EXHIBIT G

DEPARTMENT OF HUMAN SERVICES, DIVISION OF COUNTY OPERATIONS

SUBJECT: Medical Services Policy Manual Section B-700 through B-730 Transitional Medicaid

DESCRIPTION:

Statement of Necessity

Federal law requires Medicaid programs to provide coverage for Transitional Medicaid (TM). This rule must be promulgated by DHS to ensure coverage for TM, which is required by 42 U.S.C. § 1396r-6. The TM program is for families who were previously receiving Parent/Caretaker Relative Medicaid coverage and lost it due to increased wages or increased hours of employment. The federal statute requires states to grant an initial 6-month period of eligibility under the TM program. An additional 6 months of eligibility may be granted after undergoing a review determination. This proposed rule outlines the program, the services available, eligibility, and reporting requirements.

The federal statute requiring the TM program, 42 U.S.C. § 1396r-6, previously contained a sunset provision, and as a result DHS allowed its TM program policy to lapse in 2014. After the implementation of the Affordable Care Act, it was unclear whether Congress would reauthorize the program as they had done in the past. In addition, the Centers for Medicare and Medicaid Services (CMS) expressed doubt in their communication with the states that the TM program would continue. However, CMS has now confirmed to DHS that the TM program is and will remain a federal requirement.

Rule Summary

Effective December 1, 2020, the Transitional Medicaid (TM) program will provide a temporary extension of Medicaid eligibility when a family was previously receiving Parent/Caretaker Relative Medicaid coverage and lost it due to increased wages or increased hours of employment. Medical Services Policy Section B-700 has been created to update the TM program procedure to follow Modified Adjusted Gross Income rules. The section includes extent of services and eligibility, as well as residence, employment, income, and reporting requirements for the initial 6-month period and the extension of the 6-month period.

PUBLIC COMMENT: No public hearing was held on these rules. The public comment period expired on September 12, 2020. The agency indicated that it received no public comments.

Lacey Johnson, an attorney with the Bureau of Legislative Research, asked the following questions and received the following responses:

1. Is CMS approval required for this rule? If so, what is the status on that approval?
RESPONSE: CMS approval is not required for this rule.

2. The financial impact statement indicates that DHS intends to use a 12 month initial Transitional Medicaid eligibility period rather than an initial 6 month eligibility period with an additional 6 months granted upon redetermination. However, the proposed rules appear to split eligibility into two 6-month periods. Could you explain this apparent discrepancy? **RESPONSE:** This was an error and corrected in the updated packet attached.

3. What is the source for the requirement that TM recipients have been residents of Arkansas in the last month of PCR Medicaid eligibility and continue to reside in Arkansas throughout the TM period (Sections B-710(3), B-725)? **RESPONSE:** 42 U.S. Code § 602 (B) Special Provisions (i) The document shall indicate whether the State intends to treat families moving into the State from another State differently than other families under the program, and if so, how the State intends to treat such families under the program.

4. Sections B-710(8) and B-755 indicate that the parent or caretaker relative must continue to be employed and receive earnings unless "good cause" exists. What does "good cause" mean in this context? **RESPONSE:** 42 U.S.C. § 1396r-6 (B) Reporting Requirements "State may permit such additional extended assistance under this subsection notwithstanding a failure to report under this clause if the family has established, to the satisfaction of the State, good cause for the failure to report on a timely basis." The state has defined good cause for other Medicaid requirements and those requirements will be the same for good cause in this context.

5. Section B-730 indicates that, if the only dependent child leaves home, TM eligibility will terminate at the end of the month and, once closed, the TM case cannot be reopened even if the child returns home. Is there a specific source for this provision? **RESPONSE:** This is a current business process that follows other MAGI categories where when ineligibility is determined coverage will end at the end of the month.

6. 42 U.S.C. § 1396r-6 requires reporting to occur by the twenty-first day of the fourth month. However, Sections B-735 and B-750 require notice and report forms to be returned by the fifth day of the fourth month. Is there a separate source for the fifth-day requirement? **RESPONSE:** Per 42 U.S.C. § 1396r-6 requires reporting to occur by the twenty-first day of the fourth month not on the twenty-first day. The fifth day follows our current business processes defined for reporting capabilities.

7. Sections B-735 and B-750 require TM recipients to report the household composition on the notice and report forms. What is the source for this requirement? **RESPONSE:** Per 42 U.S.C. § 1396r-6 under reporting requirements (page 3) and termination of extension (page 1) both list a dependent child therefore it is imperative we have house hold comp changes to ensure the dependent child still lives in the home.

8. Section B-735 indicates that a client must establish good cause to meet the reporting requirements if a report is received untimely. What constitutes good cause in this

context? **RESPONSE:** 42 U.S.C. § 1396r-6 states good cause satisfactory to the state. Good cause requirements have already been defined for other reporting requirements with Medicaid. Good cause in this context will follow the same business process defined for other Medicaid requirements that have good cause.

9. Section B-765 states that minor children entering the household who were not part of the household when the determination for TM was made will not be added to the case and that eligibility for this child will be determined in another category. What is the source for this provision? **RESPONSE:** Our agency has always interpreted 42 U.S.C. § 1396r-6 to mean that each family member had to be part of the household at the time of ineligibility to qualify for the TM extension.

The proposed effective date is December 1, 2020.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact.

Per the agency, this rule implements a federal rule or regulation. The cost to implement the federal rule or regulation is estimated at $2,686,230 for the current fiscal year ($769,605 in general revenue and $1,916,625 in federal funds) and $4,604,966 for the next fiscal year ($1,312,876 in general revenue and $3,292,090 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government as a result of this rule is $769,605 for the current fiscal year and $1,312,876 for the next fiscal year.

The agency indicated that this rule will result in a new or increased cost of at least $100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of those entities combined. Accordingly, the agency provided the following written findings:

(1) a statement of the rule's basis and purpose;

Some low-income families are eligible for Medicaid under Section 1931 of the Social Security Act. When these families become ineligible for Medicaid due to earnings, extended Medicaid coverage is required by 42 U.S.C. § 1396r-6.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

The agency seeks to resolve the problem that our current rules do not include the Transitional Medicaid Program. This rule is required by 42 U.S.C. § 1396r-6.

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and

Extended Medicaid services are mandatory under 42 U.S.C. § 1396r-6. The agency is required by federal regulations to offer this program.

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

42 U.S.C. § 1396r-6 allows states the option of using a 12 month initial Transitional Medicaid eligibility period rather than an initial 6 month eligibility period with an additional 6 months granted upon redetermination. Our current eligibility system is designed to provide 12 month eligibility periods for our MAGI categories. Using the two 6 month eligibility periods would require costly updates and system development. The 12 month eligibility period will allow us to automate the program using our current system rules.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

There are no less costly alternatives.

(5) a list of alternatives to the proposed rules that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

The proposed rule will be posted for public comment with the initial filing of this document.

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

Existing rules have had no impact on the proposed rule change.

(7) an agency plan for review of the rule no less than every ten years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Our agency is in constant contact with CMS to ensure that mandated changes are implemented as required. If a change is made to the federal statute governing the proposed rule, we will act immediately to make sure that we are achieving the statutory objectives and meeting the costs objectives.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark.

Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

These proposed rule changes implement 42 U.S.C. § 1396r-6, which addresses extensions of eligibility for medical assistance. Under certain conditions, this statute requires an initial six-month extension of eligibility followed by an additional six-month extension.

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL

DEPARTMENT/AGENCY Department of Human Services

DIVISION Division of County Operation

DIVISION DIRECTOR Mary Franklin

CONTACT PERSON Mac Golden

ADDRESS P. O. Box 1437, Slot S295 Little Rock, AR 72203-1437

PHONE NO. 501-563-7634 **FAX NO.** 501-404-4619 **E-MAIL** Mac.Golden@dhs.arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Mary Franklin

PRESENTER E-MAIL Mary.Franklin@dhs.arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Jessica C. Sutton
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

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1. What is the short title of this rule? Medical Services Policy Manual Sections B-700 through B-730 Transitional Medicaid.

2. What is the subject of the proposed rule? Promulgation of the Transitional Medicaid Assistance (TMA) program required by federal law.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☒ No ☐
   If yes, please provide the federal rule, regulation, and/or statute citation. 42 U.S.C. § 1396r-6

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act?
   Yes ☐ No ☒
   If yes, what is the effective date of the emergency rule? _____
   When does the emergency rule expire? _____
   Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act?
   Yes ☐ No ☐

5. Is this a new rule? Yes ☒ No ☐
If yes, please provide a brief summary explaining the regulation. _____

Does this repeal an existing rule? Yes ☐ No ☒
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. _____

Is this an amendment to an existing rule? Yes ☐ No ☒
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

See attached.

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Code §§ 20-76-201, 20-77-107, and 25-10-129

7. What is the purpose of this proposed rule? Why is it necessary? See Attached.

See attached.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).

http://humanservices.arkansas.gov/resources/legal-notices

9. Will a public hearing be held on this proposed rule? Yes ☐ No ☒
If yes, please complete the following:

Date: _____
Time: _____
Place: _____

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
September 12, 2020

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
December 1, 2020

12. Please provide a copy of the notice required under Ark. Code Ann. § 25-15-204(a). and proof of the publication of said notice. See Attached.

13. Please provide proof of filing the rule with the Secretary of State as required pursuant to Ark. Code Ann. § 25-15-204(e). See Attached.

14. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known. Unknown.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Brian Jones

TELEPHONE (501) 537-2064 **FAX** (501) 682-3889 **EMAIL:** Brian.jones@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Medical Services Policy Manual Sections B-700 through B-730 Transitional Medicaid

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost:

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	769,605	General Revenue	1,312,876
Federal Funds	1,916,625	Federal Funds	3,292,090
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total	2,686,230	Total	4,604,966

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$ 0	General Revenue	$ 0
Federal Funds	$ 0	Federal Funds	$ 0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 0	Total	$ 0

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**
$	$

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	**Next Fiscal Year**
$ 769,605	$ 1,312,876

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☒ No ☐

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose:

- Some low-income families are eligible for Medicaid under section 1931 of the Social Security Act. When these families become ineligible for Medicaid due to earnings, extended Medicaid coverage is required by 42 U.S.C. § 1396r-6.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

- The agency seeks to resolve the problem that our current rules do not include the Transitional Medicaid Program. This rule is required by 42 U.S.C. § 1396r-6.

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(a) justifies the agency's need for the proposed rule; and

- Extended Medicaid services are mandatory under 42 U.S.C. § 1396r-6. The agency is required by federal regulations to offer this program.

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

- 42 U.S.C. § 1396r-6 requires States to grant an initial 6-month period of eligibility under the TM program. An additional 6 months of eligibility may be granted after undergoing a review determination.

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- There are no less costly alternatives.

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(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

- Our agency is in constant contact with CMS to ensure that mandated changes are implemented as required. If a change is made to the federal statute governing the proposed rule, we will act immediately to make sure that we are achieving the statutory objectives, and meeting the costs objectives.

Statement of Necessity and Rule Summary

Medical Services Policy Manual B-700 Transitional Medicaid

Statement of Necessity

Federal law requires Medicaid programs to provide coverage for Transitional Medicaid (TM). This rule must be promulgated for DHS to ensure coverage for TM, which is required by 42 U.S.C. § 1396-r. The TM program is for families who were previously receiving Parent/Caretaker Relative Medicaid coverage and lost it due to increased wages or increased hours of employment. The federal statute requires States to grant an initial 6-month period of eligibility under the TM program. An additional 6 months of eligibility may be granted after undergoing a review determination. This proposed rule outlines the program, the services available, eligibility, and reporting requirements.

The federal statute requiring the TM program, 42 U.S.C. § 1396r-6, previously contained a sunset provision, and as a result DHS allowed its TM program policy to lapse in 2014. After the implementation of the Affordable Care Act, it was unclear whether Congress would reauthorize the program as they had done in the past. In addition, the Centers for Medicare and Medicaid Services (CMS) expressed doubt in their communications with the States that the TM program would continue. However, CMS has now confirmed to DHS that the TM program is and will remain a federal requirement.

Rule Summary

Effective December 1, 2020, the Transitional Medicaid (TM) program will provide a temporary extension of Medicaid eligibility when a family was previously receiving Parent/Caretaker Relative Medicaid coverage and lost it due to increased wages or increased hours of employment. Medical Services Policy Section B-700 has been created to update the TM Program procedure to follow Modified Adjusted Gross Income rules. The section includes extent of services and eligibility, as well as residence, employment, income, and reporting requirements for the initial 6-month period and the extension of the additional 6-month period.

NOTICE OF RULE MAKING

The Director of the Division of Medical Services of the Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-76-201, 20-77-107, and 25-10-129.

Effective December 1, 2020:

Federal law, 42 U.S.C. § 1396-r, requires Medicaid programs to provide coverage for Transitional Medicaid (TM), which is a temporary extension of Medicaid eligibility when a family was previously receiving Parent/Caretaker Relative Medicaid coverage and lost it due to increased wages or increased hours of employment. The federal statute requires States to grant an initial 6-month period of eligibility, and a possible additional 6 months of eligibility after a review determination. Medical Services Policy Section B-700 has been created to update the TM Program procedure to follow Modified Adjusted Gross Income rules. The section includes extent of services and eligibility, as well as residence, employment, income, and reporting requirements for the initial 6-month period and the extension of the additional 6-month period.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule on the Medicaid website at https://medicaid.mmis.arkansas.gov/General/Comment/Comment.aspx. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than **September 12, 2020**. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-320-6266.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4501960528

Mary Franklin, Director
Division of County Operations