

NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the Register 1st as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the Arizona Administrative Register after the final rules have been submitted for filing and publication.

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TITLE 9. HEALTH SERVICES

CHAPTER 29. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
QUALIFIED MEDICARE BENEFICIARY (QMB)

PREAMBLE

1. Sections Affected

R9-29-101
R9-29-201
R9-29-202
R9-29-202
R9-29-203
R9-29-203
R9-29-204
R9-29-301
R9-29-302
R9-29-401
R9-29-402
R9-29-403
R9-29-404
R9-29-501
R9-29-502
R9-29-503
R9-29-504
R9-29-601
R9-29-602

Rulemaking Action

Amend
Amend
Repeal
New Section
Repeal
New Section
Repeal
Amend
Amend
Amend
Repeal
Repeal
Repeal
Repeal
Amend
Amend
Amend
Repeal
Amend
Amend

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

Authorizing statute: A.R.S. §§ 36-2903.01(H), 36-2932(P), and 36-2972(B)

Implementing statute: A.R.S. §§ 36-2903.03, 36-2904(H), 36-2907, 36-2931, 36-2939, 36-2971, 36-2972, 36-2973, 36-2974, and 36-2975

3. The effective date of the rules:

April 14, 1998

4. A list of all previous notices appearing in the Register addressing the final rule:

Notice of Rulemaking Docket Opening: 3 A.A.R. 3497, December 12, 1997.

Notice of Proposed Rulemaking: 3 A.A.R. 3533, December 19, 1997.

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

Name: Cheri Tomlinson, Federal and State Policy Administrator
Address: AHCCCS Administration, Office of Policy Analysis and Coordination
801 East Jefferson, Mail Drop #4200
Phoenix, Arizona 85034
Telephone: (602) 417-4198
Fax: (602) 256-6756

6. An explanation of the rule, including the agency's reasons for initiating the rule:

Changes are proposed to the 6 Articles in 9 A.A.C. 29, Qualified Medicare Beneficiary (QMB) as a result of the recommendations in the previous 5-year-review report. The changes are also designed to provide additional clarity, conciseness, and under-

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standability to the Chapter. This Chapter provides guidelines and requirements for the Administration, contractors, and providers to utilize in the coordination and delivery of services to QMB eligible individuals.

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

Not applicable.

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

The economic impact is nominal because the changes are designed to:

- Implement recommendations from the previous 5-year-review report;
- Update citations to federal and state law and regulation;
- Align and cross-reference with AHCCCS acute care rules, whenever appropriate and possible;
- Clarify that as a result of recent changes regarding prior period coverage, the Administration or a Medicare risk contractor is responsible for recoupment of funds as specified in contract;
- Clarify and modify language to conform to actual agency practice; and
- Simplify language to make the rules more user friendly.

The primary beneficiaries of the improvements made to the Article include:

- The AHCCCS Administration;
- AHCCCS contractors, including AHCCCS health plans and ALTCS program contractors;
- The AHCCCS TPL contractor;
- AHCCCS and ALTCS providers; and
- AHCCCS and ALTCS members.

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

The changes between the proposed rules and the final rules are grammatical, verb tense, punctuation and minor wording changes to make the rules more clear, concise, and understandable.

10. A summary of the principal comments and the agency response to them:

There was 1 formal public comment received. A commenter wanted to know how do AHCCCS health plans coordinate benefits for QMB duals when Medicare risk plans have low to no out-of-pocket copayments. The question was procedural in nature and did not require a rule change. The health plans do not pay deductibles and copayments or premiums assessed by Medicare HMO's for dual eligibles, per contract.

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

Not applicable.

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

- 42 U.S.C. § 1396d(p), August 5, 1997, incorporated in R9-29-201
- 42 CFR 435, Subpart J, incorporated in R9-29-201
- 42 CFR 435.403, incorporated in R9-29-201
- 42 CFR 431.210, incorporated in R9-29-203
- 42 CFR 431.211, incorporated in R9-29-203
- 42 CFR 431.213, incorporated in R9-29-203
- 42 CFR 435.919, incorporated in R9-29-203

13. Was this rule previously adopted as an emergency rule?

No.

14. The full text of the rules follows:

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TITLE 9. HEALTH SERVICES

**CHAPTER 29. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
QUALIFIED MEDICARE BENEFICIARY (QMB)**

ARTICLE 1. DEFINITIONS

Section

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ARTICLE 5. GRIEVANCE AND APPEAL PROCESS

R9-29-501. Eligibility appeals and hearing requests for applicants or recipients of QMB services General Provisions for All Grievance and Appeals
R9-29-502. Member grievances Eligibility Appeals and Hearing Requests for Applicants or Recipients of QMB Services
R9-29-503. Nonmember grievances Grievances
R9-29-504. Program contractor, health plan, provider, noncontracting provider, nonprovider and TPA grievances Repealed

ARTICLE 6. THIRD-PARTY 1ST- AND 3RD-PARTY LIABILITY AND RECOVERIES

R9-29-601. Third party liability and coordination of benefits 1st- and 3rd-Party Liability and Coordination of Benefits
R9-29-602. Third party liability monitoring and compliance 1st- and 3rd-Party Liability Monitoring and Compliance

ARTICLE 1. DEFINITIONS

R9-29-101. Definitions

The following words and phrases, in addition to definitions contained in A.R.S. § 36-2971, have the following meanings unless the context of the Chapter explicitly requires another meaning:

1. "1st-party liability" has the meaning in 9 A.A.C. 22, Article 1.
2. "3rd party" has the meaning in 9 A.A.C. 22, Article 1.
3. "3rd-party liability" has the meaning in 9 A.A.C. 22, Article 1.

- 1-4. "AHCCCS" means the Arizona Health Care Cost Containment System as authorized by A.R.S. § 36-2901 et seq. has the meaning in 9 A.A.C. 22, Article 1.
- 2-5. "ALTCS" means the Arizona Long Term Care System as authorized by A.R.S. § 36-2931 et seq.
- 3-6. "CFR" means the Code of Federal Regulations, October 1, 1988, edition, unless otherwise specified in this Chapter.
7. "Contractor" has the meaning in 9 A.A.C. 22, Article 1.
8. "Dual eligible" has the meaning in A.R.S. § 36-2971.
- 4-9. "Enrollment" means the process by which a person who has been determined eligible becomes a member with an AHCCCS health plan or an ALTCS program contractor. has the meaning in 9 A.A.C. 22, Article 1.
5. "Federal poverty guidelines" means the federal statistical poverty thresholds published annually by the United States Department of Health and Human Services.
6. "Health plan" means an organization or entity participating in AHCCCS on a prepaid capitation basis that contracts with the Administration to provide AHCCCS-covered services. In AHCCCS contracts for the provision of state assisted care, health plans are referred to as "contractors."
7. "Institutionalized individual" means an individual who is in a medical institution or nursing facility and receiving an appropriate level of care at a nursing facility (NF) or intermediate care facility—mentally retarded (ICF-MR) or who receives, or will receive, home and community-based services (HCBS).
8. "MCCA" means the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, July 1, 1988, as amended by the Family Support Act of 1988, Public Law 100-485, October 13, 1988, and the Technical and Miscellaneous Revenue Act of 1988, Public Law 100-647, November 10, 1988.
- 9-10. "Program contractor" means a county or group of counties, the Arizona Department of Economic Security or any other person that contracts with the Administration to provide ALTCS-covered services. has the meaning in A.R.S. § 36-2971.
- 10-11. "QMB" "OMB-only" means Qualified Medicare Beneficiary only and is defined in A.R.S. § 36-2971.
11. "Third Party Administrator or TPA" means an organization or entity that contracts with the Administration to coordinate the payment of deductibles and coinsurance amounts for QMB-eligible persons not otherwise AHCCCS-eligible to obtain coverage or secure benefits authorized by A.R.S. Title 36, Chapter 29, Article 3.

ARTICLE 2. ELIGIBILITY AND ENROLLMENT

- R9-29-201. General provisions Provisions of OMB Eligibility**
- A. Applications shall be processed and eligibility determined by the Administration shall process applications and determine eligibility in accordance with 42 U.S.C. § 1396d(p) August 5, 1997, and 42 CFR 435, Subpart J, and Section 1905(p) of the Social Security Act, November 10, 1988, incorporated by reference herein and on file with the Office of the Secretary of State, incorporated by reference and on file with the Administration and the Office of the Secretary of

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State. This incorporation by reference contains no future editions or amendments.

- B.** Individuals who meet the requirements set forth in this Section and R9-29-202 shall be determined eligible to receive QMB benefits.
- B.** Eligibility for OMB benefits becomes effective the 1st day of the month following the month in which an eligibility decision is made.
- C.** In accordance with A.R.S. § 36-2903.03, an individual shall be a U.S. citizen or have qualified alien status to be eligible for OMB benefits.
- D.** All OMB members shall be residents of Arizona in accordance with 42 CFR 435.403, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

R9-29-202. Conditions of QMB eligibility OMB Enrollment

- A.** U.S. citizenship or legal alienage shall be a condition of eligibility for QMB benefits in accordance with 42 CFR 435.402, incorporated by reference herein and on file with the Office of the Secretary of State.
- B.** All QMB members shall be residents of Arizona in accordance with 42 CFR 435.403, incorporated by reference herein and on file with the Office of the Secretary of State.
- C.** Institutionalized individuals who, for the purpose of being determined eligible for QMB, transferred assets for less than the fair market value shall be subject to disqualification from eligibility as follows:
 - 1. The disqualification period for transfers occurring prior to July 1, 1988, shall be calculated in accordance with Section 1917(e)(1) of the Social Security Act, December 22, 1987, incorporated by reference herein and on file with the Office of the Secretary of State.
 - 2. The disqualification period for non-interspousal transfers occurring on or after July 1, 1988, and interspousal transfers occurring on or after October 1, 1989, shall be calculated in accordance with Section 1917(e)(1) of the Social Security Act, as amended by Sections 303(b) and (c) of the MCCA, incorporated by reference herein and on file with the Office of the Secretary of State.
 - 3. The disqualification period for interspousal transfers occurring prior to October 1, 1989, shall be calculated in accordance with paragraph (1).

Dual eligibles shall be enrolled or remain enrolled with the health plan, program contractor, or fee-for-service network in accordance with the provisions specified in 9 A.A.C. 22 and 9 A.A.C. 28.

R9-29-203. QMB enrollment OMB Discontinuance

Dual eligibles shall be enrolled or remain enrolled with the health plan, program contractor or fee-for-service network as appropriate.

- A.** The Administration shall provide notice of discontinuance in accordance with 42 CFR 431.210, 431.211, 431.213, and 435.919 to members who become ineligible for QMB benefits, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
- B.** The Administration shall discontinue immediately and without notice members who lose OMB eligibility due to death; discontinuance shall be effective the day after the date of death.
- C.** A member shall lose OMB eligibility due to incarceration and shall be discontinued the date the Administration is notified.

R9-29-204. QMB discontinuance and disenrollment Repealed

- A.** ~~Members who become ineligible for QMB benefits shall receive notice of discontinuance in accordance with Section 2 of the Computer Matching and Privacy Protection Act of 1988, Public Law 100-503, October 18, 1988, or 42 CFR 431.210, 431.211, 431.213, and 435.919, incorporated by reference herein and on file with the Office of the Secretary of State.~~
- B.** ~~Members who lose QMB eligibility due to death shall be discontinued immediately; discontinuance shall be effective the day after the date of death.~~
- C.** ~~Members who lose eligibility for QMB due to any other reason shall be discontinued from QMB after appropriate discontinuance notice has been given pursuant to subsection (A).~~

ARTICLE 3. COVERED BENEFITS AND SERVICES

R9-29-301. Qualified Medicare Beneficiary only Only

- A.** A person determined eligible as a QMB-only shall be entitled to may receive the following benefits and services:
 - 1. Payment of Medicare Part A premiums, coinsurance, and deductibles;
 - 2. Payment of Medicare Part B premiums, coinsurance, and deductibles; and
 - 3. Medicare-covered services defined in 42 CFR 409 and 410.410, incorporated by reference herein and on file with the Office of the Secretary of State.
- B.** A person determined eligible as a QMB-only who receives covered services from a provider that does not accept Medicare assignment shall be is entitled to coverage of the coinsurance and deductible up to and not exceeding the Medicare-approved amount. The AHCCCS Administration shall make Payment payment of the coinsurance and deductible shall be made for a QMB-only member only to the provider, and under Under no circumstances shall the AHCCCS Administration make such a coinsurance or deductible payment to a QMB-only member. If there is The QMB-only member is responsible for any balance due to the provider after reimbursement of the applicable coinsurance and deductible by the AHCCCS Administration, then payment of that amount is the responsibility of the member. the The AHCCCS Administration shall have no liability for any balance.

R9-29-302. Qualified Medicare Beneficiary with dual eligibility Dual Eligibility

- A.** A person determined dual eligible shall be entitled to may receive the following benefits and services:
 - 1. The benefits and services described in R9-29-301; and
 - 2. Medical services and provisions as specified in A.A.C. Title 9, Chapter 22, Article 2, R9-22-Article 2, subject to the limitations and exclusions specified specified limitations and exclusions therein or services and provisions as specified in A.A.C. Title 9, Chapter 28, Article 2; R9-28-Article 2, subject to the limitations and exclusions specified specified limitations and exclusions therein.
- B.** The AHCCCS Administration may deny Payment payment for covered benefits and services may be denied when: if:
 - 1. The Services services are not obtained within the member's health plan or program contractor or fee-for-service network-network; or
 - 2. The Services-services are not provided in conformance with the provisions as specified in the 9 A.A.C. 22 or 9 A.A.C. 28.

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- C. A person determined dual eligible who receives covered services from a provider within the health plan, program contractor, or fee-for-service network, and which services were authorized by the health plan, program contractor or the AHCCCS Administration Office of the Medical Director, shall have no liability shall not be liable for any coinsurance or deductibles associated with those services.

**ARTICLE 4. HEALTH PLAN, PROVIDER AND PROGRAM CONTRACTOR REQUIREMENTS
CONTRACTOR, PROVIDER, NONPROVIDER, AND NONCONTRACTING PROVIDER REQUIREMENTS**

R9-29-401. Health plans and other providers Contractor, Provider, Nonprovider, and Noncontracting Provider Requirements

- A. Health plans Contractors and other providers shall be responsible for providing the covered services specified in R9-29-302 to dual eligible and enrolled OMB-only members in accordance with the provisions as specified in 9 A.A.C. 22.
- B. Program contractors and other providers shall be responsible for providing the covered services specified in R9-29-302 to dual eligible and OMB-only members as specified in 9 A.A.C. 28.
- C. Nonproviders and noncontracting providers shall submit all claims for services rendered to a dual eligible and OMB-only member including claims for copayments, as specified in A.R.S. § 36-2904(H).
- D. The Administration or a Medicare risk contractor shall be responsible for recoupment of funds as specified in contract.

R9-29-402. Program contractors and other providers Repealed

Program contractors and other providers shall be responsible for providing the covered services specified in R9-29-302 to dual eligible and enrolled members in accordance with the provisions specified in A.A.C. Title 9, Chapter 28.

R9-29-403. Nonproviders and noncontracting providers Repealed

Nonproviders and noncontracting providers shall submit clean claims as defined by A.R.S. § 36-2904(H) for the co-insurance and deductibles to the AHCCCS Administration, the Third Party Administrator or other designated representative. Payment shall be limited to the lesser of the Medicare maximum allowable amount or the AHCCCS capped fee-for-service rate for such services.

R9-29-404. Physician services Repealed

Primary care physicians (PCPS) who are obstetricians or gynecologists shall only be PCPs for pregnant females.

ARTICLE 5. GRIEVANCE AND APPEAL PROCESS

R9-29-501. Eligibility appeals and hearing requests for applicants or recipients of OMB services General Provisions for All Grievances and Appeals

All grievances and appeals regarding OMB shall be filed and processed as specified in A.A.C. R9-22-801.

- A. Individuals affected by adverse eligibility actions may appeal and request a hearing concerning any of the following adverse eligibility actions:
1. Denial of eligibility;
 2. Discontinuance of eligibility;
 3. Delay in the eligibility determination.
- B. Notice of an adverse eligibility action shall be personally delivered or mailed to the affected individual by regular mail. For purposes of this Section, the date of the Notice of Action

shall be the date of personal delivery to the individual or the date of mailing.

C. Eligibility appeals and hearing request process.

1. The applicant, eligible person or an authorized representative may appeal and request a hearing from any adverse eligibility action by completing and submitting the AHCCCS Request for Hearing form or by submitting a written request as described in paragraph (3) not later than 35 days after the date of the notice of an adverse action.
2. The Request for Hearing form or the written request shall be submitted to the Office of the Grievance and Appeals, AHCCCS Administration. If the Request for Hearing is submitted by mail, the date of request shall be the postmarked date. If the Request for Hearing is submitted in person, the date of request shall be the date on which the request is submitted to the Office of the Grievance and Appeals.
3. If the appellant or authorized representative does not utilize the Request for Hearing form, he shall provide the following information on a written hearing request:
 - a. The case name; and
 - b. Adverse eligibility decision being appealed; and
 - c. Reason for appeal; and
 - d. Request for continuance of OMB services, if applicable.
4. If requested, the eligibility office shall assist the appellant or authorized representative in the completion of the Request for Hearing form or the written request.
5. The eligibility office shall send to the AHCCCS Office of the Grievance and Appeals the Pre-Hearing Summary and documents pertinent to the denial or discontinuance action within five days after the date of the receipt of the request for such materials by the Office of the Grievance and Appeals.
6. The Pre-Hearing Summary shall be completed by the eligibility office and shall summarize the facts and factual basis for the adverse eligibility action.

D. Withdrawal and denial of the hearing request

1. The AHCCCS Hearing Officer shall dismiss a Request for Hearing and close the appeal if a written request for withdrawal is received from the appellant prior to the scheduled date of the hearing.
2. The AHCCCS Hearing Officer shall deny an appeal and Request for Hearing if:
 - a. The date of request is subsequent to the timeframes specified in subsection (C);
 - b. The appeal and Request for Hearing is for a reason(s) other than those identified in subsection (A); or
 - c. The appellant's appeal rights have been waived.

E. Postponement.

1. The Hearing Officer on his own motion may postpone a hearing. When the request for postponement is made by a party, it shall be made in writing and received by the AHCCCS Office of the Grievance and Appeals no later than five days prior to the scheduled hearing date. The AHCCCS Hearing Officer shall grant a party's request for postponement on a showing that there is substantial cause for the postponement and the cause is beyond the reasonable control of the party.
2. If a postponement is granted by the AHCCCS Hearing Officer, the hearing shall be rescheduled at the earliest practicable date.

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2. If a postponement is granted by the AHCCCS Hearing Officer, the hearing shall be rescheduled at the earliest practicable date.
- F.** Notice of Hearing. The Notice of Hearing shall be in accordance with A.R.S. § 41-1061 and shall include a statement detailing how an appellant may require a postponement of the hearing.
- G.** Failure to appear for hearing. Should the appellant, his representative, or AHCCCS eligibility representative fail to appear at the hearing without good cause or a postponement, the AHCCCS Hearing Officer may:
1. proceed with the hearing;
 2. reschedule the hearing with further notice on his own motion;
 3. issue a decision based on the evidence of record; or
 4. issue a default disposition.
- H.** Eligibility and benefits during the appeal process.
1. Individuals appealing a discontinuance. A discontinuance is a termination of eligibility and benefits. Individuals requesting a hearing within the time frame specified in subsection (C) shall continue to be eligible and receive benefits until an adverse decision on appeal is rendered.
 2. Individuals appealing a denial of eligibility.
 - a. A denial is an adverse eligibility decision which finds the applicant ineligible as a Qualified Medicare Beneficiary.
 - b. The effective date of a denial is the date of notice of an adverse action. Individuals may appeal this denial within the time frame specified in subsection (C). In the event that the denial is overturned, the effective date of eligibility shall be established by the Director in accordance with applicable law.
- I.** Appellant's hearing rights.
1. Each appellant shall be afforded those hearing rights specified in A.R.S. §§ 41-1061 and 41-1062.
 2. Each appellant has the right to obtain copies of any relevant documents from the case record at the appellant's expense.
 3. Each appellant has the right to appear at the hearing and be heard in person, by telephone if available, through a representative designated in writing by the appellant, or to submit to the Office of the Grievance and Appeals a written statement that is signed and notarized prior to the hearing.
 4. Each appellant has the right to bring an interpreter to assist at the hearing.
 5. Persons who are deaf or mute according to A.R.S. § 12-242 shall be provided an interpreter by the Administration.
- J.** Conduct of hearing. The hearing shall be conducted pursuant to A.R.S. §§ 41-1061 and 41-1062.
- K.** AHCCCS Hearing Officer decision.
1. Except as provided in paragraph (2), after the conclusion of the hearing, the AHCCCS Hearing Officer shall prepare written findings of fact and conclusions of law and render a recommended decision to the Director.
 2. Under the following circumstances the AHCCCS Hearing Officer shall issue a final disposition in a case without a hearing by:
 - a. Default order when the appellant or eligibility representative fails to appear at the hearing without good cause; or,
 - b. Disposition order when the appellant withdraws his appeal or there is a stipulated agreement to the disposition; or,
 - c. Dismissal order when the appeal was not timely filed.
- L.** Decision of the Director.
1. After receipt of the Hearing Officer's recommended decision, the Director shall issue his decision in writing, which shall include findings of fact and conclusions of law and, unless otherwise provided by law, personally deliver or mail by certified mail a copy thereof to all parties at their last known residence or place of business. If a discontinuance or denial is upheld, the decision also shall state that the appellant may reapply for eligibility. The decision shall notify any party adversely affected of the right to request rehearing or review.
 2. As part of his decision, the Director may remand the case for eligibility decision.
 3. Except as provided in subsection (M), the Director's decision made pursuant to this subsection shall be a final administrative decision. Such a decision is not subject to judicial review unless the Director makes the finding provided for in subsection (M).
- M.** Request for Rehearing or Review.
1. Unless the Director incorporates a finding in his decision that good cause exists otherwise, an aggrieved party may petition the Director for rehearing or review of the decision for any of the following causes which materially affects the appellant's rights:
 - a. Irregularity in the proceedings of the hearing or appeal whereby the aggrieved party was deprived of a fair hearing or appeal;
 - b. Misconduct of a party or the agency;
 - c. Newly discovered material evidence, which with reasonable diligence could not have been discovered and produced at the hearing;
 - d. That the decision is the result of passion or prejudice; or
 - e. That the decision is not justified by the evidence or is contrary to law.
 2. The Director may remand the case for eligibility decision, open the decision, order the taking of additional testimony or evidence before the Hearing Officer, amend findings of fact and conclusions of law or make new findings and conclusions, and render a new decision.
 3. The petition for review or rehearing shall be in writing and shall specify the grounds upon which the petition is based. The Director shall review the sufficiency of the evidence if the petition is made upon the ground that the decision is not justified by the evidence.
 4. A petition for rehearing or review shall be filed not later than 15 days after the date of the Director's decision. The date of the Director's decision shall be the date of personal delivery to the aggrieved party or the date of mailing. In the event that a timely petition for rehearing or review is filed, the Director's decision shall not be considered a final administrative decision until the Director renders a final decision on the petition for rehearing. The final decision of the Director after consideration of a petition for rehearing or review shall be subject to review as provided by A.R.S. § 12-901 et seq.
- N.** Failure to submit a grievance or appeal in a timely manner shall constitute a failure to exhaust administrative remedies required as a condition to seeking judicial relief.

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R9-29-502. Member grievances Eligibility Appeals And Hearing Requests for Applicants or Recipients of OMB Services

A. A member aggrieved by any adverse decision or action by a program contractor, health plan, subcontractor, noncontracting provider, nonprovider, Third Party Administrator or the Administration may file a grievance and request a hearing as specified in this Section.

B. Member grievances to program contractor.

1. All grievances filed by members relating to the program contractor, subcontractor, health plan, TPA, noncontracting provider, or nonprovider shall be filed with the member's program contractor, health plan or TPA for review, investigation and resolution in accordance with the grievance requirements of this Subsection and the applicable contract.
2. All grievances shall be filed orally or in writing with the member's program contractor, health plan or TPA not later than 35 days after the date of such adverse decision or action.
3. The program contractor, health plan or TPA shall record and retain sufficient information to identify the grievant, date of receipt and nature of the grievance.
4. A final decision shall be rendered by the program contractor, health plan or TPA on grievances that involve issues related to continuity or delivery of medical services within 15 days of filing. A final decision shall be rendered by the program contractor, health plan or TPA on all other grievances within 30 days of filing. A copy of the decision by the program contractor, health plan or TPA shall be personally delivered or mailed by regular mail to all parties and shall state the basis for the decision as well as information regarding the individual's right to appeal the decision to the Administration.
5. At the time of enrollment, each member shall be given material explaining grievance procedures available through the program contractor, health plan or TPA and through the Administration.
6. This Section shall not apply to actions or decisions affecting a member's eligibility, or to actions or decisions that reduce a categorically eligible member's benefits as a result of changes in state or federal law.

C. Member's grievance or appeal to Administration:

1. Members may appeal to and request a hearing from the AHCCCS Office of the Grievance and Appeals if:
 - a. The member files a written notice of appeal not more than 15 days after the date of the final decision of the program contractor, health plan or TPA. The date of the final decision shall be the date of personal delivery to the member or the date of mailing.
 - b. In the event that a decision was not timely rendered by the program contractor, health plan or TPA in accordance with the provisions of this Section, the member files a written notice of appeal not more than 60 days after the date the grievance was filed with the program contractor, health plan or TPA, based upon the program contractor's, health plan's or TPA's failure or refusal to timely decide the grievance.
 - c. The member has a grievance against the Administration and files the grievance not more than 35 days after the date of adverse decision or action by the Administration.

2. Grievances filed pursuant to this subsection shall be in writing and state with particularity the factual and legal basis therefor and the relief requested.
3. If the Office of the Grievance and Appeals is unable to resolve the appeal to the appellant's satisfaction, a hearing shall be scheduled.

D. AHCCCS Hearing Officer decision

1. The Notice of Hearing shall be in accordance with A.R.S. § 41-1061.
2. The hearing shall be conducted before an AHCCCS Hearing Officer designated by the Director and held in accordance with A.R.S. §§ 41-1061 and 41-1062.
3. After the conclusion of the hearing, the AHCCCS Hearing Officer shall prepare written findings of fact and conclusions of law and render a recommended decision to the Director.

E. Decision of the Director:

1. After receipt of the Hearing Officer's recommended decision, the Director shall issue his decision in writing, which shall include findings of fact and conclusions of law, and unless otherwise provided by law, personally deliver or mail by certified mail a copy thereof to all parties at their last known residence or place of business. The decision shall notify any party adversely affected of the right to request rehearing or review.
2. Except as provided in subsection (F), the Director's decision made pursuant to this subsection shall be a final administrative decision. Such a decision is not subject to judicial review unless the Director makes the finding provided for in subsection (F).

F. Request for Rehearing or Review:

1. Unless the Director incorporates a finding in his decision that good cause exists otherwise, an aggrieved party may petition the Director for rehearing or review of the decision for any of the following causes which materially affects the appellant's rights:
 - a. Irregularity in the proceedings of the hearing or appeal whereby the aggrieved party was deprived of a fair hearing or appeal;
 - b. Misconduct of a party or the agency;
 - c. Newly discovered material evidence, which with reasonable diligence could not have been discovered and produced at the hearing;
 - d. That the decision is the result of passion or prejudice; or
 - e. That the decision is not justified by the evidence or is contrary to law.
2. The Director may open the decision, order the taking of additional testimony or evidence before the Hearing Officer, amend findings of fact and conclusions of law or make new findings and conclusions, and render a new decision.
3. The petition for review or rehearing shall be in writing and shall specify the grounds upon which the petition is based. The Director shall review the sufficiency of the evidence if the petition is made upon the ground that the decision is not justified by the evidence.
4. A petition for rehearing or review shall be filed not later than 15 days after the date of the Director's decision. The date of the Director's decision shall be the date of personal delivery to the member or the date of mailing. In the event that a timely petition for rehearing or review is filed, the Director's decision shall not be considered a final administrative decision until the Director renders a final decision on the petition for rehearing. The final

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decision of the Director after consideration of a petition for rehearing or review shall be subject to review as provided by A.R.S. § 12-901 et seq.

- G.** Failure to submit a grievance and appeal in a timely manner shall constitute a failure to exhaust administrative remedies required as a condition to seeking a judicial relief.
- A.** An individual affected by an adverse eligibility action may appeal and request a hearing concerning any of the following adverse eligibility actions:
1. Denial of eligibility;
 2. Discontinuance of eligibility; or
 3. Delay in the eligibility determination.
- B.** Notice of an adverse eligibility action shall be personally delivered or mailed to the affected individual by regular mail. For purposes of this Section, the date of the Notice of Action shall be the date of personal delivery to the individual or the postmark date, if mailed.
- C.** Appeals and requests for hearing.
1. An applicant, eligible person, or authorized representative may appeal and request a hearing from an adverse eligibility action by completing and submitting, no later than 35 days after the date of the Notice of Action, the AHCCCS request for hearing form, or a written request that contains the following information:
 - a. The case name;
 - b. The adverse eligibility action being appealed; and
 - c. The reason for appeal.
 2. The request for hearing shall be submitted to the Office of Grievance and Appeals, AHCCCS Administration. If the request for hearing is submitted by mail, the date of request shall be the postmark date. If the request for hearing is submitted in person, the date of the request shall be the date on which the request is submitted to the Office of Grievance and Appeals.
- D.** Eligibility office responsibilities.
1. If requested, the eligibility office shall assist the individual or authorized representative to complete the request for hearing.
 2. The eligibility office shall send to the AHCCCS Office of Grievance and Appeals the Pre-Hearing Summary and documents pertinent to the denial or discontinuance action within 5 days after the date of receipt of a request for materials from the AHCCCS Office of Grievance and Appeals.
 3. The eligibility office shall complete and send to the AHCCCS Office of Grievance and Appeals with the Pre-Hearing Summary a summary of the factual basis for the adverse eligibility action.
- E.** Eligibility and benefits during the appeal process.
1. Individuals appealing a discontinuance. A discontinuance is a termination of eligibility and benefits. An individual requesting a hearing within the time-frame specified in subsection (C) shall continue to be eligible and receive benefits until an adverse decision on appeal is rendered.
 2. Individuals appealing a denial of eligibility.
 - a. A denial is an adverse eligibility decision that finds an applicant ineligible as a Qualified Medicare Beneficiary.
 - b. The effective date of a denial is the date of notice of an adverse action. An individual may appeal this denial within the time-frame specified in subsection (C). If the denial is overturned, the effective date of eligibility shall be established by the Director in accordance with federal and state law.

R9-29-503. Nonmember grievances Grievances

- A.** An eligible but nonenrolled individual may request a hearing by filing a written grievance with the AHCCCS Office of the Grievance and Appeals:
- B.** The written grievance shall be filed with and received by the Administration not later than 35 days after the date of adverse decision or action being grieved:
- C.** If the Office of the Grievance and Appeals is unable to resolve the grievance to the grievant's satisfaction, a hearing shall be conducted and decision rendered, in accordance with the applicable provisions of R9-29-502.
- D.** Grievances that involve issues related to continuity or delivery of medical services shall be resolved as expeditiously as practicable considering the medical needs presented by the grievant:
- E.** Failure to submit a grievance and appeal in a timely manner shall constitute a failure to exhaust administrative remedies required as a condition to seeking judicial relief.
- F.** This Section shall not apply to actions or decisions affecting an individual's eligibility or to actions or decisions that reduce a categorically eligible individual's benefits as a result of changes in state or federal law.

All grievances regarding OMB shall be filed and processed as specified in A.A.C. R9-22-804.

R9-29-504. Program contractor, health plan, provider, non-contracting provider, nonprovider and TPA grievances Repealed

- A.** The provisions of this Section provide the exclusive manner through which program contractors, health plan, TPA, providers, noncontracting providers, and nonproviders may grieve against the Administration, its officers and employees, program contractors, health plans and TPA in connection with any adverse action or decision:
- B.** Grievances against program contractor, health plan and TPA:
1. All grievances by providers, noncontracting providers and nonproviders relating to an adverse decision or action by a program contractor, health plan or TPA shall be filed with the program contractor, health plan or TPA for review, investigation and resolution in accordance with the grievance requirements of this subsection and any applicable contract.
 2. All grievances, excluding those challenging claim denials, shall be filed in writing with the program contractor, health plan or TPA not later than 35 days after the date of such adverse decision or action. All grievances challenging claim denials shall be filed in writing with the program contractor, health plan or TPA not later than 12 months from the date of the service for which payment is claimed. The grievance shall state with particularity the factual and legal basis therefor, and the relief requested.
 3. The program contractor, health plan or TPA shall record and retain information to identify the grievant, date of receipt and nature of the grievance.
 4. A final decision shall be rendered by the program contractor, health plan or TPA within 30 days of filing, unless the parties agree to a longer period of time. A copy of the decision of the program contractor, health plan or TPA shall be personally delivered or mailed by regular or certified mail to all parties and shall state the basis for the decision.
- C.** Grievances to the Administration:
1. Program contractors, health plans, TPA, providers, non-contracting providers and nonproviders may grieve to

- the Office of the Grievance and Appeals of the Administration if:
- a. The provider, noncontracting provider or nonprovider files a grievance with the Administration not more than 15 days after the final decision of the program contractor, health plan or TPA rendered pursuant to subsection (B). The date of the final decision shall be the date of personal delivery or the date of mailing.
 - b. In the event that a decision was not timely rendered by the program contractor, health plan or TPA in accordance with subsection (B), and the provider, noncontracting provider or nonprovider files a grievance more than 60 days after the date the grievance was filed with the program contractor, health plan or TPA. Such a grievance may be filed because the program contractor, health plan or TPA failed or refused to timely decide the grievance. The program contractor, health plan or TPA shall reimburse all administrative costs incurred by the Administration for adjudicating any such grievance.
 - c. The program contractor, health plan, TPA, provider, noncontracting provider or nonprovider has a grievance against the Administration and files the grievance not more than 35 days after the date of adverse action, decision or policy implementation by the Administration; provided, however, any grievances challenging claim denials by the Administration must be filed not more than 12 months after the date of the service for which payment is claimed.
2. Grievances filed pursuant to this subsection shall be in writing and state with particularity the factual and legal basis therefor and the relief requested.
 3. The Administration shall investigate the grievance and render a written decision regarding the grievance or schedule the grievance for a hearing in accordance with the provisions of this Section.
- D. Appeals.** A party may appeal the Administration's grievance decision by filing a request for hearing with the Director. The request for hearing shall be filed and received by the Director not later than 15 days after the date of the Administration's grievance decision. The date of the grievance decision shall be the date of personal delivery to the grievant or the date of mailing.
1. The Notice of Hearing shall be in accordance with A.R.S. § 41-1061.
 2. The hearing shall be conducted before an AHCCCS Hearing Officer designated by the Director and held in accordance with A.R.S. §§ 41-1061 and 41-1062.
 3. After the conclusion of the hearing, the AHCCCS Hearing Officer shall prepare written findings of fact and conclusions of law and render a recommended decision to the Director.
- E. Decision of the Director.**
1. After receipt of the Hearing Officer's recommended decision, the Director shall issue his decision in writing, which shall include findings of fact and conclusions of law and, unless otherwise provided by law, personally deliver or mail by certified mail a copy thereof to all parties at their last known residence or place of business. The decision shall notify any party adversely affected of the right to request rehearing or review.
 2. Except as provided in subsection (F), the Director's decision made pursuant to this subsection shall be a final administrative decision. Such a decision is not subject to judicial review unless the Director makes the finding provided for in subsection (F).
- F. Request for Rehearing or Review.**
1. Unless the Director incorporates a finding in his decision that good cause exists otherwise, an aggrieved party may petition the Director for rehearing or review of the decision for any of the following causes which materially affects the grievant's rights:
 - a. Irregularity in the proceedings of the hearing or appeal whereby the aggrieved party was deprived of a fair hearing or appeal;
 - b. Misconduct of a party or the agency;
 - c. Newly discovered material evidence which with reasonable diligence could not have been discovered and produced at the hearing;
 - d. That the decision is the result of passion or prejudice; or
 - e. That the decision is not justified by the evidence or is contrary to law.
 2. The Director may open the decision, order the taking of additional testimony or evidence before the Hearing Officer, amend findings of fact and conclusions of law or make new findings and conclusions, and render a new decision.
 3. The petition for review or rehearing shall be in writing and shall specify the grounds upon which the petition is based. The Director shall review the sufficiency of the evidence if the petition is made upon the ground that the decision is not justified by the evidence.
 4. A petition for rehearing or review shall be filed not later than 15 days after the date of the Director's decision. The date of the Director's decision shall be the date of personal delivery to the grievant or the date of mailing. In the event that a timely petition for rehearing or review is filed, the Director's decision shall not be considered a final administrative decision until the Director renders a final decision on the petition for rehearing. The final decision of the Director after consideration of a petition for rehearing or review shall be subject to review as provided by A.R.S. § 12-901 et seq.
- G.** Pending final resolution of a grievance, appeal, or request for judicial review, a grieving program contractor, health plan or Third-Party Administrator shall proceed diligently with the performance of the contract and in accordance with the Administration's or Director's decision.
- H.** Failure to comply with the provisions of this Section shall constitute a failure to exhaust administrative remedies required as a condition to seeking judicial relief.
- ARTICLE 6. THIRD-PARTY 1ST- AND 3RD-PARTY LIABILITY AND RECOVERIES**
- R9-29-601. Third-party liability and coordination of benefits-1st- and 3rd-Party Liability and Coordination of Benefits**
- A.** Payor of last resort. AHCCCS shall be used as a source of payment for covered services only after all other sources of payment for members and eligible persons receiving care have been used. AHCCCS shall be the payor of last resort unless prohibited by federal law. AHCCCS shall not be liable for coinsurance or deductibles when Medicare denies payment. The provisions specified in A.A.C. R9-22-1001 apply to this Section.
- B.** Collections.

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1. The Administration shall coordinate and pursue collection from underinsured and uninsured motorist insurers, third-party liability insurers and tort-feasors in cases of probable third-party liability.
 2. Providers, health plans, program contractors, nonproviders and noncontracting providers are responsible for:
 - a. Identifying and pursuing collection of reimbursement from probable sources of third-party liability set forth in R9-29-602(A)(1) through (7).
- B. The Administration shall not be liable for payment of coinsurance and deductibles when Medicare denies payment.**
- b. Identifying and notifying the Administration in accordance with R9-29-602(D) of the potential liability of underinsured and uninsured motorist insurers, third-party liability insurers and tort-feasors.
 - e. Cooperating with the Administration in its collection efforts.
- C. Duplication of benefits.** Payments made for covered services by AHCCCS shall not duplicate benefits otherwise available from probable third-party payors. Payments by AHCCCS for covered services may supplement payment or benefits from third parties to the extent authorized by this Chapter or applicable contracts.
- D. Recovery.** A health plan or program contractor may retain not more than 100% of its third-party collections provided that:
1. Total payments received do not exceed the total amount of the health plan's or program contractor's financial liability for the member;
 2. AHCCCS fee-for-service, deferred liability and reinsurance benefits have not duplicated the recovery;
 3. Such recovery is not prohibited by federal or state law; and
 4. The payments collected are reflected in capitation rates. The Administration may require a health plan or program contractor to reimburse the Administration not more than 100% of third-party payments collected which are not reflected in reduced capitation rates.
- E. Recovery; Administration.** The Administration may retain its third-party collections up to 100% of capitation, fee-for-service, deferred liability and reinsurance payments.
- R9-29-602. Third-party liability monitoring and compliance 1st and 3rd-Party Liability Monitoring and Compliance**
- A. Categories of third-party liability.** The Administration shall monitor third-party payments to a health plan, program contractor, noncontracting provider, provider or nonprovider, which may include all situations creating liability in a third person for care rendered to a QMB recipient, such as:
1. Workers' compensation;
 2. Disability insurance;
 3. A hospital and medical service corporation;
 4. A health care services organization or other health or medical or insurance plan;
 5. Standard health insurance;
 6. Medicare and other governmental payors;
 7. Medical payments insurance for accidents; and
 8. Underinsured or uninsured motorist insurance, third-party liability insurance or tort-feasors.
- B. Monitoring.** The Administration shall determine whether a health plan, program contractor, provider, nonprovider or noncontracting provider is in compliance with the requirements set forth in this Article by inspecting source documents for:
1. Verifiability and reliability;
 2. Appropriateness of recovery attempt;
 3. Timeliness of billing;
 4. Accounting for reimbursements;
 5. Auditing of receipts; and
 6. Other monitoring deemed necessary by the Administration.
- C. Notification for perfection, recording and assignment of AHCCCS liens.**
1. County requirements. The county of residence shall notify the Administration pursuant to subsection (E) not later than five days after it files a lien pursuant to A.R.S. § 11-291 for charges for hospital or medical services provided to an injured person who is determined AHCCCS eligible, so that the Administration may preserve its lien rights pursuant to A.R.S. § 36-2915, 36-2935, or 36-2956.
 2. Hospital requirements. Hospitals providing emergency or urgent medical services to an eligible non-enrolled person or member for an injury or condition resulting from circumstances reflecting the probable liability of a third party shall notify the Administration pursuant to subsection (E) not later than 15 days after discharge. A hospital also may satisfy the requirement of this paragraph by mailing to the Administration a copy of the lien it proposes to record or has recorded pursuant to A.R.S. § 33-932 not later than 15 days after discharge.
 3. Health plan, program contractor, provider, nonprovider and noncontracting provider requirements. Health plans, program contractors, providers, nonproviders and noncontracting providers, other than hospitals rendering medical services to an eligible non-enrolled person or member for an injury or condition resulting from circumstances reflecting the probable liability of a third party, shall notify the Administration pursuant to subsection (E) not later than five days after providing such services.
- D. Notice requirements.** Notice requirements shall be satisfied when all of the following information is mailed to the Administration:
1. Name of provider, health plan, program contractor, nonprovider or noncontracting provider;
 2. Address of provider, health plan, program contractor, nonprovider or noncontracting provider;
 3. Name of patient;
 4. Patient's Social Security number or AHCCCS identification number;
 5. Address of patient;
 6. Date of patient's admission;
 7. Amount due for care of patient;
 8. Date of patient's discharge;
 9. Name of county in which injuries were sustained; and
 10. Names and addresses of all persons, firms or corporations and their insurance carriers claimed by the patient or the patient's legal representative to be liable for damages.
- E. Sanctions.** Health plans, program contractors, providers, nonproviders or noncontracting providers who fail to meet the notice requirements set forth in this Section shall forfeit their right to reimbursement, including fee-for-service, deferred liability and reinsurance payments, from the Administration for services provided to eligible non-enrolled persons or members, unless the health plan, program contractor, provider, nonprovider or noncontracting provider demonstrates

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~~good cause for such failure. Good cause means a cause that was not within their control.~~

The provisions in A.A.C. R9-22-1002 apply to this Section.