NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION – ARIZONA LONG TERM CARE SYSTEM

PREAMBLE

1. Article, Part, or Section Affected (as applicable) **Rulemaking Action:**

R9-28-408 Amend

2. Citations to the agency's statutory rulemaking authority to include both the authorizing statute (general) and the implementing statute (specific):

Authorizing statute: A.R.S. §§ 36-2903.01, 36-2903, 36-2932

Implementing statutes: A.R.S. §§ 36-2904, 36-2933

3. The effective date of the rule:

AHCCCS requests an immediate effective date citing A.R.S. § 41-1032(A)(2). The immediate effective date is necessary to ensure consistency with CMS interpretation of 42 CFR 435.726. CMS and the Administration have worked together to craft new language for the Administration's State Plan Amendment that reflects how share of cost is determined. This rulemaking mirrors that language. However, CMS has made it clear that prompt revision of the State Plan is necessary to conform to CMS interpretation.

4. Citations to all related notices published in the Register to include the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 23 A.A.R. 3430, December 15, 2017

Notice of Proposed Rulemaking 23 A.A.R. 3397, December 15, 2017

5. The agency's contact person who can answer questions about the rulemaking:

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6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

There are two major changes in this rulemaking. First, the proposed rulemaking will amend and clarify rules to provide further flexibility as to the amount of money that may be retained in limited situations for persons who are ALTCS eligible, residents of a nursing facility, and who are responsible for court ordered spousal and/or child support. In particular, this rulemaking is requested to allow institutionalized members subject to court ordered child and/or spousal support to increase their personal needs allowance beyond the current limit of 15% of the Federal Benefit Rate (FBR) in limited circumstances. An individual's personal needs allowance is deducted from the member's share of cost which is the monthly amount an individual contributes to his or her cost of care calculated from the individual's income. With respect to share of cost for the ALTCS Program, ARS §36-2932 (L)(1) provides that rules "shall provide that a portion of income may be retained for: 1. A personal needs allowance for members receiving institutional services of at least fifteen per cent of the maximum monthly supplemental security income payment for an individual or a personal needs allowance for members receiving home and community based services based on a reasonable assessment of need." AHCCCS Rule R9-28-408(E)(5)(a) limits the personal needs allowance for institutionalized member to 15% of the FBR, stating the following with respect to calculation of share of cost: "The following expenses are deducted from the share-of-cost of an eligible person to calculate the person's share of-cost: a. A personal-needs allowance equal to 15 percent of the FBR for a person residing in a medical institution for a full calendar month." Some ALTCS members have had income garnished for payment of child or spousal support, and, as a result, the nursing facility did not receive full payment for institutional services provided to the member. This rulemaking will address these unusual situations, allowing providers to receive full payment for these residents.

Second, the rulemaking clarifies the requirements for deduction of medical or remedial care expenses from the share of cost calculation. As a result of the revisions, the rule specifies a three month time frame for incurring the expense as well as the requirement that the individual have a legal liability to pay the expense. Since the description of the list of services eligible for share of cost deductions was clarified, there was no longer a need for an itemized description of qualified services. Moreover the list of qualifying services in the current rule does not reflect the full scope of expenses that may be deducted.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not 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:

A study was not referenced or relied upon when revising these regulations.

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

Not applicable.

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

It is anticipated that the members and the Administration will be minimally impacted by the changes to the rule language although these changes will require system and policy changes. There will be a minimal small business or private industry economic impact because these articles deal with members' share of cost and the Administration's reimbursement of certain expenses. The economic impact upon members and the Administration is unknowable because it is not determined how members' behavior may change in response to this rulemaking and therefore which expenses will be submitted for reimbursement going forward.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

The changes made between the proposed rulemaking and the final rulemaking were mainly a reorganization of the order of subsection (E)(5) to make it more easily understandable by stakeholders and members.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

Only one member of the public attended the oral proceeding and provided comments.

Item #	Comment From and Date rec'd.	Comment	Analysis/ Recommendation
1.	Kathleen Collins-Pagels 01/04/18 Executive Director of the AZHCA	I am writing to offer my support for the revision of Article 4. Eligibility and Enrollment R9-28-408 Income Criteria for AHCCCS eligibility. This addresses an issue we brought to AHCCCS a few years ago, the growing number of younger residents of skilled nursing facilities who had their Share of Cost (SOC) garnished for spousal maintenance and child support, thereby creating financial hardship for them and the facilities providing their care. We appreciate your consideration of our documentation of the issue, and your subsequent effort in revising the rule to address this problem. We know there are other SOC issues that may arise in the future as our ever changing SNF resident population evolves- tax and insurance liens, for example, are now presenting. The future may lie in some sort of a universal policy for an exception to the personal needs allowance and	AHCCCS thanks Ms. Collins-Pagels for the support.

		SOC calculation. That said, we are very grateful for this current proposed change. It will be of great service to our high Medicaid facilities, particularly those serving younger behavioral care residents…a great need in Arizona, and a vulnerable population to be sure. Thank you for your responsiveness to stakeholders, and AHCCCS members.	

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

No other matters have been prescribed.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

Not applicable.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

The rules were updated to align with CMS's current interpretation of post-eligibility treatment-of-income (PETI) rules found at 42 CFR 435.726. However, the Administration's rules are not more stringent than the federal regulations.

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No analysis was submitted.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:

Not applicable.

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

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

ARTICLE 4. ELIGIBILITY AND ENROLLMENT

Section

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R9-28-408. Income Criteria for Eligibility

A. The following Medicaid-eligible persons shall be deemed to meet the income requirements for ALTCS eligibility unless ineligible due to federal and state laws regarding trusts.

1. A person receiving Supplemental Security Income (SSI);
2. A person receiving Title IV-E Foster Care Maintenance Payments; or
3. A person receiving Title IV-E Adoption Assistance.

B. If the person is not included in subsection (A), the Administration shall count the income described in 42 U.S.C. 1382a and 20 CFR 416 Subpart K to determine eligibility with the following exceptions:

1. Income types excluded by 42 U.S.C. 1382a(b) for determining net income are also excluded in determining gross income to determine eligibility;
2. Income of the parent or spouse of a minor child is counted as part of income under 42 CFR 435.602, except that the income of the parent or spouse is disregarded for the month beginning when the person is institutionalized;
3. In-kind support and maintenance, under 42 U.S.C. 1382a(a)(2)(A), are excluded for both net and gross income tests;
4. The income exceptions under A.A.C. R9-22-1503(B) apply to the net income test; and
5. Income described in subsection (C) is excluded.

C. The following are income exceptions:

1. Disbursements from a trust are considered in accordance with federal and state law; and
2. For an institutionalized spouse, a person defined in 42 U.S.C. 1396r-5(h)(1), income is calculated in accordance with 42 U.S.C. 1396r-5(b).

D. Income eligibility. Except as provided in R9-28-406(B)(2)(b), countable income shall not exceed 300 percent of the FBR.

E. The Administration shall determine the amount a person shall pay for the cost of ALTCS services and the post-eligibility treatment of income (share-of-cost) under A.R.S. § 36-2932(L) and 42 CFR 435.725 or 42 CFR 435.726. The Administration shall consider the following in determining the share-of-cost:

1. Income types excluded by 42 U.S.C. 1382a(b) for determining net income are excluded in determining share-of-cost.
2. SSI benefits paid under 42 U.S.C. 1382(e)(1)(E) and (G) to a person who receives care in a hospital or nursing facility are not included in calculating the share-of-cost.
3. The share-of-cost of a person with a spouse is calculated as follows:
    a. If an institutionalized person has a community spouse under 42 U.S.C. 1396r-5(h), share-of-cost is calculated under R9-28-410 and 42 U.S.C. 1396r-5(b) and (d); and
    b. If an institutionalized person does not have a community spouse, share of cost is calculated solely on the income of the institutionalized person.
4. Income assigned to a trust is considered in accordance with federal and state law.

5. The following expenses are deducted from the share-of-cost of an eligible person to calculate the person's share-of-cost:

   a. ~~A personal-needs allowance equal to 15 percent of the FBR for a person residing in a medical institution for a full calendar month. A personal-needs allowance equal to 300 percent of the FBR for a person who receives or intends to receive HCBS or who resides in a medical institution for less than the full calendar month;~~A personal-needs allowance (PNA) equal to 300 percent of the FBR for a person who receives or intends to receive HCBS or who resides in a medical institution for less than the full calendar month. A personal-needs allowance equal to 15 percent of the FBR for a person residing in a medical institution for a full calendar month, except:

      i. The PNA shall be increased above 15 % of the FBR by the amount of income garnished for child support under a court order, including administrative fees garnished for collection efforts, but only to the extent that the amount garnished is not deducted as a monthly allowance for the dependent under any other provision of the post-eligibility process. The increase to the PNA due to the garnishment shall not exceed the actual garnishment paid in the month for which the PNA is calculated; and

      ii. The PNA shall be increased above 15 % of the FBR by the amount of income garnished for spousal maintenance under a judgment and decree for dissolution of marriage, including administrative fees garnished for collection efforts, but only to the extent that the amount garnished is not deducted as a monthly allowance for the spouse under any other provision of the post-eligibility process. The increase to the PNA due to the garnishment shall not exceed the actual garnishment paid in the month for which the PNA is calculated.

   b. A spousal allowance, equal to the FBR minus the income of the spouse, if a spouse but no children remain at home;

   c. A household allowance equal to the standard specified in Section 2 of the Aid for Families with Dependent Children (AFDC) State Plan as it existed on July 16, 1996 for the number of household members minus the income of the household members if a spouse and children remain at home;

   d. Expenses for ~~the~~ medical and remedial care services ~~listed in subsection (6)~~ if the expenses were for services rendered to the applicant or beneficiary and prescribed by a health care practitioner acting within the scope of practice as defined by State law. The applicant or recipient must have, or have had, a legal obligation to pay the medical or remedial expense. Deductions do not include the cost of services to the extent a third party paid for, or is liable for, the service. Deductions for expenses incurred prior to application are limited to expenses incurred during the three months prior to the filing of an application. Documents shall be submitted within a reasonable time as determined by the Director.~~have not been paid or are not subject to payment by a third-party, the person still has the obligation to pay the expense, and one of the following conditions is met:~~

      ~~i. The expense represents a payment made and reported to the Administration during the application period or a payment reported to the Administration no later than the end of the month following~~

~~the month in which the payment occurred and the expense has not previously been allowed a share-of-cost deduction; or~~

~~ii. The expense represents the unpaid balance of an allowed, noncovered medical or remedial expense, and the expense has not been previously a share-of-cost deduction;~~

e. An amount determined by the Director for the maintenance of a single person's home for not longer than six months if a physician certifies that the person is likely to return home within that period; or

f. An amount for Medicare and other health insurance premiums, deductibles, or coinsurance not subject to third-party reimbursement; and

6. The deductible expense under subsection (5)(~~b~~d) shall not include any amount for a service covered under the Title XIX State Plan. ~~The deductible expense may include the TPL deductible, co-insurance, and co-payment charges for the following medically necessary services:~~

~~a. Nonemergency dental services for a person who is age 21 or older;~~

~~b. Hearing aids and hearing aid batteries for a person who is age 21 or older;~~

~~c. Nonemergency eye care and prescriptive lenses for a person who is age 21 or older;~~

~~d. Chiropractic services, including treatment for subluxation of the spine, demonstrated by x-ray;~~

~~e. Orthognathic surgery for a person who is age 21 or older; or~~

~~f. Co-payments for Medicare Part D prescriptions, if not paid by the State.~~

~~g. On a case by case basis, other noncovered medically necessary services that a person petitions the Administration for and the Director approves.~~

F. A person shall provide information and verification of income under A.R.S. § 36-2934(G) and 20 CFR 416.203.