

Dear Senators HEIDER, Nuxoll, Schmidt, and
Representatives WOOD, Packer, Rusche:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of
the Department of Health and Welfare:

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Temporary and Proposed Rule (Docket No.
16-0310-1601);

IDAPA 16.03.18 - Medicaid Cost-Sharing - Temporary and Proposed Rule (Docket No.
16-0318-1601).

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the
cochairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research
and Legislation no later than fourteen (14) days after receipt of the rules' analysis from Legislative
Services. The final date to call a meeting on the enclosed rules is no later than 06/23/2016. If a meeting is
called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules' analysis
from Legislative Services. The final date to hold a meeting on the enclosed rules is 07/22/2016.

The germane joint subcommittee may request a statement of economic impact with respect to a
proposed rule by notifying Research and Legislation. There is no time limit on requesting this statement,
and it may be requested whether or not a meeting on the proposed rule is called or after a meeting has
been held.

To notify Research and Legislation, call 334-4834, or send a written request to the address on the
memorandum attached below.



Eric Milstead
Director

Legislative Services Office

Idaho State Legislature

Serving Idaho's Citizen Legislature

MEMORANDUM

TO: Rules Review Subcommittee of the Senate Health & Welfare Committee and the House Health & Welfare Committee

FROM: Senior Legislative Research Analyst - Elizabeth Bowen

DATE: June 06, 2016

SUBJECT: Department of Health and Welfare

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Temporary and Proposed Rule (Docket No. 16-0310-1601)

IDAPA 16.03.18 - Medicaid Cost-Sharing - Temporary and Proposed Rule (Docket No. 16-0318-1601)

The Department of Health and Welfare submits notice of rulemaking at IDAPA 16.03.10 and 16.03.18.

IDAPA 16.03.10

This is a temporary and proposed rule that revises an existing rule in order to implement a two-tiered routine home care reimbursement for Medicaid hospice providers. The first rate tier will apply for the first sixty days of hospice care, and the second rate tier, which includes a reduced rate, will apply from the sixty-first day of hospice care until the end of hospice care. Additionally, the rule imposes a service intensity add-on payment that will apply to visits by a registered nurse or social worker in the last seven days of a patient's life. The purpose of the temporary and proposed rule is to conform the rule to recent changes in the Code of Federal Regulations at 42 CFR 418.302. Justification for the temporary rule was found by the Governor in that the rule aligns state rules with federal regulations.

Negotiated rulemaking was not conducted due to the nature of the rule change. The Department states that the temporary and proposed rule is consistent with the authority granted by Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266 of the Idaho Code. The annual anticipated fiscal impact to the state general fund is \$64,000; the remaining \$149,000 anticipated in annual expenditures will come from federal matching funds.

IDAPA 16.03.18

This is a temporary and proposed rule that revises an existing rule in order to increase the personal needs allowance for Medicaid participants who are responsible for their own mortgage payments or rent. Specifically, the rule increases the personal needs allowance from 150% of the federal Supplemental Security Income (SSI) amount to 180% of the SSI amount. The purpose of the rule is to address the increases in housing and utility expenses in Idaho. Justification for the temporary rule was found by the Governor in that the rule confers a benefit.

Mike Nugent, Manager
Research & Legislation

Cathy Holland-Smith, Manager
Budget & Policy Analysis

April Renfro, Manager
Legislative Audits

Glenn Harris, Manager
Information Technology

Negotiated rulemaking was not conducted this year but was conducted last year for this rule on a docket that was eventually cancelled. The Department has apprised stakeholders that the rule is moving forward this year. The Department states that the temporary and proposed rule is consistent with the authority granted by Sections 56-253 and 56-257 of the Idaho Code. The anticipated fiscal impact to the state general fund is \$443,337 per year, with additional costs being covered by federal matching funds.

cc: Department of Health and Welfare
Tamara Prisock

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1601

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2016.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code, and 42 CFR 418.302.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Monday, June 13, 2016 - 3:00 p.m. (MDT)

**Medicaid Central Office
3232 W. Elder Street
Conf. Room D -- West/East
Boise, ID**

The hearing site will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

These rule changes implement a two-tiered routine home care reimbursement for Medicaid hospice providers, and add a new service intensity add-on payment to the hospice payment methodology for Medicaid. This will align this chapter of rules with recent changes in federal regulations (42 CFR 418.302).

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate as this rulemaking aligns this chapter of rules with recent changes in federal regulations (42 CFR 418.302) due to go into effect January 1, 2016.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year as a result of this rulemaking:

There is an estimated increase of \$213,000 in annual aggregate expenditures as a result of this rulemaking. \$64,000 of this will come from the State General Fund; the remaining \$149,000 will come from federal matching funds.

The associated system changes needed are minor and will occur within existing business processes and funding.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is Temporary and brings the chapter into alignment with recent changes to federal regulation.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Cale Coyle at (208) 364-1817.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 22, 2016.

DATED this 6th Day of May, 2016.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

**THE FOLLOWING IS THE TEMPORARY RULE AND THE PROPOSED TEXT
OF DOCKET NO. 16-0310-1601
(Only Those Sections With Amendments Are Shown.)**

456. HOSPICE: PROVIDER REIMBURSEMENT.

With the exception of payment for physician services under Section 458 of these rules, Medicaid reimbursement for hospice care will be made at one (1) of ~~four~~ five (45) predetermined rates for each day in which a participant receives the respective type and intensity of the services furnished under the care of the hospice. The ~~four~~ five (45) rates are prospective rates; there will be no retroactive rate adjustments other than the application of the "cap" on overall payments, the service intensity add-on, and the limitation on payments for inpatient care, if applicable. A description of the payment for each level of care is described in Subsections 456.01 through 456.04 of these rules.

~~(3-19-07)~~(1-1-16)T

01. Routine Home Care. The hospice provider will be paid ~~the~~ one (1) of two (2) routine home care rates for each day the patient is in residence, under the care of the hospice, and not receiving continuous home care. ~~This~~ rate is paid without regard to the volume or intensity of routine home care services provided on any given day. The two-rate payment methodology will result in a higher based payment for days one (1) through sixty (60) of hospice care and a reduced rate for days sixty-one (61) to end-of-care. If a participant leaves hospice care and then later is placed back on hospice care, regardless of hospice provider, a minimum of a sixty (60) day gap in hospice services is required in order for the routine home care rate to be paid at the higher base payment rate. If there is not a minimum of a sixty (60) day gap in hospice services being provided, the hospice provider will be paid at the rate for which the participant is qualified.

~~(3-19-07)~~(1-1-16)T

02. Continuous Home Care. Continuous home care is to be provided only during a period of crisis. A period of crisis is a period in which a patient requires continuous care which is primarily nursing care to achieve palliation and management of acute medical symptoms. Care must be provided by either a registered nurse or a licensed practical nurse and a nurse must provide care for at least half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day which begins and ends at midnight. This care need not be continuous and uninterrupted. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to twenty-four (24) hours per day.

(3-19-07)

03. Inpatient Respite Care. The hospice will be paid at the inpatient respite care rate for each day that the participant is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five (5) days at a time including the date of admission but not counting the date of discharge in any monthly election period. Payment for the sixth and any subsequent day is to be made at the appropriate rate routine,

continuous, or general inpatient rate. (3-19-07)

04. General Inpatient Care. Payment at the inpatient rate will be made when general inpatient care is provided. No other fixed payment rates will be applicable for a day on which the participant receives hospice general inpatient care except as described in Section 458 of these rules. (3-19-07)

a. Date of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged as deceased, the inpatient rate, either general or respite, is to be paid for the discharge date. (3-19-07)

b. Hospice payment rates. The Medicaid hospice payment rates are the same as the Medicare hospice rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. Under the Medicaid hospice benefit, no cost sharing may be imposed with respect to hospice services rendered to Medicaid participants. (3-19-07)

c. Obligation of continuing care. After the participant's hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide that participant's care until the patient expires or until the participant revokes the election of hospice care. (3-19-07)

05. Service Intensity Add-On. For hospice services with dates of service on and after January 1, 2016, a service intensity add-on payment will be made for a visit by a registered nurse (RN) or social worker when provided in the last seven (7) days of life. Payment for the service intensity add-on is in addition to the routine home care rate and is calculated by multiplying the continuous home care rate per fifteen (15) minutes by the number of units for the combined visits for the day. Payment must not exceed sixteen (16) units per day, and is adjusted for geographic differences in wages. Phone time for a provider's social worker is not eligible for a service intensity add-on payment. (1-1-16)T

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The Federal Register

The Daily Journal of the United States Government

Rule

Medicare Program; FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

A Rule by the [Centers for Medicare & Medicaid Services](#) on [08/06/2015](#)

Action

Final Rule.

Summary

This final rule will update the hospice payment rates and the wage index for fiscal year (FY) 2016 (October 1, 2015 through September 30, 2016), including implementing the last year of the phase-out of the wage index budget neutrality adjustment factor (BNAF). Effective on January 1, 2016, this rule also finalizes our proposals to differentiate payments for routine home care (RHC) based on the beneficiary's length of stay and implement a service intensity add-on (SIA) payment for services provided in the last 7 days of a beneficiary's life, if certain criteria are met. In addition, this rule will implement changes to the aggregate cap calculation mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), align the cap accounting year for both the inpatient cap and the hospice aggregate cap with the federal fiscal year starting in FY 2017, make changes to the hospice quality reporting program, clarify a requirement for diagnosis reporting on the hospice claim, and discuss recent hospice payment reform research and analyses.

- Health facilities
- Hospice care
- Medicare
- Reporting and recordkeeping requirements

For the reasons set forth in the preamble, the Centers for Medicare and Medicaid Services amends 42 CFR chapter IV as set forth below:

begin regulatory text

PART 418—HOSPICE CARE

1.The authority citation for part 418 continues to read as follows:

Authority:

Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh)

Subpart G—Payment for Hospice Care

2.Section 418.302 is amended by—

a. Adding paragraph (b)(1)(i) and (ii).

b. Amending paragraphs (d)(1), (d)(2), (e) introductory text, (f)(2) and (f)(5)(ii) by removing the word “intermediary” and adding in its place the words “Medicare Administrative Contractor”.

c. Revising paragraph (e)(1).

The revisions and additions read as follows:

§ 418.302 Payment procedures for hospice care.

* * * * *

(b)

(1) * * *

(i) *Service intensity add-on.* Routine home care days that occur during the last 7 days of a hospice election ending with a patient discharged due to death are eligible for a service intensity add-on payment.

(ii) The service intensity add-on payment shall be equal to the continuous home care hourly payment rate, as described in paragraph (e)(4) of this section, multiplied by the amount of direct patient care actually provided by a RN and/or social worker, up to 4 hours total per day.

* * * * *

(e) * * *

(1) Payment is made to the hospice for each day during which the beneficiary is eligible and under the care of the hospice, regardless of the amount of services furnished on any given day (except as set out in paragraph (b)(1)(i) of this section).

* * * * *

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.18 - MEDICAID COST-SHARING

DOCKET NO. 16-0318-1601

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2016.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-253 and 56-257, Idaho Code, and 42 CFR 435.726.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be held as follows:

Friday, June 10, 2016 2:00 p.m. (MDT)	Friday, June 10, 2016 2:00 p.m. (PDT)	Wednesday, June 22, 2016 2:00 p.m. (MDT)
Medicaid Central Office 3232 W. Elder Street Conf. Rm D - West/East Boise, ID	Medicaid Reg. II Office 1118 "F" Street 3rd Floor Conference Room Lewiston, ID	Medicaid Reg. VII Office 150 Shoup Avenue Large Conference Room 2nd Floor Idaho Falls, ID

The hearing site will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Advocates for Idaho residents with disabilities requested the Department review the Personal Needs Allowance (PNA) amounts used in the financial eligibility calculation for those Medicaid participants who reside in the community and who are responsible for their own rent or mortgage expenses. The Department has determined that while the Supplemental Security Income (SSI) amount is adjusted annually by the Social Security Administration to account for cost of living increases, it has not kept pace with the increase of housing and utility expenses in Idaho.

To address this, these rule changes increase the Personal Needs Allowance from 150% of the federal SSI amount to 180% of the federal SSI amount for eligible waiver participants who incur a mortgage or rent expense.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate as this rulemaking confers a benefit to Home and Community Based Services waiver participants.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: NA

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year as a result of this rulemaking:

The total anticipated cost of this rule change is projected to be \$1,524,158 per year, due to the reduced participant Share of Cost for Medicaid waiver services. The SFY17 blended rate Federal Medical Assistance Percentage (FMAP) is 70.91%. The impact to the state general fund is projected to be \$443,377 per year, based on current participant counts. This rule change will result in an increased cost of \$443,337 per year in state general funds and \$1,080,780 in federal dollars.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking is not being conducted for this docket because negotiated rulemaking for these rule changes was held last year -- see the Notice of

Negotiated Rulemaking in the July 1, 2015, [Idaho Administrative Bulletin - Vol. 15-7, p. 58](#). (This docket was originally planned for 2015, but was canceled). Since then, the Department has been working with stakeholders informally and has notified them that the changes they negotiated last year are moving forward again under this temporary and proposed rule docket.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Ali Fernández at (208) 287-1156.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 22, 2016.

DATED this 6th Day of May, 2016.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

**THE FOLLOWING IS THE TEMPORARY RULE AND THE PROPOSED TEXT
OF DOCKET NO. 16-0318-1601
(Only Those Sections With Amendments Are Shown.)**

400. PARTICIPATION IN THE COST OF HOME AND COMMUNITY-BASED WAIVER SERVICES.

Medicaid participants required to participate in the cost of Home and Community-Based Waiver (HCBS) services as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," must have their share of cost determined as described in Subsections 400.01 through 400.10 of this rule. (3-19-07)

01. Excluded Income. Income excluded under the provisions of IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Sections 723 and 725, is excluded in determining participation. (3-19-07)

02. Base Participation. Base participation is income available for participation after subtracting all allowable deductions, except for the incurred medical expense deduction in Subsection 400.07 of this rule. Base participation is calculated by the participant's Self Reliance Specialist. The incurred medical expense deduction is calculated by the Regional Medicaid Services (RMS). (3-19-07)

03. Community Spouse. Except for the elderly or physically disabled participant's personal needs allowance, base participation for a participant with a community spouse is calculated under IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 725. A community spouse is the spouse of an HCBS participant who is not an HCBS participant and is not institutionalized. The HCBS personal needs allowance for a participant living in adult residential care equals the federal Supplemental Security Income (SSI) benefit rate for an individual living independently. (3-19-07)

04. Home and Community Based Services (HCBS) Spouse. Except for the elderly or physically disabled participant's personal needs allowance (PNA), base participation for a participant with an HCBS spouse is calculated and specified under IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and

Disabled (AABD),” Section 723. An HCBS spouse is the spouse of a participant who also receives HCBS. (3-19-07)

05. Personal Needs Allowance. The participant's personal needs allowance depends on his marital status and legal obligation to pay rent or mortgage. The participant's personal needs allowance is deducted from his income after income exclusions and before other allowable deductions. To determine the amount of the personal needs allowance, use Table 400.05 of this rule:

TABLE 400.05 - PERSONAL NEEDS ALLOWANCE			
Amount of Personal Needs Allowance (PNA) for Participation			
Not Responsible for Rent or Mortgage		Responsible for Rent or Mortgage	
Marital Status	PNA	Marital Status	PNA
No Spouse	One-hundred percent (100%) of the federal SSI benefit for a person with no spouse	No Spouse	One-hundred and fifty eighty percent (150 %) of the Federal SSI benefit for a person with no spouse
Married with Community Spouse	One-hundred and fifty percent (150%) of the Federal SSI benefit for a person with no spouse	Married with Community Spouse	One-hundred and fifty eighty percent (150 %) of the Federal SSI benefit for a person with no spouse
Married with HCBS Spouse	One-hundred percent (100%) of the Federal SSI benefit for a person with no spouse. Each spouse receives this amount as his PNA.	Married with HCBS Spouse	One-hundred and fifty eighty percent (150 %) of the Federal SSI benefit for a single person. Each spouse receives this amount as his PNA.

~~(3-19-07)~~(7-1-16)T

06. Developmentally Disabled Participants. These allowances are specified in IDAPA 16.03.05, “Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD).” The HCBS personal needs allowance for adult participants receiving waiver services under the Developmentally Disabled Waiver is three (3) times the federal SSI benefit amount to an individual in his own home. (3-19-07)

07. Incurred Medical Expenses. Amounts for certain limited medical or remedial services not covered by the Idaho Medicaid Plan and not paid by a third party may be deducted from the base participation amount. The Department must determine whether a participant’s incurred expenses for such limited services meet the criteria for deduction. The participant must report such expenses and provide verification in order for an expense to be considered for deduction. Costs for over-the-counter medications are included in the personal needs allowance and will not be considered a medical expense. Deductions for necessary medical or remedial expenses approved by the Department will be deducted at application, and changed, as necessary, based on changes reported to the Department by the participant. (3-19-07)

08. Remainder After Calculation. Any remainder after the calculation in Subsection 400.05 of this rule is the maximum participation to be deducted from the participant's provider payments to offset the cost of services. The participation amount will be collected from the participant by the provider. The provider and the participant will be notified by the Department of the amount to be collected. (3-19-07)

09. Recalculation of Participation. The participant’s participation amount must be recalculated annually at redetermination or whenever a change in income or deductions becomes known to the Department. (3-19-07)

10. Adjustment of Participation Overpayment or Underpayment Amounts. The participant’s participation amount is reduced or increased the month following the month the participant overpaid or underpaid the provider. (3-19-07)

42 CFR 435.726 - Post-eligibility treatment of income of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

- [CFR](#)
- [eCFR](#)
- [Authorities \(U.S. Code\)](#)

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§ 435.726 Post-eligibility treatment of income of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

(a) The agency must reduce its payment for home and community-based services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) of this section from the individual's income.

(b) This section applies to individuals who are eligible for Medicaid under § [435.217](#) and are receiving home and community-based services furnished under a waiver of Medicaid requirements specified in part [441](#), subpart G or H of this subchapter.

(c) In reducing its payment for home and community-based services, the agency must deduct the following amounts, in the following order, from the individual's total income (including amounts disregarded in determining eligibility):

(1) An amount for the maintenance needs of the individual that the State may set at any level, as long as the following conditions are met:

(i) The deduction amount is based on a reasonable assessment of need.

(ii) The State establishes a maximum deduction amount that will not be exceeded for any individual under the waiver.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement beneficiaries under § [435.230](#); or

(iii) The amount of the medically needy income standard for one person established under §§ [435.811](#) and [435.814](#), if the agency provides Medicaid under the medically needy coverage option.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's AFDC plan or the medically needy income standard established under § [435.811](#) for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

[[46 FR 48539](#), Oct. 1, 1981, as amended at [50 FR 10026](#), Mar. 13, 1985; [57 FR 29155](#), June 30, 1992; [58 FR 4932](#), Jan. 19, 1993; [59 FR 37715](#), July 25, 1994]

This is a list of [United States Code](#) sections, Statutes at Large, Public Laws, and Presidential Documents, which provide rulemaking authority for this CFR Part.

[Hide U.S. Code: Title 42 - THE PUBLIC HEALTH AND WELFARE](#)

[§ 1302 - Rules and regulations; impact analyses of Medicare and Medicaid rules and regulations on small rural hospitals](#)

[§ 1396a - State plans for medical assistance](#)

[§ 1396b - Payment to States](#)

[§ 1396k - Assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State](#)