnosis of Hepatitis C transplants, I am wondering why you are singling out Hepatitis C transplants, my husband is 37 years old and has hepatitis C. I understand cuts have to be made and transplants are expensive, but people who need transplants are going to die, it is their last opportunity. If my husband receives a transplant he can go on a therapy that could clear his hepatitis C and he could be better for the rest of his life. I don't understand how you can cut out certain transplants; other things can be taken out.	The legislation identified the specific transplants that are excluded from AHCCCS coverage. These rules put into effect the requirements of HB 2010 as directed by the Legislature.
13.		Robert Lynch Attorney	Some of the regulatory proposal that you have here I cannot find in A.R.S. 36-2907, specifically the lower limb microprocessor as an exclusion in rule. This does not fall in the list of the statute. And everything else is directly quoted from the statute. So I was curious about that. What happens if the expected savings that you called out in this rule do not materialize? Do you have another rulemaking? Will there be another rulemaking under subsection B2b, in your discretionary authority? The authority to put a cap on prosthetics, but you decided to leave alone for now. It is not off the table, your just leaving it alone for now?	State Law A.R.S. 36-2907 provides the AHCCCS Administration with the general authority to limit any service. The legislation authorizes the AHCCCS Administration to engage in rulemaking to implement the provisions of the law.. Therefore, additional rulemakings are an option available to the Agency. You are correct that the Agency still has the authority to implement a cap on prosthetics. .
			Tucson Office	
14.		Eric Burns Hanger Prosthetics and Orthotics	There are many studies related in the overall health care system, in regards to orthotic care, chronic conditions, traumatic conditions, and diabetes. These savings are reflected in the reduction of inpatient stays, reduction of long term care….etc Are these considered when making decisions and changes?	The Agency does not have the discretion to override the legislative decision to exclude orthotics. Information from the AHCCCS Administration which was provided to the Legislature did take into consideration potential increases in other costs due to the elimination of coverage for orthotics.
15.		James Dustin Hanger Prosthetics and Orthotics	On page 26, section A line 8 it states that "orthotic is a device used for healing a weak or deformed body portion". Does this include an orthotic utilized to aid in the healing of fractures due to an injury and/or trauma, such as spinal brace for a spinal fracture, or halo for a cervical fracture? Phoenix Speaker added to this topic: We deal a lot with halo care and it is not something that ends in the	Yes, although in some instances there are other options which are covered by AHCCCS. For example, instead of a spinal brace or walking boot, a cast (which is not considered an orthotic) may be used. An orthotic, including a halo, that is provided as part of an inpatient stay is reimbursed by AHCCCS as part of the inpatient tier per diem payment.

			hospital, patients are seen in our office to control costs. They are seen monthly if not biweekly to maintain the halo care to prevent ulcers, prevent any need for further surgical procedures. So halo care while maybe covered in the hospital, the codes that are accompanied in treating those patients afterward are done through orthotic coding. In eliminating that, then those patients are on their own in sense. That is not a device a person should be on their own with, you cannot function without help. Keep this in mind and in consideration.	
16.		Holly Tuchscherer Hanger Prosthetics and Orthotics	All the care that is preventative care, such as orthotic care diabetic shoes, which are in the A codes, are they still covered? And the diabetic shoe inserts which are A5513, A5512 are they covered? Written comment received 6/22/10: It appears from what is written in the rule that only the physical therapy area has been analyzed before limitations were made. It is concerning that no other areas of eliminated benefits have been analyzed to determine the elimination or limited benefits. It would be beneficial to consider the long-term effects of eliminating orthotic and assistive device coverage for the AHCCCS patients…. There are many scientific studies….	Diabetic shoes are not orthotics. They are in the A code section as a medical supply. The exclusion for orthotics refers to those items described with an L codes, up to L4999. Yes, the inserts are covered since items described by A codes are not considered orthotics. The Agency does not have the discretion to override the legislative decision to exclude orthotics. Information from the AHCCCS Administration which was provided to the Legislature did take into consideration potential increases in other costs due to the elimination of coverage for orthotics.
17.		Beth Horowitz	Did you look at other ways to deal with cost savings, for example …. 1. In France it would be one third of the costs, significantly cheaper than our medical services, and yet the best by using a card, all the medical records is on this card. This would cut back on billing costs. The savings could go to the patient. 2. Organ transplants can we make it an opt-out system rather than opt-in system to be an organ donor. Then the supply would increase and the cost decrease. 3. Take the profit out of the system. Anyone participating in the system by a certain time has to become a not for profit organization. 4. Have you thought of expanding rather than limiting coverage… the system would pay for itself. Many small business owners cannot get health care coverage, this is detrimental. Expanding the	The purpose of this rule is to implement statutory limitations, including the elimination of certain services. The suggestions that have been made are beyond the scope of this rulemaking.

			coverage, increase the number of people in the program and have them paying for the program, then the system would pay for itself. Have you considered any of those options? .	
			Flagstaff Office	
18.		Jim McCalmont Hanger Orthotics and Prosthetics	You said you would cover A codes for diabetics but not L codes, by cutting out the L5000 how does that save you money?	The only A codes devices that are appropriate for the treatment of diabetes are shoes and inserts. Orthotics described by L codes are not covered for diabetic members or any other AHCCCS members. These exclusions result in savings to the AHCCCS Program.
			Tucson Office	
19.		Eric Burns	What other areas are you looking at cutting?	Costs for the AHCCCS Program are from three main areas: the number of members served, the scope of benefits which are provided, and the payment made for these services. The federal health care reform law prohibits the Agency from eliminating covered populations. Therefore, to maximize cost savings while ensuring compliance with federal and state law, the AHCCCS Administration considered measures that would achieve cost savings in an equitable fashion. It has reduced covered services, and it has proposed additional rate reductions for all providers, including physicians, hospitals, and nursing homes. Although AHCCCS recognizes the significant burdens associated with these decisions, it believes that it has achieved the best balance possible given the the legal requirements.
			Written Comment	
20.		James Haynes AZ Hospital and Healthcare Association	We wish to bring to the Administration's attention that we received last month after passage of the FY2011 budget, information from transplant physicians regarding the impact of eliminating certain transplant coverage from the benefit package and the cost-efficiency of transplant coverage as reference in recent scientific literature. This information raises doubt about the cost effectiveness and impact of eliminating the following transplant services for AHCCCS patients 21 years of age or older: 1. Heart Transplantation for Non-Ischemic Cardiomyopathy; 2. Lung Transplantation; 3. Pancreas – only and Pancreas after Kidney Transplantation; and 4. Liver Transplantation for Patients with Hepatitis C.	The Agency does not have the discretion to override the legislative directive to exclude certain transplant types. The Az Hospital and Healthcare Association may wish to share this information with the Legislature.

			For example, the letter raises concerns that some of the data used to substantiate elimination of these services is outdated. New treatment modalities have dramatically increased survival rates in certain transplant patients. Without receiving transplant services, several patients on the wait list will likely develop secondary complications leading to multiple hospital admissions. Also encouraging AHCCCS Administration to collaborate with the transplant community in an effort to find alternative cost savings in the transplant benefit rather than eliminating the aforementioned benefits. AzHHA urges the Administration to reexamine the scientific literature that informed the earlier recommendation to eliminate certain hear, lung, pancreas, and liver transplant benefits, and bring forth new recommendations as appropriate.	

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable.

13. Incorporations by reference and their location in the rules:

None.

14. Was this rule previously made as an emergency rule? If so, please indicate the *Register* citation:

No.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 2. COVERED SERVICES

Section

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ARIZONA LONG-TERM CARE SYSTEM

ARTICLE 2. COVERED SERVICES

R9-28-206. ALTCS Services that may be Provided to a Member Residing in either an Institutional or HCBS Setting

The Administration shall cover the following services if the services are provided to a member within the limitations listed:

1. Occupational and physical therapies, speech and audiology services, and respiratory therapy:
   a. The duration, scope, and frequency of each therapeutic modality or service is prescribed by the member's primary care provider or attending physician;
   b. The therapy or service is authorized by the member's contractor or the Administration; and
   c. The therapy or service is included in the member's case management plan.
   d. AHCCCS will not cover more than 15 outpatient physical therapy visits for the contract year with the exception of the required Medicare coinsurance and deductible payment as described in 9 A.A.C. 29, Article 3.
2. Medical supplies, durable medical equipment, and customized durable medical equipment, which conform with the requirements and limitations of 9 A.A.C. 22, Article 2;
3. Ventilator dependent services:
   a. Inpatient or institutional services are limited to services provided in a general hospital, special hospital, NF, or ICF-MR. Services provided in a general or special hospital are included in the hospital's unit tier rate under 9 A.A.C. 22, Article 7;
   b. A ventilator dependent member may receive the array of home and community based services under R9-28-205 as appropriate.
4. Hospice services:
   a. Hospice services are covered only for a member who is in the final stages of a terminal illness and has a prognosis of death within six months;
   b. Covered hospice services for a member are those allowable under 42 CFR 418.202, December 20, 1994, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments; and
   c. Covered hospice services do not include:
      i. Medical services provided that are not related to the terminal illness; or
      ii. Home delivered meals.
   d. Medicare is the primary payor of hospice services for a member if applicable.