Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 22, Article 1

October 2016

I. General Information about 9 A.A.C. 22, Article 1

Overview:

On October 1, 1982, AHCCCS became the first statewide Medicaid managed care system in the nation. AHCCCS has operated under a Research and Demonstration Waiver under Section 1115 of the Social Security Act since 1982 when the original Waiver was granted by the Centers for Medicare and Medicaid Services (CMS). During that period, a number of waiver extensions have been approved by CMS. AHCCCS was created as a partnership between the state and private and public managed care Health Plans that mainstreamed Medicaid members into private physician offices. This arrangement opened up the private physician network to Medicaid recipients and allowed AHCCCS members to choose a Health Plan and a primary care provider. AHCCCS oversees contracted health plans in the delivery of both acute care and long term care services to persons who qualify for Medicaid. The Agency also oversees the delivery of behavioral health services to persons who have a Serious Mental Illness as a result of the transition of those responsibilities from the Arizona Department of Health Services to the AHCCCS Administration effective July 1, 2016 pursuant to Senate Bill Senate Bill 1257 (Laws 2015, Chapter 195).

As of October 1, 2016 approximately 1.9 million individuals were enrolled in the AHCCCS Program. Article 1 was created to define terms concerning requirements of the AHCCCS Program related to the delivery of services to acute care populations. This Article was amended by exempt rulemaking at 18 A.A.R. 461, effective April 1, 2012.

II. Five Year Report on 9 A.A.C. 22 Art 1 rules:

General and specific statutes authorizing the rule:
A.R.S. § 36-2903.01(F) provides general authority to AHCCCS to adopt rules.

Objective of the rule:
R9-22-101 – The objective of the rule is to provide definitions for terms used in Title 9

Chapter 22 specific to the AHCCCS Program .

Effectively meets its objectives, including any available data supporting conclusion:

Chapter 22, Article 1 rule meets the objective listed above. No data was attained.

Consistent with Statutes, rules, (including Federal, State, Waiver, Policy)

Chapter 22, Article 1 rule is consistent with statutes and federal regulations.

Is enforced:

Chapter 22, Article 1 rules is enforced with no issues.

Clarity, conciseness and understandability of the rule:

R9-22-101 – The Administration recommends the following changes to improve clarity, conciseness, and understandability of the rule:

"Adult behavioral health therapeutic home" 9 A.A.C. 10, Article 1 – Change this citation to R9-10-101 for greater clarity.

"Chronic" R9-22-1301 – Remove this definition as it no longer has a corresponding definition in section 1301 as of October 2015.

"Clinical oversight" 9 A.A.C. 10 – Change this citation to R9-10-101 for clarity.

"CRS provider" R9-22-1301 – Remove this definition as it no longer has a corresponding definition in section 1301 as of October 2015.

"Grievance" A.A.C. Chapter 34 – Change this citation to R9-34-202 for clarity.

"Total Inpatient payments" R9-22-712.07 – Remove this definition because it has been deleted from the code.

Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods:

Written criticisms or written analyses for Chapter 22, Article have not been submitted in the past five years.

Comparison of estimated economic, small business, and consumer impact.

The economic impact estimated at the time of rule promulgation has not been significantly different than the actual economic impact.

Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states:

No.

If applicable, has the agency completed the course of action indicated in the agency's previous five-year review:

The Administration has not completed the recommended course of action described in the previous 5yr report. Since the submission of the previous five-year review, the federal

government has published, and continues to publish, proposed and final regulations implicating Medicaid Program operations and requirements as a result of the Affordable Care Act and other laws. Examples include Medicaid Managed Care final rules, Access to Care final rules, Nondiscrimination final rules, Copayment final rules, and final rules regarding eligibility requirements. Additionally, the federal government approved Arizona's Section 1115 Demonstration program in September 2016 due to the expiration of the prior Demonstration Program on September 30, 2016. As a result, the Agency will be initiating rulemaking to establish program requirements as a result of the new Waiver and to comply with the aforementioned federal rules. The recommendations for Article 1 will be addressed as part of the upcoming rulemakings.

Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective:

The Administration believes the rules as written impose the least burden and cost when meeting their objectives.

A determination after analysis that the rule is not more stringent than a corresponding federal law. Are the rules more stringent than a corresponding federal law? Is there a statutory authority that exceeds the requirements of that federal law?:

The rule is not more stringent than corresponding federal law 42 USC 1396 et seq.

Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization?

Not applicable, the Administration does not issue permits, license or agency authorization for the imposition the definitions section of Chapter 22.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend repeal or make a rule:

R9-22-101 – The Administration intends to update this rule as stated above, and these activities are anticipated to begin in 2017.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 22, Article 10

November 2012

I. General Information about 9 A.A.C. 22, Article 10

Overview

The rules in A.A.C. Title 9, Chapter 22, Article 10 support the operations and practices of third party liability provisions for members in the AHCCCS Acute Care Programs. The Acute Care Programs are authorized by Title XIX of the Social Security Act. These programs have operated under a waiver from the Centers for Medicare and Medicaid Services (CMS) since the Arizona Medicaid Program's inception in 1982.

The AHCCCS Acute Care Programs are federal and state funded programs that provide health care services to the general population meeting the designated income levels. The income level determines the program for which the individual qualifies.

Services are delivered by managed care organizations when members are enrolled with contractors, otherwise, services are received on a fee-for-service basis. On occasion a member will also have a third-party insurance that must be billed first. AHCCCS is the payor of last resort.

As of November 1, 2012 there were 1,191,765 members receiving services under the acute care programs.

II. Five Year Report on 9 A.A.C. 22 Art 10 rules:

	1. Effectively meets its objectives?	2. Is authorized by statute?	3. Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods?	4. Is consistent with statute and other rules?	5. Is enforced?	6. Is clear, concise and understandable?	7. Needs to be amended?	8. Has the same or comparable economic impact as estimated in the EIS done during the last amendment of the rule?	9. Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states?	10. If applicable, has the agency completed the course of action indicated in the agency's previous five-year review?	11. Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective?	12. Is the rule more stringent than a corresponding federal law (unless there is statutory authority to exceed the requirements of that federal law)?	13. Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization?
R9-22-1001	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	N/A
R9-22-1002	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A
R9-22-1003	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A

R9-22-1004	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	N/A
R9-22-1005	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	No	Yes	No	N/A
R9-22-1006	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A
R9-22-1007	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	N/A
R9-22-1008	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	N/A
R9-22-1009	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	N/A

III. Five Year Report on 9 A.A.C. 22 Art 10 rules:

General and specific statutes authorizing the rule:
Authorizing and Implementing: A.R.S. §§ 36-2901, 36-2903(F), 36-2903.01 (K), and 36-2915.

Objective of the rule:

R9-22-1001 – Provides definitions related to Third Party Liability (TPL) provisions.

R9-22-1002 – Provides general provisions stating that AHCCCS is the payor of last resort.

R9-22-1003 – Provides the requirement to cost avoid where a TPL insurance has responsibility to pay. This section is applicable to AHCCCS FFS claims, Contractor to provider claims, and Contractor to non-contracting provider claims.

R9-22-1004 – Provides the requirement that a member must cooperate in identifying and providing TPL information.

R9-22-1005 – Provides the requirement that the AHCCCS Administration and its contractors, providers, and noncontracting providers must attempt to collect payment from TPL sources.

R9-22-1006 – Provides requirements regarding the type of TPL sources that must be monitored and pursued as required by statute.

R9-22-1007 – Provides Hospital, provider and noncontracting provider requirements to notify AHCCCS of a possible TPL source.

R9-22-1008 – Provides the type of member information and possible TPL source liable for damages that must be reported to AHCCCS in writing by a hospital, provider, or noncontracting provider.

R9-22-1009 – Provides the type of TPL health insurance information that must be provided to AHCCCS by a provider or noncontracting provider.

Clarity, conciseness and understandability of the rule:

All rules within Article 10 should be revised to:

1. Remove “lien” language and replaces with “assignment” as directed by the Ark DHS vs. Alborne ruling.
2. Initiate rule amendments to conform to Medicare Improvements for Patients and Providers Act (MIPPA) provisions because federal law supersedes AHCCCS regulation and because AHCCCS will determine estate recoveries in compliance with MIPPA requirements (which are effective with date of service on or after 1/1/10).
3. Add a compromise factor reading: "Any other factors relevant for a fair and equitable determination under the circumstances of a particular case".
4. Reference Chapter 34 in TPL and estate recovery for clarity. (Note that for purposes of contesting TEFRA liens, current rule R9-28-805 references the hearing process currently delineated in Chapter 34).

R9-22-1002 – AHCCCS believes this rule is clear, concise, and understandable. However, the exceptions of when the Administration may not be the payor of last resort could be added as examples to increase understanding.

42 CFR 136.61 provides that Indian Health Services (IHS) is the payor of last resort. (The term "contract health services" is defined in 136.21(e).)
The Medicaid reference regarding Individuals with Disabilities Education Act (IDEA) services is 42 USC 1396b(c) which prohibits the denial or limitation of payment for services thru IDEA Parts B and C.

R9-22-1003 – AHCCCS believes this rule is clear, concise, and understandable, with the exception that the Administration must pay the difference between capped fee-for-service and a contracted amount when a member is enrolled with a contractor.
The rule currently states that only the difference between the amount paid by other insurance and capped fee can be paid. The rule should require the "lesser of" methodology that will ensure the agency pays the smaller amount.

R9-22-1005 – This rule should be updated with the exception that when a first or third party liability is found after reimbursement has occurred the Administration or contractor will require the provider or non-contracting provider to bill the appropriate party and resubmit their claim for an adjustment to the Administration or contractor.
AHCCCS believes this rule could be clarified to reflect changes as required by the Deficit Reduction Act (DRA) and CFR 433.139 as previously reported in the last 5yr review. The scope of rulemakings after the report did not provide for the addition of this change at the time.

R9-22-1006 – This rule should be updated by striking item 10, adoption related payments. The Administration has not attempted to recover adoption related costs since the Birth Hope vs. AHCCCS decision in the Ninth Circuit Court (1999 – 2000 time frame).

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend repeal or make a rule:

The rule changes identified above are intended to be submitted to Council by November 2015.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 28, Article 9

November 2012

I. General Information about 9 A.A.C. 28, Article 9

Overview

The rules in Title 9, Chapter 28, Article 9 support the operations and practices of the third party liability (TPL) provisions for members on the ALTCS program. The ALTCS program is authorized by Title XIX of the Social Security Act. This program is a federal and state funded program for aged (65 and over), blind, or disabled individuals who need ongoing services at a nursing facility level of care.

However, program participants do not have to reside in a nursing home. Many ALTCS participants live in their own homes or in an assisted living facility where they receive home and community based (HCBS) services. ALTCS participants also receive covered acute care services, including doctor's office visits, hospitalization, prescriptions, lab work, and behavioral health services.

The income limit for this program is $2,130 a month, effective 1/1/13, although persons with AHCCCS-approved income-only trusts may have income in excess of this amount.

The resource (cash, bank accounts, stocks, bonds, etc.) limit is $2,000 for a single individual. When the applicant has a spouse who resides in the community, the spouse can retain one-half of the couple's resources, up to a maximum of $115,920, effective 1/1/13. Some resources, such as a person's home, vehicle, and irrevocable burial plan generally are not counted toward the resource limit.

Where a member has third party insurance, that insurance must be billed first. AHCCCS is the payor of last resort.

As of November 1, 2012, there were 53,131 members receiving services under the ALTCS program.

II. Five Year Report on 9 A.A.C. 28 Art 9 rules:

	1. Effectively meets its objectives?	2. Is authorized by statute?	3. Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods?	4. Is consistent with statute and other rules?	5. Is enforced?	6. Is clear, concise and understandable?	7. Needs to be amended?	8. Has the same or comparable economic impact as estimated in the EIS done during the last amendment of the rule?	9. Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states?	10. If applicable, has the agency completed the course of action indicated in the agency's previous five-year review?	11. Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective?	12. Is the rule more stringent than a corresponding federal law?	13. Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization?
R9-28-901	Yes	Yes	No	Yes	Yes	Nos	Yes	Yes	No	Yes	Yes	No	N/A
R9-28-	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A

902													
R9-28-903	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A
R9-28-904	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A
R9-28-905	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A
R9-28-906	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A
R9-28-907	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A
R9-28-908	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A
R9-	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A

28-909													
R9-28-910	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A
R9-28-911	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A
R9-28-912	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A

III. Five Year Report on 9 A.A.C. 28 Art 9 rules:

General and specific statutes authorizing the rule:
Authorizing statute: A.R.S. § 36-2932
Implementing statutes: A.R.S. § 36-2915, 36-2916, 36-2935, 36-2956.

Objective of the rule:

R9-28-901 – This rule provides definitions related to third party liability requirements.

R9-28-902 – This rule cross-references Chapter 22, which provides general provisions related to third party liability.

R9-28-903 – This rule cross-references Chapter 22, which provides cost avoidance provisions related to third party liability.

R9-28-904 – This rule cross-references Chapter 22, which provides member participation provisions related to third party liability.

R9-28-905 – This rule cross-references Chapter 22, which provides collection provisions related to third party liability.

R9-28-906 – This rule cross-references Chapter 22, which provides AHCCCS monitoring responsibility provisions related to third party liability.

R9-28-907 – This rule cross-references Chapter 22, which provides notification for perfection, recording, and assignment of AHCCCS lien provisions related to third party liability.

R9-28-908 – This rule cross-references Chapter 22, which provides notification information for lien provisions related to third party liability.

R9-28-909 – This rule cross-references Chapter 22, which provides notification of health insurance information provisions related to third party liability.

R9-28-910 – This rule provides what benefits may be recovered as a result of a lien related to third party liability.

R9-28-911 – This rule provides recovery provisions and situations in which a lien will not be recovered.

R9-28-912 – This rule provides for situations in which AHCCCS will seek to recover only a partial amount of a lien.

Clarity, conciseness and understandability of the rule:

All rules within Article 9 should be revised to:
1. Combine all sections cross-referencing the Acute care chapter into one rule.
2. Initiate rule amendments to conform to Medicare Improvements for Patients and Providers Act (MIPPA) provisions because federal law supersedes AHCCCS regulation and because AHCCCS will determine estate recoveries in compliance with MIPPA requirements (which are effective with date of service on or after 1/1/10).
3. Reference to Chapter 34 is needed in TPL and estate recovery for clarity.

R9-28-911 – Delete the reference to "Az Dept. of Revenue or County Assessor's Office", because the Administration could consider a property that is out of state as well and the Department of Revenue or County Assessor would not have this information.

R9-28-912 – This rule should be amended to add a compromise factor reading: "Any other factors relevant for a fair and equitable determination under the circumstances of a particular case", which is the only factor not in rule that is contained in the State Plan.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend repeal or make a rule:

The rule changes identified above are intended to be submitted to Council by November 2015.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 28, Article 2

November 2012

I. General Information about 9 A.A.C. 28, Article 2

Overview

The rules in A.A.C. Title 9, Chapter 28, Article 2 describe the type of medical services provided to members in the AHCCCS ALTCS Program. This program has operated under a waiver from the Centers for Medicare and Medicaid Services (CMS) since the Arizona Medicaid Program's inception in 1982 and added Home Community Based Services (HCBS) under the ALTCS program in 1989.

The AHCCCS ALTCS program is a federal and state funded program that provides health care services to the financially and medically eligible Arizonans who are elderly, physically disabled or developmentally disabled and have a medical need for long-term care services.

Medical services are delivered by program contractors when members are enrolled with the program contractor, otherwise, services are received on a fee-for-service basis. These programs are intended to provide quality health care services to Arizona's frail and elderly population.

As of November, 2012 there were 53,131 members receiving services under the ALTCS program.

II. Five Year Report on 9 A.A.C. 28 Art 2 rules:

	1. Effectively meets its objectives?	2. Is authorized by statute?	3. Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods?	4. Is consistent with statute and other rules?	5. Is enforced?	6. Is clear, concise and understandable?	7. Needs to be amended?	8. Has the same or comparable economic impact as estimated in the EIS done during the last amendment of the rule?	9. Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states?	10. If applicable, has the agency completed the course of action indicated in the agency's previous five-year review?	11. Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective?	12. Are the rules more stringent than a corresponding federal law?	13. Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization?
R9-28-201	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	No	Yes	No	N/A
R9-28-202	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A

R9-28-204	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A
R9-28-205	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	No	Yes	No	N/A
R9-28-206	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	No	Yes	No	N/A

III. Five Year Report on 9 A.A.C. 28 Art 2 rules:

General and specific statutes authorizing the rule:

A.R.S. § 36-2932

Objective of the rule:

R9-28-201 -This rule sets forth definitions applicable to the Article and establishes certain requirements, limitations and exclusions that are applicable to most, if not all, health care services provided by the program.

R9-28-202 -This rule prescribes medical services covered in the ALTCS program.

R9-28-204 -This rule describes institutional services available in the ALTCS Program.

R9-28-205 -This rule establishes requirements, limitations and exclusions that are applicable to home and community based services.

R9-28-206 -This rule describes the institutional and HCBS services covered in the ALTCS Program and the limitations applicable to those services.

Previous 5yr Course of Action:

R9-28-201 – In the previous 5yr rule review it was recommended to add to the definition that the services of this chapter in addition to those in chapter 22 are covered by the case management plan. The rule review team discussed this suggestion and found that it was not necessary to add because the definition currently states that the case manager must ensure the overall management of services to meet the members needs.

R9-28-205 In the previous 5yr rule review it was recommended to "The rule is clear and understandable; however, many of the provisions of subsection (C) are mere repetitions of the language in A.R.S. § 36-2939(B) and (C). The rule could be made more concise by deleting this repetition." The administration still believes this recommendation is valid and suggests update needs to be made to rule. This change was not completed during the exempt rulemaking in 2011 because the scope of the rule change was limited to respite services at the time.

R9-28-206 In the previous 5yr rule review it was recommended to "remove from rule some portions that are repetitious of provisions in other rules. By removing duplicative language, this rule could be made more concise" The administration still believes this recommendation is valid and suggests update needs to be made to rule. This change was not completed during the exempt rulemaking in 2010 because the scope of the rule change was limited to physical therapy service limits at the time.

Clarity, conciseness and understandability of the rule:

R9-28-202 – This rule should be updated to clarify that habilitation and supported employment service are available to everyone under ALTCS.

R9-28-204 – This rule's cross-reference to R9-28-1105 under subsection (A)(3) and (D)(1) should be updated to cross-reference R9-22-1205. In addition, were "ICF/MR" is used should be changed to "ICF" only.

R9-28-205 – This rule should be updated to specify criteria for coverage of respite services Criteria may include clarifying that respite services are not available 1) to paid caregivers, irrespective of whether or not the caregivers are family members, except under limited circumstances and 2) when requested on a routine basis. It may be helpful to clarify when attendant care services, rather than respite services, must be offered, contingent upon cost effectiveness and the provisions of the Ball Settlement Agreement.

It is recommended that the rule be updated to clarify the coverage requirements for "non-medical" home and community based services such as respite and attendant care services. Although all services are currently required to be "medically necessary," this term does not accurately apply to many HCBS services. The definition of medical necessity requires the services to be provided by or under the supervision of a physician or other licensed practitioner of the healing arts within the scope of practice under state law. However, many HCBS services are authorized based upon a determination by a case manager who is not a practitioner of the healing arts. The services themselves are generally not provided by persons who are either practitioners of the healing arts or supervised by practitioners of the healing arts.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend repeal or make a rule:

The rule changes identified above are intended to be submitted to Council by November 2015.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 28, Article 1

November 2012

5 year Review Report

I. General Information about 9 A.A.C. 28, Article 1

Overview

The rules in A.A.C. Title 9, Chapter 28, Article 1 provide definitions that support the regulations describing coverage, payment and requirements for the AHCCCS ALTCS Program. This program has operated under a waiver from the Centers for Medicare and Medicaid Services (CMS) since the Arizona Medicaid Program's inception in 1982 and added Home Community Based Services (HCBS) under the ALTCS program in 1989.

The AHCCCS ALTCS program is a federal and state funded program that provides health care services to the financially and medically eligible Arizonans who are elderly, physically disabled or developmentally disabled and who are at immediate risk of institutionalization.

Medical services are delivered by program contractors when members are enrolled with the program contractor; otherwise, services are received on a fee-for-service basis. These programs are intended to provide quality health care services to Arizona's frail and elderly population.

As of November , 2012 there were 53,131 members receiving services under the ALTCS program.

II. Five Year Report on 9 A.A.C. 28 Art 1 rules:

Legend: N/A = No Action Proposed or Not Applicable
*= Further description in remaining sections

	1. Effectively meets its objectives?	2. Is authorized by statute?	3. Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods?	4. Is consistent with statute and other rules?	5. Is enforced?	6. Is clear, concise and understandable?	7. Needs to be amended?	8. Has the same or comparable economic impact as estimated in the EIS done during the last amendment of the rule?	9. Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states?	10. If applicable, has the agency completed the course of action indicated in the agency's previous five-year review?	11. Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective?	12. Is the rule more stringent than a corresponding federal law?	14. Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization?
R9-28-101	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	N/A	Yes	No	N/A

R9-28-102	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	N/A	Yes	No	N/A
R9-28-103	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	N/A	Yes	No	N/A
R9-28-106	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	N/A	Yes	No	N/A
R9-28-111	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	No	Yes	No	N/A

III. Five Year Report on 9 A.A.C. 28 Art 1 rules:

General and specific statutes authorizing the rule:
A.R.S. § 36-2932 (M)

Objective of the rule:
R9-28-101 - This rule sets forth definitions applicable to the ALTCS program.
R9-28-102 - This rule sets forth definitions applicable to covered services in the ALTCS program.
R9-28-103 - This rule sets forth definitions applicable to the Preadmission Screening in the ALTCS program.
R9-28-106 - This rule sets forth definitions applicable to Request for Proposal and the Contract Process in the ALTCS program.
R9-28-111 - This rule sets forth definitions applicable to behavioral health services in the ALTCS program.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend repeal or make a rule:
The agency does not anticipate amending these rules with the exception of R9-28-111, which should be repealed since R9-28-1101 covers the definitions necessary for the BHS program. This change is anticipated to be submitted to Council by November 2015.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 22, Article 2

November 2012

I. General Information about 9 A.A.C. 22, Article 2

Overview

The rules in A.A.C. Title 9, Chapter 22, Article 2 support the type of medical services provided to members in the AHCCCS Acute Care Programs. The Acute Care Programs are authorized by Title XIX of the Social Security Act. These programs have operated under a waiver from the Centers for Medicare and Medicaid Services (CMS) since the Arizona Medicaid Program's inception in 1982.

The AHCCCS Acute Care programs are federal and state funded programs that provide health care services to the general population meeting the designated income levels. The income level determines the program for which the individual qualifies.

Medical services are delivered by managed care organizations when members are enrolled with contractors, otherwise, services are received on a fee-for-service basis. These programs are intended to provide quality health care services to these populations in Arizona.

As of November 1, 2012 there were 1,191,765 members receiving services under the acute care programs.

II. Five Year Report on 9 A.A.C. 22 Art 2 rules:

	1. Effectively meets its objectives?	2. Is authorized by statute?	3. Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods?	4. Is consistent with statute and other rules?	5. Is enforced?	6. Is clear, concise and understandable?	7. Needs to be amended?	8. Has the same or comparable economic impact as estimated in the EIS done during the last amendment of the rule?	9. Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states?	10. If applicable, has the agency completed the course of action indicated in the agency's previous five-year review?	11. Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective?	12. Is the rule more stringent than a corresponding federal law?	13. Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization?
R9-22-201	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A
R9-22-202	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A

R9-22-203	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	No	Yes	No	N/A
R9-22-204	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-205	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	No – due to morato rium	Yes	No	N/A
R9-22-206	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A
R9-22-207	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-208	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A

22-209													
R9-22-210	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-210.01	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	No	Yes	No	N/A
R9-22-211	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-212	Yes	Yes	Yes – Alvarez lawsuit	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A
R9-22-213	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	No	Yes	No	N/A

215													
R9-22-216	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-217	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A

III. Five Year Report on 9 A.A.C. 22 Art 2 rules:

General and specific statutes authorizing the rule:
A.R.S. §§ 36-2903.01, 36-2903.03, 36-2907

Objective of the rule:

R9-22-201 - This rule sets forth definitions applicable to the Article and establishes certain requirements, limitations and exclusions that are applicable to most, if not all, health care services provided by the program.

R9-22-202 – This rule sets forth general requirements that apply to all medically necessary covered services.

R9-22-203 – This rule describes the experimental services that are not covered.

R9-22-204 - This rule prescribes coverage requirements for and limitations of inpatient hospital services.

R9-22-205 - This rule establishes requirements, limitations and exclusions that are applicable to attending physician, practitioner, and primary care services.

R9-22-206 - This rule prescribes coverage requirements of organ and tissue transplant services.

R9-22-207 - This rule establishes the requirements, limitations and exclusions that are applicable to dental services provided by the program.

R9-22-208 - This rule prescribes coverage requirements for laboratory, radiology and medical imaging services.

R9-22-209 - This rule establishes the requirements, limitations and exclusions that are applicable to pharmaceutical services provided by the program.

R9-22-210 – This rule prescribes coverage requirements for and limitations of emergency medical services for the Non-FES members.

R9-22-210.01 - This rule prescribes coverage requirements for and limitations of emergency behavioral health services for the Non-FES members

R9-22-211 - This rule establishes the requirements, limitations and exclusions that are applicable to emergency and non-emergency transportation services provided by the program.

R9-22-212 - This rule prescribes coverage requirements for and limitations of medical supplies, durable medical equipment, and orthotic and prosthetic devices.

R9-22-213 - This rule establishes the requirements applicable to “early and periodic screening, diagnosis, and treatment services” (as defined in federal law) provided by the program.

R9-22-215 - This rule establishes the requirements, limitations and exclusions that are applicable to services provided by the program from medical professions other than those set forth in other rules.

R9-22-216 - This rule prescribes coverage of services provided in a nursing facility, alternative HCBS setting or HCBS as well as billing standards.

R9-22-217 - This rule establishes the requirements, limitations and exclusions that are applicable to services included in the federal emergency services program.

Clarity, conciseness and understandability of the rule:

All rules of Article 2, where the terms "FES members" or "non-FES members" exist should be changed to "general population" or "FES population". This way the classification of the "all covered services" population, the major category, will not be defined in terms of a small population that receives very limited services.

R9-22-201 – This rule should be updated by moving the terms "RBHA," "Residential functional deficit," "psychosocial rehabilitation services" and "clinical supervision" to R9-22-1201. These terms are only used in R9-22-1205, and should be stricken from R9-22-201.

R9-22-202 - This rule should be updated for clarity including:

1. Acute services for members placed out of state in an Residential Treatment Center (RTC) by AHCCCS or placed outside of the contractor's service area should be covered. In addition, language should be added that allows Contractors to manage acute care services such as Prior Authorization (PA), etc.
2. For non-emergent services, providers need to verify AHCCCS eligibility to determine if the member is enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor.
3. Adding that chiropractic services are excluded as a covered service for all AHCCCS members. (excluding children under EPSDT, it is a covered benefit)
4. Adding that Sexual Dysfunction is excluded as a covered service such as a penile implant unless medically necessary.

R9-22-205 - This rule is clear, concise, and understandable with the following exceptions:

1. Subsection (B)(4)(d) could be clarified to indicate that services provided primarily for cosmetic purposes are excluded and to create an exception for services related to post-mastectomy breast reconstruction; and
2. Subsection (B)(4)(e) should be clarified to indicate that hysterectomies are not covered as a means of family planning.

R9-22-206 – This rule should be updated for clarity that transplants are covered as long as they meet criteria for efficacy established for medical effectiveness by Network of Organ sharing.

R9-22-210.01 – This rule needs to be clarified to ensure the contractors responsibility is applicable to prospective eligibility (enrollment) period during the 72 hours of emer emergency inpatient behavioral health services Since the current rulemaking does not specify this.

R9-22-212 – Alvarez lawsuit challenges the consistency of R9-22-212 (E)(5) with the requirements of the Medicaid act. The litigation is still pending. In addition language should be added to state that the administration shall reimburse providers once for purchase of DME during any two year period as written under R9-22-710.

R9-22-213 – This rule should be updated by removing the cross-reference to R9-22-207 for emergency dental services. Emergency dental services are no longer allowed for adults as described under R9-22-207.

R9-22-215 – The rule cross-reference to A.R.S. 36-2907(D) needs to be updated to 36-2907(E).

Economic Impact:

R9-22-201 - This rule was last updated through an exempt rulemaking, the summary of the economic impact has not significantly changed. It read: AHCCCS estimates that the limitations on inpatient days will reduce total expenditures by approximately $64 million in combined state and federal funds for the last three quarters of the state fiscal year ending June 30, 2012 and approximately $85 million for the following state fiscal year. It is difficult to estimate with any degree of certainty whether, or to what extent, this will result in less care being provided. As set forth in rule, in many instances health care providers are permitted to charge patients for services provided but not paid for by AHCCCS as a result of these limitations. It is equally difficult to estimate with any degree of certainty to what extent this rulemaking may result in health care providers rendering care without adequate compensation from sources other than AHCCCS.

R9-22-203 – This rule was last updated through an exempt rulemaking, the summary of the economic impact has not significantly changed. It read: 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.

R9-22-204 - This rule was last updated through an exempt rulemaking, the summary of the economic impact has not significantly changed. It read: AHCCCS estimates that the limitations on inpatient days will reduce total expenditures by approximately $64 million in combined state and federal funds for the last three quarters of the state fiscal year ending June 30, 2012 and approximately $85 million for the following state fiscal year. It is difficult to estimate with any degree of certainty whether, or to what extent, this will result in less care being provided. As set forth in rule, in many instances health care providers are permitted to charge patients for services provided but not paid for by AHCCCS as a result of these limitations. It is equally difficult to estimate with any degree of certainty to what extent this rulemaking may result in health care providers rendering care without adequate compensation from sources other than AHCCCS.

R9-22-205 - This rule was last updated through an exempt rulemaking, the summary of the economic impact has not significantly changed. It read: 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.

R9-22-206 – This rule was last updated through an exempt rulemaking, the summary of the economic impact has not significantly changed. It read: The AHCCCS Administration had previously estimated that the transplant services that were excluded by the 2010 Act would affect one to ten eligible persons per year at an approximate cost of $100,000.00 per transplant. Reinstatement of the transplant services is estimated to have a corresponding effect.

R9-22-207 - This rule was last updated through an exempt rulemaking, the summary of the economic impact has not significantly changed. It read: 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.

R9-22-212 - This rule was last updated through an exempt rulemaking, the summary of the economic impact has not significantly changed. It read: AHCCCS estimates that the limitations on inpatient days will reduce total expenditures by approximately $64 million in combined state and federal funds for the last three quarters of the state fiscal year ending June 30, 2012 and approximately $85 million for the following state fiscal year. It is difficult to estimate with any degree of certainty whether, or to what extent, this will result in less care being provided. As set forth in rule, in many instances health care providers are permitted to charge patients for services provided but not paid for by AHCCCS as a result of these limitations. It is equally difficult to estimate with any degree of certainty to what extent this rulemaking may result in health care providers rendering care without adequate compensation from sources other than AHCCCS.

R9-22-217 - This rule was last updated through an exempt rulemaking, the summary of the economic impact has not significantly changed. It read: AHCCCS estimates that the limitations on inpatient days will reduce total expenditures by approximately $64 million in combined state and federal funds for the last three quarters of the state fiscal year ending June 30, 2012 and approximately $85 million for the following state fiscal year. It is difficult to estimate with any degree of certainty whether, or to what extent, this will result in less care being provided. As set forth in rule, in many instances health care providers are permitted to charge patients for services provided but not paid for by AHCCCS as a result of these limitations. It is equally difficult to estimate with any degree of certainty to what extent this rulemaking may result in health care providers rendering care without adequate compensation from sources other than AHCCCS.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend repeal or make a rule:

The rule changes identified above are intended to be submitted to Council by November 2015.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 28, Article 13

January 2013

I. General Information about 9 A.A.C. 28, Article 13

Overview

The rules in A.A.C. Title 9, Chapter 28, Article 13 support the operations and practices of the Freedom to Work program (FTW) where Arizona residents can qualify for Medicaid services once they have been determined disabled and are not qualified for any other Medicaid program.

As of January 1, 2013 there were 44 long-term care members receiving services under the Freedom to Work program.

The Freedom to Work program consist of two groups: the Basic Coverage Group, sometimes referred to as the XV eligibility group; and the Medically Improved Group, sometimes referred to as the XVI eligibility group.

For the XV eligibility group, States can cover individuals at least age 16 but less than 65 years of age who, except for earned income, would be eligible to receive Supplemental Security Income (SSI) benefits, regardless of whether they have received SSI cash benefits. The persons in the XV Group can have earnings in excess of what is required to qualify for SSI but not greater than 250 percent of the federal poverty level family income limit. Under this group, states are free to establish their own income and resource standards, or have no income or resource standards if they choose, or use federal standards if provided.

II. Five Year Report on 9 A.A.C. 28 Art 13 rules:

*** See additional comments for the reviewed rules:**

	1. Effectively meets its objectives?	2. Is authorized by statute?	3. Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods?	4. Is consistent with statute and other rules?	5. Is enforced?	6. Is clear, concise and understandable?	7. Needs to be amended?	8. Has the same or comparable economic impact as estimated in the EIS done during the last amendment of the rule?	9. Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states?	10. If applicable, has the agency completed the course of action indicated in the agency's previous five-year review?	11. Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective?	12. Is the rule more stringent than a corresponding federal law?	13. Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization?
R9-28-1301	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-28-1302	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-28-1303	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A

R9-28-1304	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-28-1305	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-28-1306	Yes	Yes	No	Yes	Yes	Yes	No	*	No	N/A	Yes	No	N/A
R9-28-1307	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-28-1308	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-28-1309	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-28-1313	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-28-1316	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A
R9-28-1320	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-28-1321	Yes	Yes	No	Yes	Yes	Yes	No	*	No	N/A	Yes	No	N/A

R9-28-1323	Yes	Yes	No	Yes	Yes	Yes	No	*	No	N/A	Yes	No	N/A
R9-28-1324	Yes	Yes	No	Yes	Yes	Yes	No	*	No	N/A	Yes	No	N/A

III. Five Year Report on 9 A.A.C. 28 Art 13 rules:

General and specific statutes authorizing these rules:

A.R.S. §§ 36-2932, 36-2950

Objective of the rule:

R9-28-1301 – Provides general requirements for the Freedom to Work (FTW) program.

R9-28-1302 – Provides the general administrative requirements regarding confidentiality.

R9-28-1303 – Describes application process to apply for the FTW program.

R9-28-1304 – Describes the required notification in writing regarding the determination of eligibility for the FTW program.

R9-28-1305 – Describes the specific type of changes that a member must report.

R9-28-1306 – Describes when eligibility for FTW can change or be affected.

R9-28-1307 – Describes when the Administration may notify a member of an action.

R9-28-1308 – Describes situations when a member may request a hearing.

R9-28-1309 – Describes conditions that must be met to be eligible for the FTW program.

R9-28-1313 – Describes the premium requirement that a member must pay when qualified for FTW.

R9-28-1316 – Describes the institutionalized condition that a person could have that would not qualify them for FTW.

R9-28-1320 – Describes additional eligibility criteria for the Basic Coverage Group.

R9-28-1321 – Describes how the share of cost is determined for a person on ALTCS and the FTW program.

R9-28-1323 – Describes the enrollment requirements that a member will have when qualified for FTW.

R9-28-1324 – Describes when a redetermination of eligibility for FTW must be conducted.

Economic Impact:

*R9-28-1306, R9-28-1321, R9-28-1323 and R9-28-1324 –
The FTW program rules were implemented in 2003 as an exempt rulemaking, therefore, an economic impact statement was not required. The actual economic impact this program has had since its implementation has been minimal in comparison to vast number of members that qualify for other programs. Even though, this is a small program it was very important to help those who were disabled but could work sometimes and not lose their medical benefits.
The people who are directly affected are the tax payers and the AHCCCS Administration by the minimal cost incurred to administer this program.
The cost to AHCCCS is minimal as this program has similar requirements to ALTCS and AHCCCS acute programs for which the staff has already been trained. Regarding the other agencies that work with this particular population, the implementation of FTW allows them more flexibility in job placement assistance as the applicants are allowed to earn more money and not lose their health insurance coverage.
The premium for health insurance coverage under the FTW program is less than the amount the individual would pay in premiums for coverage provided by private industry. A member who has countable income under $500, there is no monthly premium payment; over $500 but not greater than $750, the monthly premium payment is $10; the premium for a member with countable income over $750, increases by $5 for each $250 increase in countable income above $750.

The State of Arizona is responsible for 32.75% of the cost of the FTW program. The state funds derive from a combination of State General Fund and Tobacco Settlement Funds. The Federal government pays for 67.25%.

Clarity, conciseness and understandability of the rule:

R9-28-1316 –
This rule is needs to be amended to exclude those from age 21, the age requirement should begin at the age of 22 as described under CFR 435.1009.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend repeal or make a rule:

The Administration has reviewed the rules and anticipates submitting to Council the recommended changes by January 30, 2016.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 22, Article 19

January 2013

I. General Information about 9 A.A.C. 22, Article 19

Overview

The rules in A.A.C. Title 9, Chapter 22, Article 19 support the operations and practices of the Freedom to Work program (FTW) where Arizona residents can qualify for Medicaid services once they have been determined disabled and are not qualified for any other Medicaid program.

As of January 1, 2013 there were 1,528 acute care members receiving acute services under the Freedom to Work program.

The Freedom to Work program consist of two groups; the Basic Coverage Group, sometimes referred to as the XV eligibility group; and the Medical Improvment and Employment Security Group, sometimes referred to as the XVI eligibility group.

States can cover individuals at least age 16 but less than 65 years of age who, except for earned income, would be eligible to receive Supplemental Security Income (SSI) benefits, regardless of whether they have received SSI cash benefits. The persons in the Basic Coverage (XV) Group can have earnings in excess of what is required to qualify for SSI but not greater than 250 percent of the federal poverty level family income limit. Under this group, States are free to establish their own income and resource standards, or have no income or resource standards if they choose, otherwise federal standards must be met if made available.

For the Medical Improvement and Employment Security (XVI) group, States can cover employed individuals with a medically improved disability who lose Medicaid eligibility under the XV eligibility group because their medical conditions have improved to the point where they are no longer disabled under the SSI definition of disability.

II. Five Year Report on 9 A.A.C. 22 Art 19 rules:

*** See additional comments for the reviewed rules:**

	1. Effectively meets its objectives?	2. Is authorized by statute?	3. Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods?	4. Is consistent with statute and other rules?	5. Is enforced?	6. Is clear, concise and understandable?	7. Needs to be amended?	8. Has the same or comparable economic impact as estimated in the EIS done during the last amendment of the rule?	9. Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states?	10. If applicable, has the agency completed the course of action indicated in the agency's previous five-year review?	11. Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective?	12. Is the rule more stringent than a corresponding federal law?	13. Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization?
R9-22-1901	Yes	Yes	No	Yes	Yes	Yes	No	*	No	N/A	Yes	No	N/A
R9-22-1902	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-1903	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A

R9-22-1904	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-1905	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-1906	Yes	Yes	No	Yes	Yes	Yes	No	*	No	N/A	Yes	No	N/A
R9-22-1907	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-1908	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-1909	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-1913	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-1915	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A
R9-22-1918	Yes	Yes	No	Yes	Yes	Yes	No	*	No	N/A	Yes	No	N/A
R9-22-1919	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A

R9-22-1921	Yes	Yes	No	Yes	Yes	Yes	No	*	No	N/A	Yes	No	N/A
R9-22-1922	Yes	Yes	No	Yes	Yes	Yes	No	*	No	N/A	Yes	No	N/A

III. Five Year Report on 9 A.A.C. 22 Art 19 rules:

General and specific statutes authorizing these rules:
A.R.S. §§ 36-2903.01(F), 36-2929

Objective of the rule:

R9-22-1901 – Provides general requirements for the Freedom to Work (FTW) program.

R9-22-1902 – Provides the general administrative requirements regarding confidentiality.

R9-22-1903 – Describes the application process to apply for the FTW program.

R9-22-1904 – Describes the required notification in writing regarding the determination of eligibility for the FTW program.

R9-22-1905 – Describes the specific type of changes that a member must report.

R9-22-1906 – Describes when eligibility for FTW can change or be affected.

R9-22-1907 – Describes when the Administration may notify a member of an action.

R9-22-1908 – Describes situations when a member may request a hearing.

R9-22-1909 – Describes conditions that must be met to be eligible for the FTW program.

R9-22-1913 – Describes the premium requirement that a member must pay when qualified for FTW and how the Administration process the premiums with certain exceptions.

R9-22-1915 – Describes the exclusions from eligibility for certain institutionalized persons.

R9-22-1918 – Describes additional eligibility criteria for the Basic Coverage Group.

R9-22-1919 – Describes additional eligibility criteria for the Medically Improved Group.

R9-22-1921 – References the enrollment requirements that must be followed for a member in the FTW program.

R9-22-1922 – Describes when a redetermination of eligibility for FTW must be conducted.

Economic Impact:

*R9-22-1901, R9-22-1906, R9-22-1918, R9-22-1921 and R9-22-1922 –
The FTW program rules were implemented in 2003 as an exempt rulemaking, therefore, an economic impact statement was not required. The actual economic impact this program has had since its implementation has been minimal in comparison to vast number of members that qualify for other programs. Even though, this is a small program it was very important to help those who were disabled but could work sometimes and not lose their medical benefits.
The people who are directly affected are the tax payers and the AHCCCS Administration by the minimal cost incurred to administer this program.
The cost to AHCCCS is minimal as this program has similar requirements to ALTCS and AHCCCS acute programs for which the staff has already been trained. Regarding the other agencies that work with this particular population, the implementation of FTW allows them more flexibility in job placement assistance as the applicants are allowed to earn more money and not lose their health insurance coverage.
The premium for health insurance coverage under the FTW program is less than the amount the individual would pay in premiums for coverage provided by private industry. A member who has countable income under $500, there is no monthly premium payment; over $500 but not greater than $750, the monthly premium payment is $10; the premium for a member with countable income over $750, increases by $5 for each $250 increase in countable income above $750.

The State of Arizona is responsible for 32.75% of the cost of the FTW program. The state funds derive from a combination of State General Fund and Tobacco Settlement Funds. The Federal government pays for 67.25%.

Clarity, conciseness and understandability of the rule:

R9-22-1915 – This rule is needs to be updated to exclude a person of age 21, the age requirement should begin at the age of 22 as described under 42 CFR 435.1009.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend repeal or make a rule:

The Administration has reviewed the rules and anticipates submitting to Council the recommended changes by January 30, 2016.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 22, Article 5

April 2013

5 year Review Report

I. General Information about 9 A.A.C. 22, Article 5

Overview

The rules in A.A.C. Title 9, Chapter 22, Article 5 support the operations and practices of the Acute care program. This Article consists of provisions and standards related to preexisting conditions, provider requirements regarding records, marketing, sanctions, coordination of care, safeguarding information, information provided to members, program compliance audits, prescribe licensure or accreditation of providers and management of quality and utilization of health care services. The acute care programs have operated under a waiver from the Centers for Medicare and Medicaid Services (CMS) since the Arizona Medicaid Program's inception in 1982.

The AHCCCS Acute Care programs are federal-and state-funded programs that provide health care services to the general population meeting the designated income levels. The income level determines the program for which the individual qualifies.

Services are delivered by managed care organizations when members are enrolled with contractors; otherwise, services are received on a fee-for-service basis.

As of April 1, 2013 there were 1,178,543 members receiving services under the acute care programs.

II. Five Year Report on 9 A.A.C. 22 Art 5 rules:

*** See additional comments for the reviewed rules:**

	1. Effectively meets its objectives?	2. Is authorized by statute?	3. Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods?	4. Is consistent with statute and other rules?	5. Is enforced?	6. Is clear, concise and understandable?	7. Needs to be amended?	8. Has the same or comparable economic impact as estimated in the EIS done during the last amendment of the rule?	9. Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states?	10. If applicable, has the agency completed the course of action indicated in the agency's previous five-year review?	11. Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective?	12. Is the rule more stringent than a corresponding federal law?	13. Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization?
R9-22-501	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-502	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A

R9-22-503	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-504	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-505	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A	Yes	No	N/A
R9-22-509	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-512	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A	Yes	No	N/A
R9-22-518	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	N/A	Yes	No	N/A
R9-22-	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	N/A

521													
R9-22-522	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A

III. Five Year Report on 9 A.A.C. 22 Art 2 rules:

General and specific statutes authorizing the rule:
Where there isn't a specific statute authorizing or implementing the specific topic, the Administration has general rulemaking authority for this program as described in A.R.S. § 36-2903.01(F).

R9-22-501 – Authorizing and Implementing: A.R.S. §§ 36-2903.01(F)

R9-22-502 – Authorizing and Implementing: A.R.S. §§ 36-2907(A); 42 CFR 438.6(d)(1)

R9-22-503 – Authorizing and Implementing: A.R.S. §§ 36-2903(H); 42 U.S.C. 1396a(a)(27); 42 CFR 431.107(b); 42 CFR 438.6(g).

R9-22-504 – Authorizing and Implementing: A.R.S. §§ 36-2903.01(F); 42 U.S.C. 1396u-2(d)(2); 42 CFR 438.104

R9-22-505 - Authorizing and Implementing: A.R.S. §§ 36-2903.01(F)

R9-22-509 – Authorizing and Implementing: A.R.S. §§ 36-2903(J)

R9-22-512 – Authorizing and Implementing: A.R.S. §§ 36-2903(I); 42 U.S.C. 1396a(a)(7); 42 CFR Part 431 Subpart F.

R9-22-518 – Authorizing and Implementing: A.R.S. §§ 36-2903.01(F); 42 U.S.C. 1396u-2(a)(5); 42 CFR 438.10

R9-22-521 – Authorizing and Implementing: A.R.S. §§ 36-2903(H); 36-2903.03(B); 42 U.S.C. 1396u-2(c)(1); 42 CFR 438.6(g)

R9-22-522 – Authorizing and Implementing: A.R.S. §§ 36-2903(B)(4),(5), and (8), 36-2903.03(A); 42 U.S.C. 1396a(a)(30)(A)

Objective of the rule:
R9-22-501 – Provides definitions related to the various general provisions within Article 5.

R9-22-502 – Provides the contractors' pre-existing condition medical coverage requirements. This rule states that a contractor shall provide all services and no exclusions for a pre-existing condition can be made by a contractor.

R9-22-503 – Provides the requirement that a provider or contractor must maintain records for 5 years and make them available to the Administration.

R9-22-504 – Provides limitations on a contractor related to marketing, and possible sanctions.

R9-22-505 – Provides licensure requirement for a provider of hospital and medical services.

R9-22-509 – Provides requirements for a contractor to coordinate care of a member either disenrolling from the contractors plan or enrolling in the plan.

R9-22-512 – Provides requirements applicable to the Administration and contractors, providers, and noncontracting providers establishing the standards for use and disclosure of information regarding applicants for and recipients of services under AHCCCS-administered programs.

R9-22-518 – Specifies the type of information the contractor must provide a member.

R9-22-521 – Provides requirements for program compliance audits that must be conducted by the Administration.

R9-22-522 – Provides requirements for a contractor to maintain quality and utilization management of medical services provided to an AHCCCS member.

Clarity, conciseness and understandability of the rule:

R9-22-505 – The incorporation by reference needs to be amended to reflect a current version of CFR.

R9-22-512 – The incorporation by reference needs to be amended to reflect a current version of CFR.

R9-22-521 – Compliance Audits are completed by the Administration at least once every three years during the term of a contract, but the compliance audit is not necessarily completed "onsite". The Administration found that it was more costly to complete audits onsite and had the same result when completed electronically. The Administration recommends removal of this term.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend repeal or make a rule:

The Administration intends to amend rules R9-22-505, R9-22-512 and R9-22-521 and submit rulemaking to Council by April 2016.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 28, Article 5

April 2013

5 year Review Report

I. General Information about 9 A.A.C. 28, Article 5

Overview

The rules in Title 9, Chapter 28, Article 5 support the general operations and practices of program contractors and long-term care (LTC) providers for members on the ALTCS program. The ALTCS program is authorized by Title XIX of the Social Security Act. This program is a federal-and state-funded program for aged (65 and over), blind, or disabled individuals who need ongoing services at a nursing facility level of care.

However, program participants do not have to reside in a nursing home. Many ALTCS participants live in their own homes or in an assisted living facility where they receive home and community based (HCBS) services. ALTCS participants also receive covered acute care services, including doctor's office visits, hospitalization, prescriptions, lab work, and behavioral health services.

The income limit for this program is $2,130 a month, although persons with AHCCCS approved income-only trusts may have income in excess of this amount.

- The resource (cash, bank accounts, stocks, bonds, etc.) limit is $2,000 for a single individual. When the applicant has a spouse who resides in the community, the spouse can retain one-half of the couple's resources, up to a maximum of $115,920. Some resources, such as a person's home, vehicle, and irrevocable burial plan generally are not counted toward the resource limit.

As of April 1, 2013 there were 53,332 members receiving services under the ALTCS program.

II. Five Year Report on 9 A.A.C. 28 Art 5 rules:

*** See additional comments for the reviewed rules:**

	1. Effectively meets its objectives?	2. Is authorized by statute?	3. Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods?	4. Is consistent with statute and other rules?	5. Is enforced?	6. Is clear, concise and understandable?	7. Needs to be amended?	8. Has the same or comparable economic impact as estimated in the EIS done during the last amendment of the rule?	9. Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states?	10. If applicable, has the agency completed the course of action indicated in the agency's previous five-year review?	11. Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective?	12. Is the rule more stringent than a corresponding federal law?	13. Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization?
R9-28-501	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	N/A	Yes	No	N/A
R9-28-	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	N/A	Yes	No	N/A

501.01													
R9-28-502	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	N/A
R9-28-503	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A
R9-28-504	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A	Yes	No	N/A
R9-28-505	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A	Yes	No	N/A
R9-28-506	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	N/A	Yes	No	N/A
R9-28-507	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	N/A	Yes	No	N/A

R9-28-508	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	N/A	Yes	No	N/A
R9-28-509	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	N/A	Yes	No	N/A
R9-28-510	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	N/A	Yes	No	N/A
R9-28-511	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	N/A	Yes	No	N/A
R9-28-513	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	N/A	Yes	No	N/A
R9-28-514	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	N/A	Yes	No	N/A

III. Five Year Report on 9 A.A.C. 28 Art 5 rules:

General and specific statutes authorizing the rule:
Where there isn't a specific statute authorizing or implementing the specific topic, the Administration has general rulemaking authority for this program as described in A.R.S. § 36-2932(M).

R9-28-501 – Authorizing and Implementing: A.R.S. § 36-2932(M)

R9-28-501.01 -- Authorizing and Implementing: A.R.S. §§ 36-2932, 36-2939

R9-28-502 – Authorizing and Implementing: A.R.S. § 36-2932(E); 42 U.S.C. 1396a(a)(27); 42 CFR 431.107(b); 42 CFR 438.6(g)

R9-28-503 – Authorizing and Implementing: A.R.S. § 36-2939(B)(1); 42 U.S.C 1396a(a)(28)(A); 42 U.S.C. 1396a(i); 42 CFR Part 442

R9-28-504 – Authorizing and Implementing: A.R.S. § 36-2939(B)(2) and (C); 42 U.S.C. 1315(b); 42 U.S.C. 1396d; 42 CFR Parts 440 and 441

R9-28-505 – Authorizing and Implementing: A.R.S. § 36-2932(M); 42 CFR 440.10 and 440.20

R9-28-506 – Authorizing and Implementing: A.R.S. § 36-2932(M); 42 U.S.C. 1315

R9-28-507 – Authorizing and Implementing: A.R.S. § 36-2932(E); 42 U.S.C. 1396u-2(a)(5); 42 U.S.C. 1396a(a)(27); 42 CFR 438.10; 42 CFR 431.107(b); 42 CFR 438.6(g); 42 CFR Part 435, Subpart H

R9-28-508 - Authorizing and Implementing: A.R.S. § 36-2951

R9-28-509 – Authorizing and Implementing statute: A.R.S. §§ 36-2932, 36-2938

R9-28-510 – Authorizing and Implementing: A.R.S. § 36-2938

R9-28-511 – Authorizing and Implementing: A.R.S. § 36-2932(M); 42 U.S.C. 1396a(a)(30)(A); 42 U.S.C. 1396 u-2(c)(1); 42 CFR 438.240

R9-28-513 – Authorizing and Implementing: A.R.S. § 36-2903(H); 36-2903.03(B); 42 U.S.C. 1396u-2(c)(1); 42 CFR 438.6(g)

R9-28-514 – Authorizing and Implementing: A.R.S. § 36-2932 (F), (L); 42 U.S.C. 1396a(a)(7); 42 CFR Part 431 Subpart F.

Objective of the rule:
R9-28-501 – Provides definitions related to the general provisions within Article 5 that a program contractor must follow.
R9-28-501.01 – Provides requirements that relate pre-existing conditions.

R9-28-502 – Provides the requirement for a provider to maintain records for 5 years and make them available to the Administration.

R9-28-503 – Provides licensure and certification requirements for LTC Institutional facilities.

R9-28-504 – Provides licensure and certification requirements for HCBS Providers.

R9-28-505 – Provides licensure and certification requirements for providers of hospital and medical services.

R9-28-506 – Provides requirements for a spouse to be a paid care-giver for personal care services.

R9-28-507 – Provides general requirements for Program Contractors.

R9-28-508 – Provides requirements for Self-Directed Attendant Care (SDAC) services

R9-28-509 – Provides requirements to obtain attendant care services through the agency with choice option.

R9-28-510 – Provides case management requirements.

R9-28-511 – Provides quality and utilization management requirements.

R9-28-513 – Provides cross-referenced requirements of when the Administration will conduct program compliance audits.

R9-28-514 – Provides cross-referenced requirements for the release of safeguarded information.

Clarity, conciseness and understandability of the rule:

R9-28-501 – Centers for Medicare and Medicaid Services (CMS) federal regulations 42 CFR 440.167 state that an individual representative cannot be a paid caregiver as well. This needs to be applied to all of the altcs program, currently CMS agreed that we would only apply this regulation to the Agency with Choice attendant care option. AHCCCS will work with the Division of Developmental Disabilities (DDD) to transition into separating paid caregivers from individual representatives. The definition of individual representative will be updated in the future to reflect that the individual representative cannot be a paid caregiver as well under R9-28-101, therefore applying the requirement to all the altcs rules.

R9-28-502 – After review of this rule the Administration recommends that a cross-reference be added to the parallel rules in Chapter 22.

R9-28-503 – Where ICF/MR exists it should be ICF/IID. Reference to Mentally Retarded is no longer used and inappropriate. The incorporation by reference also needs to be updated.

R9-28-504 – Cross-reference to R9-33-107 needs to be updated to R9-33-102 and strike reference to R6-6-714 as it has expired. Cross-reference under R9-28-504(B)(10) must be changed to 9 A.A.C. 8, Article 1. Cross-reference under R9-28-504(B)(12) must be changed to 9 A.A.C. 25 for licensure requirement for emergency medical services. Where the term “speech therapist” exists it needs to be changed to “speech pathologist” per 42 CFR 440.100(c)(2). and “speech therapy” as “speech-language pathology” per A.R.S. §36-1901(23) and 9A.A.C. 16, Article 2.

R9-28-505 –A crossreference should be made to R9-22-505 and language stricken since it is duplicative.

R9-28-511 – Incorporation by reference needs to be updated and crossreference to R9-28-505 removed.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend repeal or make a rule:

The Administration intends to amend the above rules and submit the rulemaking to Council by April 2016.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 31, Article 11

June 2013

I. General Information about 9 A.A.C. 31, Article 11

Overview

The rules in A.A.C. Title 9, Chapter 31, Article 11 support the operations and practices of the agency's Civil Monetary Penalties (CMP) and assessments. CMP applies to persons who knowingly submit or have reason to know that a claim is for services not provided, in excess of the actual amount provided, for another item or service, or when the person no longer qualifies to receive or provide Medicaid services.

A person who violates these provisions, in addition to other penalties, is subject to a civil penalty not exceeding two thousand dollars for each item or service claimed and is subject to an assessment at the person's expense.

As of State Fiscal Year (SFY) 2013, there were $23,261,608 in CMP penalties recovered and $628,367 in investigative costs recovered from a combination of members, providers and contractors. The recoveries and costs span members and providers of all the AHCCCS programs. There are also internal recoveries from employees that paid restitution. Overall the investigative efforts and enforcement of the Civil Monetary Penalties has resulted in a savings for all AHCCCS programs of $59,476,106.

II. Five Year Report on 9 A.A.C. 31 Art 11 rules:

*** See additional comments for the reviewed rules:**

	1. Effectively meets its objectives?	2. Is authorized by statute?	3. Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods?	4. Is consistent with statute and other rules?	5. Is enforced?	6. Is clear, concise and understandable?	7. Needs to be amended?	8. Has the same or comparable economic impact as estimated in the EIS done during the last amendment of the rule?	9. Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states?	10. If applicable, has the agency completed the course of action indicated in the agency's previous five-year review?	11. Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective?	12. Are the rules more stringent than a corresponding federal law?	13. Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization?
R9-31-1101	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A

III. Five Year Report on 9 A.A.C. 31 Art 11 rules:

General and specific statutes authorizing the rule:
R9-31-1101 Authorizing and Implementing: A.R.S. §§ 36-2986, 36-2991(B), 36-2993

Objective of the rule:

R9-31-1101 – Provides a cross-reference to the civil and monetary penalty rules outlined in Chapter 22. The same processes and practice are applied to those persons providing services to the Kids Care population.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend repeal or make a rule:

The Administration does not find a need to revise the CMP rules reviewed and does not intend on submitting a rulemaking to the Governors Regulatory Review Council.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 28, Article 10

June 2013

I. General Information about 9 A.A.C. 28, Article 10

Overview

The rules in A.A.C. Title 9, Chapter 28, Article 10 support the operations and practices of the agency's Civil Monetary Penalties (CMP) and assessments. CMP applies to persons who knowingly submit or have reason to know that a claim is for services not provided, in excess of the actual amount provided, for another item or service, or when the person no longer qualifies to receive or provide Medicaid services.

A person who violates these provisions, in addition to other penalties, is subject to a civil penalty not exceeding two thousand dollars for each item or service claimed and is subject to an assessment at the person's expense.

As of State Fiscal Year (SFY) 2013, there were $23,261,608 in CMP recovered and $628,367 in investigative costs recovered from a combination of members, providers and contractors.

The recoveries and costs span members and providers of all the AHCCCS programs. There are also internal recoveries from employees that paid restitution. Overall, the investigative efforts and enforcement of the CMP has resulted in a savings for all AHCCCS programs of $59,476,106.

II. Five Year Report on 9 A.A.C. 28 Art 10 rules:

*** See additional comments for the reviewed rules:**

	1. Effectively meets its objectives?	2. Is authorized by statute?	3. Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods?	4. Is consistent with statute and other rules?	5. Is enforced?	6. Is clear, concise and understandable?	7. Needs to be amended?	8. Has the same or comparable economic impact as estimated in the EIS done during the last amendment of the rule?	9. Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states?	10. If applicable, has the agency completed the course of action indicated in the agency's previous five-year review?	11. Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective?	12. Are the rules more stringent than a corresponding federal law?	13. Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization?
R9-28-1001	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A

III. Five Year Report on 9 A.A.C. 28 Art 10 rules:

General and specific statutes authorizing the rule:

R9-28-1001 Authorizing and Implementing: A.R.S. §§ 36-2932, 36-2957

Objective of the rule:

R9-28-1001 – Provides a cross-reference to the civil and monetary penalty rules outlined in Chapter 22. The same processes and practice are applied to those persons providing services to the ALTCS population.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend repeal or make a rule:

The Administration does not find a need to revise the CMP rules reviewed and does not intend on submitting a rulemaking to the Governors Regulatory Review Council.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 22, Article 11

June 2013

I. General Information about 9 A.A.C. 22, Article 11

Overview

The rules in A.A.C. Title 9, Chapter 22, Article 11 support the operations and practices of the agency's Civil Monetary Penalties (CMP) and assessments. CMP applies to persons who knowingly submit or have reason to know that a claim is for services not provided, in excess of the actual amount provided, for another item or service, or when the person no longer qualifies to receive or provide Medicaid services.

A person who violates these provisions, in addition to other penalties, is subject to a civil penalty not exceeding two thousand dollars for each item or service claimed and is subject to an assessment at the person's expense.

As of State Fiscal Year (SFY) 2013, there were $23,261,608 in CMP recovered and $628,367 in investigative costs recovered from a combination of members, providers and contractors. The recoveries and costs span members and providers of all the AHCCCS programs. There are also internal recoveries from employees that paid restitution. Overall, the investigative efforts and enforcement of the CMP has resulted in a savings for all AHCCCS programs of $59,476,106.

II. Five Year Report on 9 A.A.C. 22 Art 11 rules:

*** See additional comments for the reviewed rules:**

	1. Effectively meets its objectives?	2. Is authorized by statute?	3. Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods?	4. Is consistent with statute and other rules?	5. Is enforced?	6. Is clear, concise and understandable?	7. Needs to be amended?	8. Has the same or comparable economic impact as estimated in the EIS done during the last amendment of the rule?	9. Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states?	10. If applicable, has the agency completed the course of action indicated in the agency's previous five-year review?	11. Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective?	12. Are the rules more stringent than a corresponding federal law?	13. Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization?
R9-22-1101	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-1102	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A

R9-22-1104	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-1105	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-1106	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-1108	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-1109	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-1110	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-22-1111	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A
R9-	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	N/A

22-1112													

III. Five Year Report on 9 A.A.C. 22 Art 11 rules:

General and specific statutes authorizing the rule:

R9-22-1101 – R9-22-1112 Authorizing and Implementing: A.R.S. §§ 36-2903.01(C), 36-2903.01(F), 36-2918, 36-2905.04, 36-2912(I)(5)

Objective of the rule:

R9-22-1101 – Provides the scope, purpose and definitions related to the imposition of civil monetary penalties and assessments for fraudulent claims.

R9-22-1102 – Provides how a penalty is determined.

R9-22-1104 – Provides situations that would be considered when determining penalties and/or assessments.

R9-22-1105 – Describes criteria to determine the penalty and assessment.

R9-22-1106 – Delineates the process for filing a Notice of Intent.

R9-22-1108 – Informs the public how to request a compromise of a penalty and how the Administration would respond to that request.

R9-22-1109 – Describes the consequence of not responding to a Notice of Intent.

R9-22-1110 – Describes the process of requesting and scheduling a fair hearing.

R9-22-1111 – Describes the burden of proof for establishing the amount of the civil monetary penalty.

R9-22-1112 – Provides the opportunity to withdraw a Notice of Intent or agree to a continuance prior to a formal evidentiary hearing.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend repeal or make a rule:

The Administration does not find a need to revise the CMP rules reviewed and does not intend on submitting a rulemaking to the Governors Regulatory Review Council.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 22, Article 21

October 2013

I. General Information about 9 A.A.C. 22, Article 21

Overview

The rules in A.A.C. Title 9, Chapter 22, Article 21 support the methodology of how the Trauma and Emergency Services Fund is distributed to hospitals that provide services to the acute care members.

The Acute care programs have operated under a Waiver from the Centers for Medicare and Medicaid Services (CMS) since the Arizona Medicaid Program's inception in 1982. The AHCCCS Acute Care programs are federal and state funded programs that provide health care services to the general population meeting the designated income levels. The income level determines the program for which the individual qualifies.

Services are delivered by managed care organizations (MCO) when members are enrolled with contractors, otherwise, services are received on a fee for service (FFS) basis. Hospitals that provide trauma and emergency services either are contracted with an MCO or provide the service on a FFS basis. These hospitals often provide trauma and emergency services that end up being uncompensated or where the hospitals cost to provide the service was more than the compensated amount, therefore causing the hospital to have financial distress. The legislature promulgated statute A.R.S. 36-2903.07 giving the Administration authority and funding to reimburse Arizona hospitals, registered to provide trauma and emergency services, that have in good faith provided trauma and emergency services resulting in unrecovered costs.

As of October 1, 2013 there were 1,173,994 members receiving services under the acute care programs.

II. Five Year Report on 9 A.A.C. 22 Art 21 rules:

General and specific statutes authorizing the rule:
The Administration has general rulemaking authority as described in A.R.S. § 36-2903.01 and implementing rulemaking authority for this fund as described in A.R.S. § 36-2903.07.

Objective of the rule including the purpose:

The purpose of rules R9-22-2101 through R9-22-2104 is to describe how the distribution of the funds will be made and for the type of service provided.

R9-22-2101 – Provides general provisions discussing the distribution of the fund and the guidelines to qualify as a trauma and emergency hospital.
R9-22-2102 – Provides specific date timeframes for which the Level 1 trauma centers will receive reimbursement for the services provided during the year.
R9-22-2103 – Provides specific date timeframes for which the Emergency services hospitals will receive reimbursement for the services provided during the year.
R9-22-2104 – Provides description of the distribution to be made from the Trauma and Emergency Services fund for the reporting years ending June 30, 2011 and June 30, 2012.

Effectively meets its objectives, including any available data supporting conclusion:
R9-22-2101 through R9-22-2104 meets the objectives. No data was attained.

Is consistent with state statute, federal statute and other rules:
R9-22-2101 through R9-22-2104 is consistent with statute A.R.S. § 36-2903.07.

Is enforced:
R9-22-2101 through R9-22-2104 rules are enforced with no issues.

Is clear, concise and understandable:
R9-22-2101, R9-22-2103 and R9-22-2104 rules are clear, concise and understandable. R9-22-2102 can be clarified by striking subsection (A)(1) through (A)(3) since this section applies to calculation from 2003 and 2004, this language is no longer needed.

Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods:
R9-22-2101 through R9-22-2104 did not have any written criticisms or analyses submitted in the past five years.

Comparison of estimated economic, small business, and consumer impact.

R9-22-2101 thru R9-22-2104 – These rules were promulgated within an exempt rulemaking were an Economic Impact Statement was not required. The Administration finds that the funding provided has reimbursed trauma and emergency hospitals appropriately.
For the State Fiscal Year 2013 the following funds have been distributed to the registered trauma and emergency room hospitals:
Trauma = $19,369,558
Emergency = $2,152,173

While the statute, ARS 36-2903.07 at subsection C., clearly requires the fund to be used to "reimburse hospitals in Arizona for unrecovered trauma center readiness costs ***and*** unrecovered emergency services costs" (emphasis added), the statute does not establish any particular method for determining which costs take priority or how the funds available for reimbursing trauma and emergency costs should be allocated. As such, it was clearly the intention of the voters (as this was added by voter initiative) that

those determination should be left to the sound discretion of the agency. Prior to adopting the 90/10 split, AHCCCS reviewed the relative proportion of unrecovered costs and the relative importance of trauma services and emergency services. Before the final decision was made AHCCCS sought and received positive input from the hospital association. Historical information regarding the economic impact (specifically, the annual payments to individual hospitals), is available on the AHCCCS website at www.azahcccs.gov/commercial/HospitalSupplements/Proposition202.aspx. AHCCCS has not received any formal challenges or objections to the rule include no challenges or objections to the proportionate use of the fund.

Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states:
R9-22-2101 through R9-22-2104 did not have an analyses submitted regarding the rule's impact on state business or compared to competitiveness of businesses in other states.

If applicable, has the agency completed the course of action indicated in the agency's previous five-year review:
Not applicable, no course of action was proposed in the last 5 year review.

Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective:

The Administration believes the rules as written impose the least burden and costs when meeting their objectives.

Are the rules more stringent than a corresponding federal law:
The rules as written are not more stringent than federal law, since there is not a federal law to rely upon. The fund described in these rules are only supported by state statute.

Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization:
Not applicable, the Administration does not issue permits, license or agency authorization in relation to Article 21.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend, repeal, or make a rule:

R9-22-2102 (A)(1) – (A)(3) can be stricken since it applies to a previous time frame, no longer necessary. The Administration intends to file an amendment by January 2017.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 22, Article 17

January 2014

I. General Information about 9 A.A.C. 22, Article 17

Overview

The rules in A.A.C. Title 9, Chapter 22, Article 17 support the operations and practices of the enrollment requirements for a person who is qualified to receive Acute Medicaid services.

9 A.A.C. 22, Article 17 describes enrollment requirements with an AHCCCS contractor, effective dates of enrollment, newborn enrollment, and the guaranteed enrollment period. The Article was originally created as part of a January 1999 rulemaking.

As of January 1, 2014 there were 1,243,601 acute care members receiving services under the acute care programs.

II. Five Year Report on 9 A.A.C. 22 Art 17 rules:

General and specific statutes authorizing the rule:
The Administration has general and implementing rulemaking authority as described in A.R.S. § 36-2903.01.

Objective of the rule including the purpose:

The purpose of rules R9-22-1701 through R9-22-1705 is to describe the enrollment requirements to a contractor who will be responsible for the provision of medical services through their contracted network.

R9-22-1701 – Provides definitions related specifically to enrollment of a member with an AHCCCS contractor.

R9-22-1702 – Establishes parameters for enrollment of a member with an AHCCCS contractor. The rule addresses the following areas: General enrollment, fee-for-service, foster care, family planning, and enrollment changes.

R9-22-1703 – Defines the effective date of enrollment with a contractor and provides for financial liability of a contractor as specified in contract.

R9-22-1704 – Defines the general requirements for enrollment of a newborn child and provides the financial liability of a contractor as specified in contract. Requires the Administration to notify the mother of the newborn's enrollment and give the mother the opportunity to select a different contractor or Indian Health Service (IHS).

R9-22-1705 – Establishes parameters for the guaranteed enrollment period. This rule addresses effective enrollment and disenrollment dates, exceptions to the guaranteed enrollment period, and retroactive adjustments.

Effectively meets its objectives, including any available data supporting conclusion:
R9-22-1701 through R9-22-1705 meets the objectives. No data was attained.

Is consistent with state statute, federal statute and other rules:
R9-22-1701 through R9-22-1705 is consistent with statute A.R.S. § 36-2903.01.

Is enforced:
R9-22-1701 through R9-22-1705 rules are enforced with no issues.

Is clear, concise and understandable:
R9-22-1701, R9-22-1703 through R9-22-1705 rules are clear, concise and understandable. R9-22-1702 can be revised for clarity by changing the term "Native American" to "American Indian", which is used throughout other laws, including federal laws unrelated to AHCCCS, because the new term is more culturally sensitive. In addition, under subsection (A)(5)(a), a reference to "coverage of emergency services only under R9-22-305(6)" should replace the cross-reference to R9-22-1419 since that rule was repealed in the Medicaid Eligibility rulemaking approved by the Council on January 7, 2014.

Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods:
R9-22-1701 through R9-22-1705 did not have any written criticisms or analyses submitted in the past five years.

Comparison of estimated economic, small business, and consumer impact.

R9-22-1701 thru R9-22-1705 –The economic impact estimated in May 2008 has not changed significantly.

Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states:
R9-22-1701 through R9-22-1705 did not have an analyses submitted regarding the rule's impact on state business or compared to competitiveness of businesses in other states.

If applicable, has the agency completed the course of action indicated in the agency's previous five-year review:
Not applicable, no course of action was proposed in the last 5 year review.

Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective:

The Administration believes the rules as written impose the least burden and costs when meeting their objectives.

Are the rules more stringent than a corresponding federal law:
The rules as written are not more stringent than federal law, since there is not a federal law to rely upon. The fund described in these rules is only supported by state statute.

Does the rule comply with section 41-1037 for issuance of a permit, license or agency authorization:
The rules reviewed do not require issuance of permits, licenses, or agency authorization.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend, repeal, or make a rule:

R9-22-1701 thru R9-22-1705 – After review of these rules, the Administration has determined that a technical amendment is only necessary to R9-22-1702 as described under the clarity section. The Administration intends on revising the rule by January 2017. All other rules do not require an amendment.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 28, Article 4

January 2014

I. General Information about 9 A.A.C. 28, Article 4

Overview

These rules apply to the Arizona Long Term Care System (ALTCS) program, a statewide managed care system which delivers long-term care and acute care services through prepaid, capitated program contractors.

The ALTCS program is authorized by Title XIX of the Social Security Act. This program is a federal-and state-funded program for aged (65 and over), blind, or disabled individuals who need ongoing services at a nursing facility level of care. As of January 1, 2014, there were 54,608 ALTCS members.

Program participants do not have to reside in a nursing home. Many ALTCS participants live in their own homes or in an assisted living facility where they receive home-and community-based (HCBS) services. ALTCS participants also receive covered acute-care services, including doctor's office visits, hospitalization, prescriptions, lab work, and behavioral health services.

II. Five Year Report on 9 A.A.C. 28 Art 4 rules:

General and specific statutes authorizing the rule:
The Administration has general and implementing rulemaking authority as described in A.R.S. §§ 36-2932, 36-2933, 36-2934, and 36-2934.01.

Objective of the rule including the purpose:

The purpose of rules R9-28-401 through R9-22-418 is to describe how eligibility and enrollment are determined and process for the members/applicants of the ALTCS program.

R9-28-401 – Provides definitions related to the provisions within Article 4.

R9-28-401.01 – The objective of this rule is to provide eligibility requirements for the ALTCS program.

R9-28-406 – The objective of the rule is to establish provisions for treatment of different living arrangements for the ALTCS program.

R9-28-407 – The objective of the rule is to establish resource requirements for ALTCS eligibility.

R9-28-408 - The objective of the rule is to establish income requirements for ALTCS eligibility.

R9-28-409 - The objective of the rule is to establish provisions for allowable transfers of assets and penalties for transfers of assets that do not meet the criteria for allowable transfers.

R9-28-410 – The objective of the rule is to establish provisions for the treatment of resources and income of an institutionalized person with a spouse in the community. The rule also provides specific provisions for transfers of assets and hearing rights applicable to community spouses and institutionalized spouses.

R9-28-411 – The objective of the rule is to establish requirements for reporting specified changes to the Administration, requirements for the processing of changes and redeterminations by the Administration, and requirements for notice of action on the changes and redeterminations.

R9-28-412 - The objective of the rule is to establish general requirements for enrollment of members with a program contractor.

R9-28-413 – The objective of the rule is to establish requirements for the enrollment of elderly or physically disabled ALTCS members.

R9-28-414 – The objective of the rule is to establish requirements for the enrollment of developmentally disabled ALTCS members.

R9-28-415 - The objective of the rule is to establish requirements for the enrollment of American Indian ALTCS members.

R9-28-416 - The objective of the rule is to establish requirements for the enrollment of ALTCS members when there is no Elderly or Physically Disabled (EPD) or tribal contractor in a geographical service area, or the member is only eligible for services during prior period coverage.

R9-28-417 - The objective of the rule is to establish requirements for the Administration to notify the program contractor when a member is enrolled or disenrolled from the ALTCS program. The rule also establishes requirements for the program contractor to notify the Administration when a change occurs that may affect a member's eligibility for the ALTCS program.

R9-28-418 - The objective of the rule is to establish requirements for disenrolling an ALTCS member.

Effectively meets its objectives, including any available data supporting conclusion:
R9-28-401 through R9-28-418 meets the objectives. No data was used to support this conclusion.

Is consistent with state statute, federal statute and other rules:
R9-28-401 through R9-28-418 is consistent with statute A.R.S. §§ 36-2932 36-2933, 36-2934, and 36-2934.01.

Is enforced:
R9-28-401 through R9-28-418 rules are enforced with no issues.

Is clear, concise and understandable:
R9-28-401 through R9-28-418 rules are clear, concise and understandable.

Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods:
R9-28-401 through R9-28-418 did not have any written criticisms or analyses submitted in the past five years.

Comparison of estimated economic, small business, and consumer impact.

R9-28-401 thru R9-28-418 – The majority of these rules were amended in a rulemaking made effective January 7, 2014, with the exception of 2. The Administration finds that the recent rulemaking reflects the current economic impact appropriately and finds that the 2 rules not changed (R9-28-412 and R9-28-417) did not cause a significant change in the estimated economic impact.

Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states:
R9-28-401 through R9-28-418 did not have an analyses submitted regarding the rule's impact on state business or compared to competitiveness of businesses in other states.

If applicable, has the agency completed the course of action indicated in the agency's previous five-year review:
The Administration has completed the course of action proposed in the last 5 year review report submitted in 2009.
R9-28-402, R9-28-403, and R9-28-405, were repealed and placed under new rules in Chapter 22, Article 3 cross-referenced for the eligibility requirements under R9-28-401.
R9-28-406 has been amended by removing the coverage groups.
R9-28-409 has been amended to reflect current practice of transfers.

R9-28-411 was not changed. The rule team agreed that the term "post-eligibility computed income" is appropriate.
R9-28-413, R9-28-414, and R9-28-416 have been updated as recommended in the 5 year report.
R9-28-417 was not changed. The rule was reviewed from the perspective of Medicaid Eligibility changes and the Administration did not see a change required. The change recommended in the 5yr regarding the Administration notifying the Tribal case management entity of a member's enrollment or disenrollment was overlooked and will be addressed in a future rulemaking.

Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective:

The Administration believes the rules as written impose the least burden and costs when meeting their objectives.

Are the rules more stringent than a corresponding federal law:
The rules as written are not more stringent than federal law, since there is not a federal law to rely upon. The fund described in these rules are only supported by state statute.

Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization:
The rules reviewed do not require issuance of permits, licenses, or agency authorization.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend, repeal, or make a rule:

R9-28-401 thru R9-28-418 – After review of these rules, the Administration has determined that an amendment is not necessary at this time. This rule meets the agency's goals, objectives and business practices.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 28, Article 8

January 2014

I. General Information about 9 A.A.C. 28, Article 8

Overview

The rules in Title 9, Chapter 28, Article 8 support the operations and practices of the Tax Equity and Fiscal Responsibility Act (TEFRA) lien provisions for members on the ALTCS program. The ALTCS program is authorized by Title XIX of the Social Security Act. This program is a federal and state funded program for aged (65 and over), blind, or disabled individuals who need ongoing services at a nursing facility level of care.
Where a member has third party insurance, that insurance must be billed first. AHCCCS is the payor of last resort.

Under federal law, AHCCCS has the option of filing TEFRA liens on real property of Medicaid members if they are determined to be permanently institutionalized (PI) and cannot return home. The TEFRA rules allow AHCCCS to place a lien on the member's real property before the death of the member. If there is an intention to sell or transfer the real property before the death of the member, the lien must be satisfied first. Implementing TEFRA liens will protect the state's interest and right of recovery against real property owned by the member at the time of application to the ALTCS program.

The TEFRA lien process helps eliminate the possibility of a sale or transfer of real property to avoid estate recovery before the death of a member.

The TEFRA lien secures the state's interest in the debt so that it increases the likelihood that AHCCCS will be able to recover an ALTCS covered service debt compared to seeking recovery of that debt without a lien.

As of December 1, 2013, there were 54,557 members receiving services under the ALTCS program.

II. Five Year Report on 9 A.A.C. 28 Art 8 rules:

General and specific statutes authorizing the rule:
The Administration's authorizing statute for this article is A.R.S. § 36-2932. The implementing authority is A.R.S. § 36-2935 and 36-2956.

Objective of the rule including the purpose:

R9-28-801 – This rule provides definition for the terms used to describe the process of a TEFRA lien.

R9-28-801.01 – This rule provides the purpose of the TEFRA lien.

R9-28-802 – This rule identifies the type of members who would have a TEFRA lien filed against their properties or assets.

R9-28-803 – This rule describes a situation in which the Administration is prohibited from filing a TEFRA lien.

R9-28-804 – This rule describes the Administration's notification requirements when intending to file a TEFRA lien, giving the member the opportunity to file a request for an exemption.

R9-28-805 – This rule provides state fair hearing rights and timeframes for requesting a hearing as a result of a TEFRA lien.

R9-28-806 – This rule provides recovery provisions related to TEFRA liens.

R9-28-807 – This rule provides when a TEFRA lien will be released or removed from the member's property.

Effectively meets its objectives, including any available data supporting conclusion:
R9-28-801 through R9-28-807 effectively meet their objectives. No data was used to support this conclusion.

Is consistent with state statute, federal statute and other rules:
R9-28-801 through R9-28-807 is consistent with statutes A.R.S. § 36-2935 and 36-2956, and federal law 42 U.S.C. 1396p.

Is enforced:
R9-28-801 through R9-28-807 rules are enforced with no issues.

Is clear, concise and understandable:
R9-28-801 through R9-28-807 rules are clear, concise and understandable.

Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods:
R9-28-801 through R9-28-807 did not have any written criticisms or analyses submitted in the past five years.

Comparison of estimated economic, small business, and consumer impact.

R9-28-801 through R9-28-807 – These rules were promulgated as of September 11, 2004 under Article 9 and were subsequently moved to Article 8 in November 8, 2008. The economic impact has not been significantly different than either of these estimates. The increase in recovery dollars from TEFRA liens was

anticipated to be an additional $300,000 within the first year of implementation. For CY 2013 we had $701,919.96 in recoveries with a filed TEFRA lien in CY 2013.

Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states:
R9-28-801 through R9-28-807 did not have an analyses submitted regarding the rule's impact on state business or compared to competitiveness of businesses in other states.

If applicable, has the agency completed the course of action indicated in the agency's previous five-year review:
The Administration completed the recommended course of action described in the previous 5yr report within the rulemaking promulgated November 8, 2008. These rules were previously described under Article 9.
The recommended course of action of moving the TEFRA rules into their own Article and the recommended change to R9-28-916 of removing the hearing rights from the notice of intent process have been made.

Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective:

The Administration believes the rules as written impose the least burden and costs when meeting their objectives.

Are the rules more stringent than a corresponding federal law:
The rules as written are not more stringent than federal law 42 U.S.C. 1396p.

Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization:
Not applicable, the Administration does not issue permits, license or agency authorization for the imposition of TEFRA liens.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend, repeal, or make a rule:

R9-28-801 thru R9-28-807 – After review of these rules, the Administration has determined that an amendment is not necessary at this time. This rule meets the agency's goals, objectives and business practices.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 34

February 2014

I. General Information about 9 A.A.C. 34

Overview

The Arizona Health Care Cost Containment System is Arizona's Medicaid program. AHCCCS oversees contracted health plans in the delivery of health care to individuals and families who qualify for Medicaid and other medical assistance programs.

The AHCCCS population as of February 1, 2014 was 1,315,356.

This Chapter describes the regulations that must be followed by all parties when requesting a State Fair Hearing regarding an Adverse action. Members, providers, and applicants express their concerns or complaints about issues, actions, or conditions they have encountered in their health care experience. Applicants, members, and/or their authorized representatives can file a grievance when they have a complaint about anything, even if it does not involve appealing a decision, such as a denial or discontinuance of services or benefits.

An appeal is a request from an applicant, member, provider, health plan, or other approved entity to reconsider or change a decision, also known as an action. An action includes any denial, reduction, suspension, or termination of a service or benefit, or a failure to act in a timely manner. All applicants, members, or their authorized representatives, including those enrolled in an AHCCCS Health Plan or fee-for-service program, may file a grievance or appeal a decision. The representative must be authorized in writing.

Disputes are submitted by providers and contractors to reconsider or change a reimbursement decision. The dispute could be regarding a denied, paid, or recovered payment of a claim.

II. Five Year Report on 9 A.A.C. 34 rules:

General and specific statutes authorizing the rule:
The Administration has general and implementing rulemaking authority for this fund as described in A.R.S. § 36-2903.01.

Objective of the rule including the purpose:

The purpose of rules is to:

R9-34-101. - Provide the purpose of eligibility hearings regulations to ensure understanding of the public of the reason to request a state fair hearing.
R9-34-102. - Provide definitions related to eligibility hearings within Article 1 to ensure understanding of terms used through the rule text.
R9-34-103. –Describe when the time frame to file for a state fair hearing begins to ensure understanding of the date the timeframes begin for filing.
R9-34-104. –Describe what the petitioner's rights are to ensure the public understands of what right they have when requesting a hearing or documentation.
R9-34-105. - Describe who may file a request for a State Fair Hearing to ensure the public understands who can file a request.
R9-34-106. - Describe that a petitioner may only request a State Fair Hearing for an adverse action to ensure the public understands what is considered an adverse action and under what circumstance they can file. .
R9-34-107. - Describe the time limit for requesting a State Fair Hearing to ensure that the public understands how much time they have to request a state fair hearing.
R9-34-108. - Describe the format and contents of the request for a State Fair Hearing to ensure that the public understands what the request must contain.
R9-34-109. - Specifies that AHCCCS will send a Notice of Hearing if the request is timely and contains the information listed in R9-34-108, to ensure that the public understands within what timeframe they should expect a response.
R9-34-110. - Describe under which circumstances a Request for a State Fair Hearing will be denied, to ensure that the public understands the reason their request can be denied.
R9-34-111. - Identify the time frame for sending a Director's decision after a State Fair Hearing is requested, to ensure that the public understands within what timeframe a Director's decision will be made.
R9-34-112. - Describe when a petitioner may withdraw a Request for a State Fair Hearing from AHCCCS or from OAH, to ensure that the public understands when a withdrawal may be submitted.
R9-34-113. - Describe when the Director shall grant a motion for Rehearing or Review, to ensure that the public understands when a motion for rehearing or review will be granted.
R9-34-114. - Describe under which circumstances AHCCCS Coverage shall continue during a State Fair Hearing Process, to ensure that the public understands that they could continue to receive AHCCCS service while their request for a State Fair Hearing is in process.
R9-34-201. - Identify the purpose of appeal, grievance and hearings regulations, to ensure that the public understands the reason and how an appeal, grievance and hearing can apply to their circumstances.
R9-34-202. - Provide definitions related to appeals, grievances and hearings within Article 2, to ensure that the public understands the meaning of the terms used within the rules.
R9-34-203. - Describe when the time frame to file for a State Fair Hearing begins, to ensure that the public understands the time frame that must be met to file a State Fair Hearing request.
R9-34-204. - Describe the format and language of a Notice of Action, to ensure that the public understands the format and language used when receiving a Notice of Action.
R9-34-205. - Describe the content of the Notice of Action, to ensure that the public understands what the Notice of Action contains.

R9-34-206. - Describe the contractor Notice of Action time-frame for Service Authorization Requests, to ensure that the public understands the timeframe a contractor must meet when issuing a Notice of Action.

R9-34-207. - Describe when the contractor shall send a Notice of Action, to ensure that the public understands the timeframe that must be met from the contractor when issuing a Notice of Action.

R9-34-208. - Describe who may file a grievance, an appeal, or request a State Fair Hearing, to ensure that the public understands which person or entity may file a grievance, appeal or request for State Fair Hearing.

R9-34-209. - Describe the time-frame an enrollee has for filing an appeal or grievance with the contractor, to ensure that the public understands what timeframe they must meet when filing an appeal or grievance.

R9-34-210. - Describe the contractor's general requirements for the grievance or appeal process, to ensure that the public understands the requirements that must be met by the contractor.

R9-34-211. - Describe contractor special requirements for the appeal process, to ensure that the public understands the requirements that must be met by the contractor.

R9-34-212. - Describe the contractor's time-frame for a standard disposition of a grievance, to ensure that the public understands the timeframe that must be met by the contractor for a standard disposition of a grievance.

R9-34-213. - Describe the contractor's time-frame for a standard resolution of an appeal, to ensure that the public understands the timeframe that must be met by the contractor for a standard resolution of an appeal.

R9-34-214. - Describe when the contractor's must process an expedited resolution of an appeal and to ensure that punitive action is not taken, to ensure that the public understands the requirements that must be met by the contractor for an expedited resolution of an appeal.

R9-34-215. - Describe the contractor's time-frame for an expedited appeal resolution, to ensure that the public understands the timeframe that must be met by the contractor for expedited appeal resolution.

R9-34-216. - Describe the content of the contractor's Notice of Appeal resolution, to ensure that the public understands what the NOA must contain from the contractor.

R9-34-217. - Describe requirements for the enrollee's request for a State Fair Hearing, to ensure that the public understands the requirements that must be met when filing a State Fair Hearing with the contractor.

R9-34-218. - Describe the AHCCCS time-frame for a resolution of a State Fair Hearing, to ensure that the public understands the timeframe that must be met by the contractor when resolving a State Fair Hearing request.

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R9-34-219. - Describe requirements for the enrollee's request for an expedited State Fair Hearing, to ensure that the public understands the requirements that must be met when filing an expedited State Fair Hearing with the contractor.

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R9-34-220. –Describe the AHCCCS time-frame for a resolution of an expedited State Fair Hearing, to ensure that the public understands the timeframe that must be met by the contractor when resolving an expedited State Fair Hearing.

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R9-34-221. - Describe the withdrawal of a request for a State Fair Hearing, to ensure that the public understands the withdrawal requirements that must be met when withdrawing a State Fair Hearing request with the contractor.

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R9-34-222. - Describe the circumstances when AHCCCS must deny a request for a State Fair Hearing, to ensure that the public understands when a contractor may deny a request for a State Fair Hearing with the contractor.

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R9-34-223. - Describe the circumstances when a motion for rehearing or review will be granted, to ensure that the public understands the situations that must be met to receive a motion for rehearing or review with a contractor.

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R9-34-224. - Describe the continuation of services while the contractor appeals and the State Fair Hearing is pending, to ensure that the public understands that services may continue while their appeal or State Fair Hearing is in process with the contractor.

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R9-34-225. - Describe when disputed services will be provided when a reversed appeal resolution occurs, to ensure that the public understands how services disputed may be covered if an appeal is reversed by the contractor.

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R9-34-301. - Describe the purpose of the appeal and state fair hearing requirements for a fee-for-service member, to ensure that the public understands the circumstances or reasons applicable to file an appeal or a State Fair Hearing request with the Administration.

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R9-34-302. - Describe the definitions applicable to the appeal and state fair hearing process for a fee-for-service member, to ensure that the public understands the meanings of the terms used within rule describing the appeal and State Fair Hearing process with the Administration.

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R9-34-303. - Describe how to compute time for purposes of Article 3, to ensure that the public understands the timeframe applicable to file an appeal or a State Fair Hearing request with the Administration.

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R9-34-304. - Describe the language and format of the Notice of Action, to ensure that the public understands the language and format used by the Administration when receiving a NOA from the Administration.

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R9-34-305. - Describe the content of the Notice of Action, to ensure that the public understands what the NOA must contain when receiving the NOA from the Administration.

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R9-34-306. - Describe the time-frame for sending a Notice of Action for Service Authorization Requests, to ensure that the public understands the timeframes that must be met by the Administration when sending a NOA.

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R9-34-307. - Describe the time-frame for sending a Notice of Action for Service Termination, Suspension, or Reduction, to ensure that the public understands the timeframes that must be met by the Administration when sending a NOA.

R9-34-308. - Describe who may file an appeal or request a State Fair Hearing to ensure that the public understands which person or entity may file an appeal or State Fair Hearing with the Administration.

R9-34-309. - Describe the time-frame for filing an appeal to ensure that the public understands the timeframes that must be met when filing an appeal.

R9-34-310. - Describe the general requirements for the appeal process to ensure that the public understands the requirements that must be met when filing an appeal with the Administration.

R9-34-311. - Describe the special requirements for the appeal process to ensure that the public understands the requirements that must be met when filing an appeal with the Administration.R9-34-312. - Describe the time-frame for a standard resolution of an appeal to ensure that the public understands the timeframes that must be met by the Administration when resolving an appeal.

R9-34-313. - Describe the content of the Notice of Appeal Resolution to ensure that the public understands what the Notice of Appeal resolution must contain.

R9-34-314. - Describe the requirements for the request for a State Fair Hearing to ensure that the public understands the requirement that must be met when filing a State Fair Hearing request with the Administration.

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R9-34-315. - Describe the time-frame for resolution of a State Fair Hearing when there is standard resolution of an appeal to ensure that the public understands the timeframes that must be met by the Administration when resolving a State Fair Hearing.

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R9-34-316. - Describe the request for an expedited resolution of an appeal to ensure that the public understands the requirements the Administration must meet when resolving an expedited appeal.

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R9-34-317. - Describe the time-frame for resolution of an expedited State Fair Hearing to ensure that the public understands the timeframes that must be met by the Administration when resolving an expedited State Fair Hearing.

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R9-34-318. - Describe the withdrawal of a request for a State Fair Hearing to ensure that the public understands the content of a withdrawal of a State Fair hearing request submitted to the Administration.

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R9-34-319. - Describe the denial of a request for a State Fair Hearing to ensure that the public understands under which circumstances the Administration may deny a request for a State Fair hearing submitted to the Administration.

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R9-34-320. - Describe when a motion for rehearing or review can occur to ensure that the public understands under which circumstances the Administration may issue a motion for rehearing or review for a State Fair hearing submitted to the Administration.

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R9-34-321. - Describe continuation of services while the appeal and the State Fair Hearing are pending, to ensure that the public understands that services may continue while their appeal or State Fair Hearing is in process with the Administration.

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R9-34-322. - Describe continuation of services when there is a reversed appeal resolution, to ensure that the public understands that services may continue while an appeal resolution is reversed by the Administration.

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R9-34-401. - Describe the purpose of the claim dispute and request for State Fair Hearing, to ensure that the public understands the reason a claim dispute may be filed or a request for State Fair hearing.

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R9-34-402. - Describe definitions that specifically apply to the claim dispute and request for State Fair Hearing to ensure that the public understands the meaning of the terms used when requesting a State Fair Hearing for a claim dispute.

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R9-34-403. - Describe computation of time for purposes of Article 4 (claim disputes), to ensure that the public understands the timeframe applicable to file an appeal or a State Fair Hearing related to a claim dispute with the Administration.

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R9-34-404. - Describe the content of a claim dispute, to ensure that the public understands what the content of the claim dispute must have to file an appeal or a State Fair Hearing request with the Administration related to a claim dispute.

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R9-34-405. - Describe the filing of a claim dispute involving a member enrolled with a contractor to ensure that the public understands the requirements that must be met when filing a claim dispute with a contractor.

R9-34-406. - Describe the filing of a claim dispute by a contractor regarding reinsurance to ensure that the public understands the requirements that must be met when filing a claim dispute related to reinsurance with the Administration.

R9-34-407. - Describe the filing of a claim dispute for a claim involving a FFS Member to ensure that the public understands the requirements that must be met when filing a claim dispute with the Administration.

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R9-34-408. - Describe the denial of a request for a State Fair Hearing to ensure that the public understands under which circumstances the Administration may deny a request for a State Fair hearing submitted to the Administration or contractor.

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R9-34-409. - Describe the motion for rehearing or review to ensure that the public understands under which circumstances the Administration or contractor may issue a motion for rehearing or review for a State Fair hearing submitted to the Administration.

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Effectively meets its objectives, including any available data supporting conclusion:
Chapter 34 rules meet their objectives. No data was attained.

Is consistent with state statute, federal statute and other rules:
Chapter 34 is consistent with statute A.R.S. § 36-2903.01, federal laws 42 CFR 438.404 and any rules related to this subject matter.

Is enforced:
Chapter 34 rules are enforced with no issues.

Is clear, concise and understandable:
Chapter 34 rules need to be updated as indicated in the previous 5yr report for clarity. For example the types of changes are formatting, citation and cross-reference updates, etc. We are working on draft amendments to our appeal rules and do intend to add a specific reference to the authority of ALJ's to order medical evaluations. The settlement agreement in Price does include a specific reference to changing this in rule. We've not heard from the plaintiffs, nor anyone making a request to an ALJ and objecting that it was denied. The issue seldom comes up because it is really only relevant to a handful of appeals and if the issue is whether the individual meets the SSA definition of disabled, independent medical examinations are often included in the appeal file.

Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods:
Chapter 34 rules did not have any written criticisms or analyses submitted in the past five years. In the previous five year report it was identified that the agency received criticism of three of the rules. Representatives from Southern Arizona Legal Aid and the Arizona Center for Disability Law submitted requests that certain rules be clarified, including clarification regarding reimbursement of services received during the appeal process when a denial of services decision is reversed. AHCCCS also indicated that the settlement agreement in the litigation of *Price v. Rodgers* will require, among other things, that the rules be amended to authorize an administrative law judge to order an independent medical evaluation. AHCCCS intends to amend the rules to address these criticisms and to comply with the settlement agreement.

Comparison of estimated economic, small business, and consumer impact.
No significant impact change has been detected since the rules were last promulgated.
For the contract year 10/1/12 thorough 9/30/13:

2345 eligibility matters (1611 went to hearing, 734 informal decisions)
6578 claim disputes matters (1982 went to hearing, 4596 informal decision)
433 member matters (202 went to hearing, 231 informal decisions)

The increased number of filing is related to the increased enrollment numbers.

The number of expedited hearings is very low, less than 10 for the reporting period of 10/1/12 – 9/30/13.

Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states:
Chapter 34 rules did not have an analyses submitted regarding the rule's impact on state business or compared to competitiveness of businesses in other states.

If applicable, has the agency completed the course of action indicated in the agency's previous five-year review:
Chapter 34 course of action proposed in the last 5 year review has not been promulgated yet; the Administration is in the process of submitting a request to the Governor's office for approval to proceed with the rulemaking as prescribed under the rule exemption moratorium. The Administration expects to file proposed by July 2014, depending upon approval from Governor's office.

Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective:

The Administration believes the rules as written impose the least burden and costs when meeting their objectives.

Are the rules more stringent than a corresponding federal law:
The rules are not more stringent than corresponding federal laws, which are 42 CFR 438.400 et. seq. and 42 CFR 431.200 et. seq., because the rules mirror and enforce what is required by federal law.

Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization:
Not applicable, the grievance requirements do not require an issuance of a permit, license or agency authorization.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend, repeal, or make a rule:

Chapter 34 – After review of these rules, the Administration has determined that an amendment is still necessary as indicated in the previous 5 year report and anticipates to file proposed in July 2014, subject to the Governor's approval and anticipate filing the notice of final rulemaking in September 2014 to the Council.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 30, Article 1- 4

March 2016

I. General Information about 9 A.A.C. 30, Article 1-4

Overview

The AHCCCS Administration has developed rules in 9 A.A.C. 30, to describe how a person can apply for the Medicare Prescription Part D Extra Help program. These rules are used only in the event that a person does not apply through Social Security.

The Extra Help (or Low Income Subsidy) program provides assistance with Medicare Part D prescription costs for people with limited income and resources.

The Extra Help program provides:

- Help paying the Medicare drug plan's monthly premium through a premium subsidy. Depending on the beneficiary's income and resources, the beneficiary may pay a reduced premium or no premium for a basic plan. For an enhanced plan (a plan that may cover more drugs and generally has a higher monthly premium), the beneficiary must pay the difference between the premium and the Part D premium subsidy amount.
- Help paying any yearly deductible,
- Help paying coinsurance and co-payments for prescription drugs that are on the plan's formulary (list of covered drugs). In most cases, with Extra Help the beneficiary will pay only a small amount for each covered prescription. The beneficiary generally pays all costs for drugs that are not on the plan's formulary.
- No coverage gap (known as the Donut Hole).

Eligibility for the Extra Help program is determined by the Social Security Administration. However, a beneficiary can also automatically qualify for Extra Help and not have to file an application if the beneficiary meets one of the following conditions.

- The beneficiary has full Medicaid coverage,
- The beneficiary is eligible for Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Individual (QI)-1, or
- The beneficiary receives Supplemental Security Income (SSI) benefits.

The beneficiary must be enrolled with a Medicare drug plan to get this Extra Help. The exact amount the beneficiary pays depends on the level of Extra Help the beneficiary is eligible for.

As of March 1, 2016 there has not been anyone who has applied for this program through the AHCCCS Administration.

This 5 year report outlines changes that are currently in the rulemaking process; the proposed rulemaking has been filed with the Secretary of State and will be published in the A.A.R. on April 22, 2016.

II. Five Year Report on 9 A.A.C. 30 Art 1-4 rules:

General and specific statutes authorizing the rule:

A.R.S. §§ 36-2903(O) and 36-2903.01(F) provides general authority to AHCCCS to adopt rules.

A.R.S. § 36-2907(A)(4) provides the specific authority to the AHCCCS Administration to assist a person in obtaining medications through a Medicare Prescription Part D program.

Objective of the rule:

R9-30-101 – The objective of the rule is to provide definitions for terms used within the Medicare Prescription Drug Program.

R9-30-201 - The objective of the rule is to describe when and how the AHCCCS Administration may assist an applicant in applying for Extra Help.

R9-30-202 - The objective of the rule is to inform the public that they have the opportunity to apply with the Administration at any time.

R9-30-203 - The objective of the rule is to provide the public information on how to apply for the Extra Help program.

R9-30-204 – The objective of the rule is to provide the public with information about an applicant's ability to choose a representative and also advise an applicant that they can receive assistance from the Administration.

R9-30-205 - The objective of the rule is to inform the public to obtain a SSN number in order to meet the eligibility requirements.

R9-30-206 - The objective of the rule is to provide Arizona residency as an eligibility requirement.

R9-30-207 - The objective of the rule is to provide the income eligibility calculation for the extra help program.

R9-30-208 - The objective of the rule is to specify that a person residing in a penal institution is not eligible for this program.

R9-30-209 - The objective of the rule is to describe the resource eligibility determination process for the Extra Help program.

R9-30-210 - The objective of the rule is to allow AHCCCS to obtain the information needed to determine eligibility.

R9-30-211 - The objective of the rule is to provide information to the public of the Medicare eligibility requirement for extra help.

R9-30-212 - The objective of the rule is to inform the public what the timeframe by when the agency will make an eligibility determination.

R9-30-213 - The objective of the rule is to provide the public information of the amount of assistance that the Extra Help program provides. The Extra Help amounts provided are set by federal regulations which are incorporated by reference. (The premium subsidy is in 423.780, copayment subsidy 423.782, deductibles 423.782, donut hole assistance 423.782, etc.)

R9-30-214 - The objective of the rule is to provide the public information regarding notice requirements when an eligibility determination is made.

R9-30-215 - The objective of the rule is to provide the public with the date eligibility will go into effect for the Extra Help program.

R9-30-216 - The objective of the rule is to provide the public with an explanation of the circumstances that can cause discontinuance or changes in benefit amounts.

R9-30-217 - The objective of the rule is to provide the public the timeframe when a redetermination will take place.

R9-30-218 - The objective of the rule is to provide the public information on how to report changes that occur in their household to the Administration.

R9-30-301 - The objective of the rule is to notify the public that the Administration does not provide pharmaceutical services.

R9-30-401 - The objective of the rule is to provide the public information on how to request a state fair hearing.

R9-30-402 - The objective of the rule is to provide the public information on their state fair hearing rights.

Effectively meets its objectives, including any available data supporting conclusion:

Chapter 30 rules meet the objectives listed above. No data was attained.

Consistent with Statutes, rules, (including Federal, State, Waiver, Policy)

Chapter 30 rules are consistent with statute and federal law, a clarification to the following rules is recommended, these rules are currently consistent with federal laws.

R9-30-207 – An amendment was made to 42 USC 1395w – 114(a)(3), which will change 20 CFR 418.3335. The amendment states that “in-kind support” and “maintenance” are not counted as part of the Income calculation. The Medicare Improvements for Patients and Providers Act (MIPPA) was signed into law on 7/15/08 and these provisions were implemented effective 1/1/10. This change is enforced consistent with federal regulations.

R9-30-209 - An amendment was made to 42 USC 1395w – 114(a)(3), which will change 20 CFR 418.3425. The amendment states that the value of any life insurance policy is not counted as part of the Resource calculation. The MIPPA was signed into law on 7/15/08 and these provisions were implemented effective 1/1/10. This change is enforced consistent with federal regulations.

Is enforced:

Chapter 30 rules are enforced with no issues.

Clarity, conciseness and understandability of the rule:

Chapter 30 rules are clear, concise and understandable, with the exceptionof the following rule clarifications:

R9-30-204 – The Administration recommends repeal of this rule since subsection (A) should be moved to R9-30-203(C)(2) and subsection (B) is already addressed within R9-30-201(A).

R9-30-205 – The Administration recommends repealing this rule and combining all the eligibility requirements into one rule.

R9-30-206 - The Administration recommends repealing this rule and combining all the eligibility requirements into one rule.

R9-30-207 – An amendment was made to 42 USC 1395w – 114(a)(3), which will change 20 CFR 418.3335. “In-kind support” and “maintenance” are not counted as part of the Income calculation. A clarification in rule is needed to add this exception.

R9-30-209 - An amendment was made to 42 USC 1395w – 114(a)(3), which will change 20 CFR 418.3425. The value of any life insurance policy is not counted as part of the Resource calculation. A clarification in rule is needed to add this exception.

R9-30-210 – The Administration recommends repealing this rule and combining all the eligibility requirements into one rule.

R9-30-211 – The Administration recommends the CFR incorporation by reference date be updated with the latest publication date for 20 CFR 418.3010.

R9-30-212 – The Administration recommends adding a crossreference to 42 CFR 435.911 describing the timeframe requirements and exceptions rather than specifying 45 days.

R9-30-213 – The Administration recommends the CFR incorporation by reference date be updated with the latest publication date for the CFR's listed in the rule.

R9-30-215 – The Administration recommends removing the date of January 1, 2006 for conciseness of the rule. The date is no longer is necessary; the date only applied at the beginning of the program.

R9-30-401 – The Administration recommends that the rules related to State Fair Hearings be combined into the general requirement section.

R9-30-402 - The Administration recommends that the rules related to State Fair Hearings be combined into the general requirement section.

Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods:

Chapter 30 regulations did not have any written criticisms or analyses submitted in the past five years.

Comparison of estimated economic, small business, and consumer impact.

The economic impact estimated at the time of rule promulgation has not been significantly different than the actual economic impact. There have not been any applicants for the Extra Help program applying through the Administration since the inception of these regulations.

Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states:

Chapter 30 rules did not have an analyses submitted regarding the rule's impact on state business or compared to competitiveness of businesses in other states.

If applicable, has the agency completed the course of action indicated in the agency's previous five-year review:

The Administration is in process of completing the recommended course of action described in the previous 5yr report within the rulemaking proposed with an estimated effective date of October 1, 2016.

Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective:

The Administration believes the rules as written impose the least burden and costs when meeting their objectives.

Are the rules more stringent than a corresponding federal law:

The rules as written are not more stringent than federal law.

Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization:

Not applicable, the Administration does not issue permits, license or agency authorization for the imposition of the Extra Help program requirements.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend repeal or make a rule:

R9-30-204 – The Administration intends to submit a rulemaking to Council by June 2016.

R9-30-205 – The Administration intends to submit a rulemaking to Council by June 2016.

R9-30-206 – The Administration intends to submit a rulemaking to Council by June 2016.

R9-30-207 – The Administration intends to submit a rulemaking to Council by June 2016.

R9-30-209 - The Administration intends to submit a rulemaking to Council by June 2016.

R9-30-210 - The Administration intends to submit a rulemaking to Council by June 2016.

R9-30-211 - The Administration intends to submit a rulemaking to Council by June 2016.

R9-30-212 – The Administration intends to submit a rulemaking to Council by June 2016.

R9-30-213 - The Administration intends to submit a rulemaking to Council by June 2016.

R9-30-215 – The Administration intends to submit a rulemaking to Council by June 2016.

R9-30-401 - The Administration intends to submit a rulemaking to Council by June 2016.

R9-30-402 - The Administration intends to submit a rulemaking to Council by June 2016.

Arizona Health Care Cost Containment System (AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 22, Article 20

May 2016

I. General Information about 9 A.A.C. 22, Article 20

Overview

In the spring of 2001, the Arizona State Legislature passed a law to add the Breast and Cervical Cancer Treatment Program (BCCCTP) to Arizona's Medicaid program (Arizona Health Care Cost Containment System (AHCCCS)) as an optional coverage group effective January 1, 2002.

State Law ARS §36-2901.05 originally specified that to be eligible for the optional coverage group, a woman must be screened and diagnosed as needing treatment for breast and/or cervical cancer by the Well Woman Healthcheck Program (WWHP) administered by the Arizona Department of Health Services (ADHS). However, based on written authorization from WWHP, AHCCCS may accept BCCTP referrals directly from Arizona's American Indian programs that are funded by the Centers for Disease Control and Prevention (CDC) to provide screening and diagnosis under the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). State Law A.R.S. § 36-2901.05 was amended in 2012 to permit screening "by a provider or entity that is recognized by the well woman health check program administered by the department of health services…." This 5-year review report includes an analysis of the rules in 9 A.A.C. 22, Article 20 in light of the statutory changes. The rules in Title 9 Chapter 22 Article 20 apply to the AHCCCS BCCTP, which delivers services through prepaid, capitated, contracted health plans. This coverage is available to women under age 65 who are screened and diagnosed as needing medical treatment for breast cancer, cervical cancer or a pre-cancerous cervical lesion by providers authorized to conduct the screenings..

As of May 1, 2016 there were 255 women receiving these services through this AHCCCS program. The Article was originally created as part of a December 6, 2001 rulemaking.

II. Five Year Report on 9 A.A.C. 22 Art 20 rules:

General and specific statutes authorizing the rule:

A.R.S. § 36-2903.01(F) provides general authority to AHCCCS to adopt rules.
A.R.S. § 36-2901.05 specifically authorizes the Breast and Cervical Cancer Treatment Program.

Objective of the rule:

R9-22-2001 – The objective of the rule is to provide definitions for terms used within the Breast and Cervical Cancer Treatment Program.

R9-22-2002 - This rule provides General Requirements that apply to the Breast and Cervical Cancer Treatment Program.

R9-22-2003 - The rule provides criteria that must be met in order to be eligible for the Breast and Cervical Cancer Treatment Program.

R9-22-2004 - The rule provides information regarding the scope of coverage for the Breast and Cervical Cancer Treatment Program.

R9-22-2005 - The rule provides how a person may apply for the Breast and Cervical Cancer Treatment Program.

R9-22-2006 - The rule provides how the administration determines, approves, denies or discontinues eligibility for BCCTP.

R9-22-2007 - The rule describes when eligibility for the Breast and Cervical Cancer Treatment Program is effective and when it ends.

R9-22-2008 - The rule describes the redetermination of eligibility for the Breast and Cervical Cancer Treatment Program.

Effectively meets its objectives, including any available data supporting conclusion:

Chapter 22, Article 20 rules meet the objectives listed above. No data was attained.

Consistent with Statutes, rules, (including Federal, State, Waiver, Policy)

Chapter 22, Article 20 rules are consistent with statutes and federal regulations 42 CFR 435 Subpart E.

Is enforced:

Chapter 22, Article 20 rules are enforced with no issues.

Clarity, conciseness and understandability of the rule:

R9-22-2002 – R9-22-2008 – The Administration recommends cross-referencing Article 3 for *all* areas that Article 3 applies to, rather than repeating the language.

R9-22-2002 - Subsection (D) is not necessary because the eligibility of an American Indian woman is addressed under R9-22-2003. A clarifying change should be made to subsection (E) stating that a woman under this program is exempt from copays as described under R9-22-711.

R9-22-2003 – The Administration believes this rule can be updated to provide clarity, conciseness and a better understanding to the reader of the eligibility criteria related to the BCCTP. Revising the rule to be consistent with ARS §36-2905.01 will ensure alignment with State Law and will remove ambiguity. In addition, updating subsection (A)(3) with a reference to Chapter 28 will provide greater clarity because a person must be ineligible for Title XIX, including Arizona Long Term Care System (ALTCS) eligibility, to qualify for the BCCTP. The reference to R9-22-112 in subsection (B)(2) will be eliminated, since that rule has been repealed. Under subsection (A)(6) a correction is needed to also include a cross-reference to Article 3; under subsection (B)(3) it is not necessary to state that a person is ineligible when the person no longer meets the eligibility

requirements; under subsection (C), the reference to the Chief Medical Officer should be stricken and replaced with a reference to the Administration since the Administration staff conduct the continuation of eligibility; and finally, subsection (D) should be reworded to clarify the reoccurrence of cancer and eligibility.

R9-22-2004 – The Administration believes the reference to the Chief Medical Officer in subsections (A)(4), (B)(4) and (C)(4) should be stricken, because the determination of whether a treatment is considered the standard of care may be made by the Administration, not necessarily by the Chief Medical Officer.

R9-22-2005 – Amend section (A) to eliminate the outdated reference to R9-22-1406.

R9-22-2008

Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods:

Chapter 22, Article 20 regulations did not have any written criticisms or analyses submitted in the past five years.

Comparison of estimated economic, small business, and consumer impact.

The economic impact estimated at the time of rule promulgation has not been significantly different than the actual economic impact.

Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competiveness as compared to the competitiveness of businesses in other states:

Chapter 22, Article 20 rules did not have an analyses submitted regarding the rule's impact on state business or compared to competitiveness of businesses in other states.

If applicable, has the agency completed the course of action indicated in the agency's previous five-year review:

The Administration is in process of completing the recommended course of action described in the previous 5yr report within the rulemaking proposed with an estimated effective date of fourth quarter 2017. We have not yet filed a request; we intend to do so later this summer.

Has there been a determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs

to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective:

The Administration believes the rules as written impose the least burden and costs when meeting their objectives.

A determination after analysis that the rule is not more stringent than a corresponding federal law. Are the rules more stringent than a corresponding federal law? Is there a statutory authority that exceeds the requirements of that federal law?:

The rules as written are not more stringent than federal law 42 U.S.C. 1320b-7, 42 U.S.C. 1396a, 42 U.S.C. 1396b(r)(3), and 42 U.S.C. 1396w-3.

Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization?

Not applicable, the Administration does not issue permits, license or agency authorization for the imposition of the BCCP program requirements.

Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend repeal or make a rule:

R9-22-2002 thru R9-22-2008 – The Administration intends to update these rules as recommended above by December 2016.