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* first as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council or the Attorney General. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-22-1405	Amend
R9-22-1419	Amend
R9-22-1419.01	New Section
R9-22-1419.02	New Section
R9-22-1419.03	New Section
R9-22-1419.04	New Section
R9-22-1501	Amend
R9-22-1903	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

Implementing statutes: A.R.S. §§ 36-2903.01, 36-2934, and 36-2929

3. The effective date of the rules:

January 3, 2004

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

Notice of Rulemaking Docket Opening: 9 A.A.R. 3061, July 11, 2003

Notice of Proposed Rulemaking: 9 A.A.R. 3456, August 8, 2003

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

Name: Barbara Ledder

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4580

Fax: (602) 253-9115

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

The Administration is making amendments to the rules to clarify and align certain application processes for its programs. The Administration is also adding rules to set forth clear, uniform terminology and methodology for determining income eligibility for the acute care program.

7. A reference to any study relevant to the rules that the agency reviewed and either relied on in its evaluation of or justification for the rules or did not rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The Administration did not review any study relevant to these rules.

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

Not applicable

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

It is anticipated that the contractors, members, providers, and the Administration will be nominally impacted by the changes to the rule language. These rules clarify and align certain application processes for the Acute Care programs. New Sections have been added to clarify the processes for determining income eligibility for these programs. The income eligibility rules were added to establish clear, uniform terminology and methodology for determining income eligibility.

It is anticipated that political subdivisions and the private sector, including small businesses, will not be impacted since the proposed rule language changes are intended to align and clarify the existing rules. The Administration, contractors, providers, and members will benefit from the increased clarity of the rule language and the establishment of rules governing methodology for determining income eligibility.

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

Location	Description	Comment
R9-22-1405(C)(1)	Added, "and the signature of the person submitting the application."	Added to clarify and align the subsection with subsection (A).
R9-22-1405(E)	Remove proposed language and retain, "requested on the application form," which was stricken in the proposed rule.	Removed redundant language and clarified that we are referring to the application form in this subsection.
R9-22-1405(I)	Removed the subsection as it is duplicative of language already in rule.	The provisions of this subsection are already in R9-22-1414.
R9-22-1419(A)	Added the definition of "in-kind income."	Added definition for clarity.
R9-22-1419.11(B)	Removed, "When calculating monthly income," and "unconverted amount under R9-22-1419.12." Added, "sum of the actual amount of income received or projected to be received during the month."	Clarified how unconverted income is calculated.
R9-22-1419.11(D)(2)	Changed "items" to "pay periods."	Clarification of language.
R9-22-1501(G)(4)	Struck "of."	Grammar correction.
R9-22-1419.12	Added headings to subsections.	Provides clarity.
R9-22-1419.10(A)	Created two sentences from the one.	Provides detail and clarity.
R9-22-1419.11(A)(3)	Reworded the second half of the "Exclusion" sentence.	Provides clarity.
R9-22-1419.11(B)(2)	Changed the sentence from "The Administration or designee shall use the sum of the actual amount of income received or projected to be received during the month." to "The Administration or designee shall sum the actual amount of income received or projected to be received during the month."	Provides consistency and clarity to the subsection.
R9-22-1501(C)(3)	Added to the end of the sentence, "approved by the Director."	Provides clarity and aligns with agency practice.
R9-22-1903((B)	Added to the end of the sentence, "or outstation location approved by the Director."	Clarifies language and aligns with current practice.
R9-22-1405(A)	Added "the Administration" to the list of places to submit an application.	Clarifies language and aligns the rule with current practice.
R9-22-1405(C)(4)	Added (C)(4)(g), to clarify the requirement that unmarried adults without a child in common each sign the application form.	Addresses unmarried adults who apply using the same application form. Legally each is financially responsible for only him/herself.
R9-22-1419(F)(2)(b)	In subsections (i) and (ii) added the word "each" before "child" and "dependent."	Clarifies that the disregards listed apply to each child and not to a group or just to the first child in an age group.

R9-22-1405(B)(8)	Final rule does not include proposed language, "none of the previously listed people are available to sign, or waiting would cause a delay in the application month and" in the first sentence of subsection (B)(8).	Changed in response to public comment that the language added a new requirement that would be unduly burdensome.
R9-22-1405(B)(8)	Moved the language, "under the direction of a licensed physician" so that it applies only to registered nurses.	Changes made in response to public comment. The language inadvertently imposed a new requirement on Nurse Practitioners and Physicians' Assistants.
R9-22-1405(C)	Moved subsections (C)(3) through (C)(6) to subsection (E). Copied and added subsection (C)(6) to subsection (B)(9) as well.	These sections are more appropriate to subsection (E).
R9-22-1405(C)	Added a lead-in sentence.	Clarifies the purpose of a "written application."
R9-22-1405(E)(1)	Changed the language to, "Complete application form. An applicant shall provide all information requested on the application form."	Clarified the intent of the subsection.
R9-22-1405(C)(1)	Added, "or location where the applicant can be reached" after the word "address."	Clarified language to address the issue of applicants who do not have a permanent address.
R9-22-1405(D)	Changed the language to read, "written application" instead of "signed application."	Clarifies the language and ties subsection (C) into subsection (D). Adds continuity to the Section.
R9-22-1501(C)(2)	Corrected the cross-reference to R9-22-1405.	The reference became incorrect when R9-22-1405(C)(3) through (C)(6) was moved to R9-22-1405(E).
R9-22-1903(C)	Corrected the cross-reference to R9-22-1405.	The reference became incorrect when R9-22-1405(C)(3) through (C)(6) was moved to R9-22-1405(E).
R9-22-1419.01(A)	Corrected the cross-reference to R9-22-1429(B).	The reference was inadvertently left incomplete.
R9-22-1501(G)(1) R9-22-1501(G)(2) R9-22-1501(H) R9-22-1501(J)(3) R9-22-1501(J)(3)(c)	Struck the CFR reference.	The reference does not impose any substantial requirements. The language is made more clear concise and understandable without the reference.
General	Other technical and grammatical changes were made at the suggestion of G.R.R.C. staff.	

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

AHCCCS received comments from three sources. The source, paraphrased comments, and agency response are included in the matrix below.

Location	Commenter/Comment	Agency Response
R9-22-1405(A)(5)	Gammage & Burnham on behalf of various hospital clients *(Supported by Banner Health System)* The proposed language requires that the hospital be approved by DES or the Administration. This subtle change implies some additional approval process will be imposed separate from that which currently exists. 42 CFR 435.904(c) requires the agency to accept applications at each disproportionate share hospital unless an alternate plan has been approved by CMS that does not adversely affect applicants. Any move away from accepting applications at all disproportionate share hospitals will adversely affect applicants. AHCCCS should maintain the current language, which allows all hospitals to be application sites.	Disagree AHCCCS is in compliance with 42 CFR 435.904(c) as R9-22-1405(A)(4) still lists disproportionate share hospitals (DSH) as sites that accept applications for medical coverage. There are hospitals that are not DSH that do not have a process in place to accept applications for AHCCCS health insurance. If an application is submitted at one of these hospitals, it may be delayed or may not be forwarded at all. Therefore the Administration amended the rule to clarify that an application must be submitted to an appropriate site to ensure timely receipt by the Department or Administration. This ensures that an applicant receives the earliest date of application and a timely eligibility determination. The rule was also amended to reflect agency practice.
R9-22-1405(A)(5)	AzHHA Leave existing language as is. Potential enrollees should be able to submit an application [at a hospital] without question or the need for any formal approval from DHS or AHCCCS. [This would add] an additional non-value added step for hospitals, DES, and AHCCCS, and would create confusion for both applicants and providers.	See response immediately above.

Location	Commenter/Comment	Agency Response
R9-22-1405(B)(5)	Gammage & Burnham *(Supported by Banner Health System)* Leave existing language as is. The proposed language is more limited, and conflicts with, the agency's own definition in R9-22-114. Moreover, 42 CFR 435.908 does not require the applicant who cannot designate a representative in writing to make their choice known only in the presence of state employees.	Disagree As a result of public comment received during the Proposition 204 rule changes, the Administration identified how a person could be designated an authorized representative in #11 of the Preamble of the Notice of Final Rulemaking published at 7 A.A.R. 4593 as follows: "The hospitalized applicant signs the authorized representative form. The hospitalized person verbally authorizes a person in the presence of an eligibility interviewer; or An incompetent/ incapacitated form is signed by a licensed physician, physician's assistant, nurse practitioner or registered nurse" While 42 CFR 435.908 does not specifically require that the applicant be in the presence of a state employee when verbally designating an authorized representative, it also does not prohibit the state from making such a requirement. This requirement safeguards the applicant's privacy rights, protects the Department or Administration from potential liability, and reduces the potential for false applications.
R9-22-1405(B)(8)	Gammage & Burnham *(Supported by Banner Health System)* Leave as is existing language regarding when a concerned party may file an application. The proposed language is unnecessary, can hinder medical care to otherwise eligible individuals, interfere with discharge planning, and adds a layer of complexity that is unnecessary to program integrity.	Agree The Administration will amend the language by striking "none of the previously listed people are available to sign, or waiting would cause a delay in the application month and" in the first sentence of subsection (B)(8).
R9-22-1405(B)(8)	Gammage & Burnham *(Supported by Banner Health System)* Individuals who are 18 are not legally children. The correct language should be "an adult who is age 18 and a student."	Disagree For the purposes of the Title XIX population and per Section 1905(n) of the Social Security Act, the term "child" means "a child who has not attained the age of 19."
R9-22-1405(B)(8)	Gammage & Burnham *(Supported by Banner Health System)* Leave existing language as is. The proposed language will cause a significant problem for hospital-based applicants and may cause a significant problem in rural areas. The proposed change restricts physician assistants and nurse practitioners from determining incapacity unless they are working "under the direction of a licensed physician."	Agree The Administration will amend the language to reflect the intent of the original rules that only the registered nurse must be under the direction of a licensed physician when verifying incapacity.

Location	Commenter/Comment	Agency Response
R9-22-1405(B)(8)	AzHHA Leave existing language as is. The proposed language would require all three types of providers to be under the direction of a physician, even if such an action would be within the scope of independent practice of the PA or NP.	See response immediately above.
R9-22-1405(C)	Gammage & Burnham *(Supported by Banner Health System)* AHCCCS has changed the reference from a "completed application" to a "valid application." During Proposition 204-related discussions and negotiations that the hospitals had with the Administration and DES, we collectively agreed that the "complete application" would be as described in the current regulations. We therefore object to any change that implies an initial attempt at a priority application is "invalid" as opposed to merely "incomplete" due to missing information.	Partly agree Subsections (C)(1) and (C)(2) are required in order to initiate the eligibility process. Without those required items, the application is not sufficient for action. Therefore the word "valid" is correct and appropriate. However, the Administration will change "valid application" to "written application" in the rule. "Written application" is defined in 42 CFR 435.907. The Administration will also move subsections (C)(3) through (C)(6) to subsection (E) as these provisions are more appropriate to "complete application" in R9-22-1405(E). A lead-in sentence will be added to subsection (C) to clarify the purpose of the written application.
R9-22-1405(E) (R9-22-1405(C)(3))	AzHHA Subsection (C)(3) appears to require the signature of an applicant's legal representative on **any** eligibility application. We recommend that this subsection read, "When an application is submitted by a legal representative, before the application can be approved the applicant's legal representative shall sign the declarations . . ."	Disagree For the purposes of AHCCCS eligibility, the agency defines a "legal representative" in rule as: A custodial parent of a child under 18, A guardian, or A conservator. When an applicant has one of these legal representatives, the legal representative and not the applicant is the responsible person. The legal representative may authorize a different representative under R9-22-1405(E)(4) to be responsible for completing the application. When a legal representative exists, the legal representative or their authorized representative is the only person with authority under the law to complete an application under penalty of perjury.
R9-22-1405(C)(3)	Gammage & Burnham *(Supported by Banner Health System)* The proposed definition of a "legal representative" eliminates many other types of "legal representatives" that are recognized in law, such as those acting under a durable power of attorney, a health care power of attorney, or a mental health power of attorney. AHCCCS should allow recognition of the various legitimate arrangements.	Disagree For the purposes of this subsection, other types of legal representatives could be recognized as "authorized representatives" if their authorization includes the authority to apply for health care benefits for the applicant. If they have this authority they would still be able to submit and complete an application on behalf of the applicant.

Location	Commenter/Comment	Agency Response
R9-22-1405(C)(4)	AzHHA The list of authorized signors in proposed subsection (C)(4) should either parallel the list of people authorized to submit an application in proposed R9-22-1405(B), or the language from the current subsection (C)(2) should be retained.	Disagree Per 42 CFR 435.907(b) the declarations made on the application must be signed under penalty of perjury. The Administration amended the rule to ensure that the most knowledgeable and most appropriate individual provides the authorized signature. This is for the protection of the applicant as the person signing the application is also attesting to the citizenship status of the applicant and assigning rights to medical support payments and third-party liability as required by A.R.S. § 36-2915.
R9-22-1405(E)	Gammage & Burnham *(Supported by Banner Health System)* This new section is circular and totally unnecessary. This circular language opens the door to denial of applications on the grounds that they are "incomplete," which DES and AHCCCS specifically agreed in our Prop. 204 meetings would not be the basis for denials.	Partly agree The rule describes the application process and conditions of eligibility. All of the information requested on the application is required by rule. The Article specifies that conditions of eligibility must be verified and that eligibility is approved when the applicant meets all eligibility requirements. An "incomplete" application is not a standard for denial. Applications are denied for not meeting a condition of eligibility, not for being "incomplete." The Administration will amend the language to clarify that the application form is to be completed in its entirety.
R9-22-1405(E)	AzHHA The proposed change eliminates the clear and concrete list of requirements for a complete application and replaces it with an amorphous standard that gives AHCCCS discretion to determine whether an application is complete or not. The requirements for a complete application should be explicit, clear, and exact, and must not be subject to program discretion. Retain the former language in the section sentence of subsection (E), and delete the words "required to make an eligibility determination."	See response immediately above.
R9-22-1405(D)	Banner Health System This wording is vague, subjective and open to interpretation and debate—and hence, potential disagreements. This is because it eliminates clear, defined standards and substitutes discretion as to what is a "complete" application.	See response above.

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

Not applicable

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

Not applicable

14. Were these rules previously adopted as emergency rules?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR FAMILIES AND INDIVIDUALS

Section
R9-22-1405. Application Process
R9-22-1419. Income Eligibility Criteria
R9-22-1419.01. Income Eligibility
R9-22-1419.02. Methods For Calculating Monthly Income
R9-22-1419.03. Calculations and Use of Methods Listed In R9-22-1419.02 Based on Frequency of Income
R9-22-1419.04. Exceptions To R9-22-1419.03

ARTICLE 15. AHCCCS MEDICAL COVERAGE FOR PEOPLE WHO ARE AGED, BLIND, OR DISABLED

Section
R9-22-1501. General Information

ARTICLE 19. FREEDOM TO WORK

Section
R9-22-1903. Application for Coverage

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR FAMILIES AND INDIVIDUALS

R9-22-1405. Application Process

A. Right to apply. A person~~,~~ identified in subsection (B)~~)~~, may apply for AHCCCS medical coverage by submitting a signed Department or Administration approved application to the Administration, ~~any~~ an FAA office or an outstation location under 42 CFR 435.904 listed below:
1. A BHS site as provided in Laws 1991, Chapter 213, ~~and~~ § 21;
2. A CRS site as provided in Laws 1991, Chapter 213, ~~and~~ § 21;
3. A Baby Arizona approved provider's office, if the applicant is a pregnant woman;
4. A FQHC or disproportionate share hospital under 42 U.S.C. 1396r-4, as required by 42 CFR 435.904, or;
~~5. A hospital; or~~
~~6.~~5. Any other site, including a hospital, approved by the Department or the Administration.

B. Who may apply for a person. Any of the following may submit an application for an applicant:
~~1. The applicant, a minor applicant's parent, or the applicant's legal or authorized representative may apply for AHCCCS medical coverage. An application shall be witnessed and signed by a third-party, if an applicant signs an application with a mark.~~
~~2. The applicant may designate an authorized representative either verbally in the presence of a Department employee or in writing.~~
~~3. If the applicant is incompetent or incapacitated, someone acting responsibly on behalf of the applicant may apply for AHCCCS medical coverage. Incapacity shall be verified by written documentation signed by a licensed physician, physician assistant, nurse protactinium, or a registered nurse under the direction of a licensed physician.~~
1. The applicant's legal representative;
2. The applicant;
3. The applicant's spouse;
4. The applicant's parent;
5. The applicant's authorized representative, designated by the applicant either verbally in the presence of an employee of the Administration or its designee, or in writing;
6. An adult who lives with the applicant;
7. The applicant's adult child; or
8. Another party if the applicant is an adult who is incapacitated, a child less than 18 years old, or a child who is age 18 and a student. The Administration or its designee shall require incapacity to be verified by written documentation signed by a licensed physician or by one of the following:
   a. A physician assistant;
   b. A nurse practitioner; or
   c. A registered nurse, under the direction of a licensed physician.

C. Written application. To initiate the application process, a person listed in subsection (B) shall submit a written application under 42 CFR 435.907 to one of the sites listed in subsection (A).
1. A written application is one that contains the legible name and address, or location where the applicant can be reached, of each person requesting AHCCCS medical coverage and the signature of the person under subsection (B) who is submitting the application. The Administration shall require that a third party witness the signing and co-sign the application if the individual signing the application signs with a mark.
2. The Administration or its designee shall accept an application for a person who is incapacitated and whose name and address are not known.

~~C.~~**D.** Date of ~~Application.~~ application.
~~1.~~ The date of application is the date a ~~signed~~ written application is received at a location listed in subsection (A).
~~2. An application shall be accepted if the application contains the legible name and address of each person requesting AHCCCS medical coverage and the signature of the person listed in subsection (B) who submitted the application. The Department shall accept an application and assign a name and address for a person who is incompetent or incapacitated and whose name and address are not known.~~
~~3. Except for the MED program under R9-22-1427 through R9-22-1432 and a newborn under R9-22-1422, the effective date of eligibility is:~~
~~a. The first day of the month that the applicant files an application if the applicant is eligible that month, or~~
~~b. The first day of the first eligible month following the application month.~~

~~D.~~**E.** Complete application form. ~~A complete application shall contain information listed in subsection (C), the names of all persons living with the applicant, and the relationship of those persons to the applicant, and all eligibility information requested on the application form.~~
1. An applicant shall provide all information requested on the application form.
2. The Administration or its designee shall not approve an application unless the applicant's legal representative, if one exists, signs the declarations on the application relating to the applicant's eligibility, under penalty of perjury. A legal representative is a custodial parent of a child under 18, a guardian, or a conservator.
3. If there is no legal representative, or the legal representative is incapacitated, one of the following shall sign the declarations on the application relating to the applicant's eligibility, under penalty of perjury:
   a. The applicant, if age 18 or older;
   b. The applicant, if less than 18 years old and married or not living with a parent;
   c. The applicant's spouse if not separated;
   d. An adult who lives with a child who is less than 18 years old or age 18 if a student;
   e. Unmarried partners if living together with a child in common, if the child is an applicant or a member; or
   f. Another party, if the applicant is incapacitated and no one listed in subsection (E)(3)(a) through (e) is available to sign the application on the applicant's behalf. The Administration shall require incapacity to be verified by written documentation signed by a licensed physician or by one of the following:
      i. A physician assistant,
      ii. A nurse practitioner, or
      iii. A registered nurse under the direction of a licensed physician.
4. Unrelated adults not applying for a child in common shall each sign the application if using the same application form.
5. A person in listed in subsections (E)(2) or (E)(3)(a) through (e) may authorize, verbally in the presence of an employee of the Administration or its designee or in writing, someone else to represent the applicant in the application process. The authorized representative may sign the declarations on the application relating to the applicant's eligibility, under penalty of perjury.
6. The application shall be witnessed and signed by a third party if the individual signing the application signs with a mark.

~~E.~~**F.** Assistance with application. The ~~Department~~ Administration or its designee shall allow a person of the applicant's choice to accompany, assist, and represent the applicant in the application process.

~~F.~~**G.** Applicants who die. If an applicant dies while an application is pending, the ~~Department~~ Administration or its designee shall complete an eligibility determination for all applicants listed on the application, including the deceased applicant.

~~G.~~**H.** Deceased applicants. The ~~Department~~ Administration or designee shall complete an eligibility determination on an application filed on behalf of a deceased applicant, ~~provided~~ if the application is filed in the month of the ~~person's~~ applicant's death.

R9-22-1419. Income Eligibility Criteria

A. Evaluation of income. In determining eligibility, the Department shall evaluate the following types of income received by a person identified in subsection (B):
1. Earned income, including in-kind income, before any deductions. For purposes of this Section, in-kind income means room, board, or provision for other needs in exchange for work performed. The provider of the in-kind income shall establish and verify the monetary value of the item provided. The provider may be, but is not limited to:

a. A landlord who provides all or a portion of rent or utilities in exchange for services;
b. A store owner who gives goods such as groceries, clothes, or furniture in exchange for services; or
c. An individual who trades goods such as a car, tools, trailer, building material, or gasoline in exchange for services;

2. For self-employed applicants, ~~the~~ gross business receipts minus business expenses; and
3. Unearned income.

B. A person whose income is counted. The Department shall include the income of the following persons under Section 1902(a)(17) of the Act ~~when~~ if living together unless the person is a SSI cash recipient ~~under Section 1902(a)(17) of the Act~~:

1. Applicant;
2. Applicant's parent, if the applicant is an unmarried ~~minor~~ dependent child, who is less than 18 years old;
3. Applicant's spouse;
4. The sponsor, under 8 CFR 213(a)(1), and sponsor's spouse of a person meeting the alien requirements under A.R.S. § 36-2903.03;
5. ~~If applying as a family under R9-22-1420 which includes a dependent child, living with a specified relative, the non-parent caretaker relative and spouse, as allowed under R9-22-1420, and their unmarried minor children~~ The non-parent caretaker relative and spouse, as allowed under R9-22-1420, and their unmarried minor children if applying as a family, which includes a dependent child living with a specified relative, under R9-22-1420;
6. ~~The Department shall not include the income of a SSI cash recipient.~~

C. Income exclusions. The Department shall exclude the following income:

1. Agent Orange settlement fund payments;
2. AmeriCorps Network Program benefits;
3. Burial benefits dispersed solely for burial expenses;
4. Cash contributions from other agencies or organizations so long as the contributions are not intended to cover the following items:
   a. Food;
   b. ~~Shelter, including only rent~~ Rent or mortgage payments for shelter;
   c. Utilities;
   d. Household supplies, ~~including~~ such as bedding, towels, laundry, cleaning, and paper supplies;
   e. Public transportation fares for personal use;
   f. Basic clothing or diapers; or
   g. Personal care and hygiene items, such as soap, toothpaste, shaving cream, and deodorant;
5. Disaster assistance provided ~~by~~ under the Federal Disaster Relief Act, disaster assistance organizations, or comparable assistance provided by state or local governments;
6. Educational grants or scholarships funded by the United States Department of Education or from a Veterans Education assistance program or the Bureau of Indian Affairs student assistance program;
7. Energy assistance ~~which~~ that is provided:
   a. Either in cash or in-kind by a government agency or municipal utility, or
   b. In-kind by a private nonprofit organization;
8. Earnings from high school on-the-job training programs;
9. Earned income of dependent children who are students enrolled and attending school at least half-time as defined by the institution;
10. Fair Labor Standard Act supplemental payment;
11. Food stamp benefits;
12. Foster care maintenance payments intended for children who are not included in the family or Medical Expense Deduction (MED) unit;
13. Funds set aside in an Individual Development Account under A.A.C. R6-12-404;
14. Governmental rent and housing subsidies;
15. Income tax refunds, including any earned income tax credit;
16. Loans from a private person, or a commercial or educational institution;
17. Nonrecurring cash gifts ~~which~~ that do not exceed $30 per person in any calendar quarter;
18. Payments made from a fund established by the Susan Walker v. Bayer Corporation class action lawsuit or the Ricky Ray Hemophilia Relief Fund Act of 1998;
19. Radiation exposure compensation payments;
20. Reimbursement for work-related expenses which do not exceed the actual expense amount;
21. Reimbursement for Job Opportunities and Basic Skills (JOBS) Program training-related expenses;
22. Reparation and restitution payments under Section 1902(r) of the Act;
23. SSI ~~Designated~~ designated account and interest earned on that account;
24. Temporary Assistance for Needy Families (TANF) or SSI cash assistance payment;

25. Vendor payment to a third-party ~~vendor~~ to cover family expenses, ~~provided~~ if the payment is made by an organization or a person who is not a member of the family or MED unit;
26. Volunteers In Service To America (VISTA) income ~~which~~ that does not exceed the state or federal minimum wage;
27. Vocational rehabilitation program payments made as reimbursement for training-related expenses, subsistence and maintenance allowances, and incentive payments ~~which~~ that are not intended as wages;
28. Women, Infants, and Children (WIC) benefits; or
29. Any other income specifically excluded ~~by applicable federal law~~ under 20 CFR Part 416 Appendix K.

D. Special income provision for child support. The Department shall consider child support to be income of the child for whom the support is intended and count the child support income received after deducting $50 per child receiving child support income from the monthly amount.

E. Determining ~~Income For a Month~~ income for a month.

1. ~~The Department shall include income which is received during the month or which the person reasonably expects to receive in the month based on reasonable expectations and knowledge of the person's current, past, and anticipated future circumstances.~~ Calculating monthly income. The Administration or its designee shall calculate monthly income under A.A.C. R9-22-1419.01 through 1419.04.
2. The ~~Department~~ Administration or its designee shall deduct the applicable disregards and deductions to which a person is entitled for the month.
3. ~~The Department shall convert income received more frequently than monthly to a monthly amount.~~
4. ~~The Department shall consider a one time lump sum income in the month the income is received.~~

F. Earned Income Disregards.

1. General. The Department shall apply the earned income disregards to each employed person's gross earnings.
2. Disregards. The Department shall apply the following method to calculate the amount of the countable earned income:
   a. Subtract a $90 cost of employment (COE) allowance from the gross amount of earned income for each person whose earned income is counted;
   b. Subtract an amount billed ~~by the child care provider~~ for the care of each dependent child or incapacitated adult member who is the responsibility of the person whose income ~~shall be~~ is counted, if the care is for the ~~purposes to allow~~ purpose of allowing the person to work, not to exceed:
      i. For a wage-earner employed full-time (86 hours or more a month), $200 for ~~a~~ each child ~~under~~ less than age two, and $175 for ~~the~~ each other ~~dependents~~ dependent; and
      ii. For a wage earner employed part-time (less than 86 hours a month), $100 for ~~a~~ each child ~~under~~ less than age two, and $88 for ~~the~~ each other ~~dependents~~ dependent.
3. Loss of disregards. The Department shall not apply the earned income disregards~~,~~ if the member fails to report to the Department a change in income within 10 days from the date the change becomes known to the member. The change report to the Department shall be postmarked no later than the 10th day from the date the change becomes known.

R9-22-1419.01. Income Eligibility

A. A person is not eligible under this Article unless the person's monthly income is equal to or below the appropriate Federal Poverty Level (FPL) listed in R9-22-1420 and R9-22-1421. A person is not eligible under R9-22-1429 unless the person's income during the period defined in R9-22-1429(C) is equal to or below the FPL under R9-22-1429(B).

B. Definitions.

1. "Monthly income" means the gross income received or projected to be received during the month or the monthly equivalent.
2. "Monthly equivalent" means a monthly income amount established by averaging, prorating, or converting a person's income.

R9-22-1419.02. Methods for Calculating Monthly Income

A. Projecting income.

1. Description. Projecting income is a method of determining the amount of income that a person will receive.
2. Calculation. The Administration or designee shall project income by:
   a. Converting income to a monthly equivalent,
   b. Using unconverted income, or
   c. Prorating income to determine a monthly equivalent.
3. Exclusion. When calculating projected monthly income, the Administration or designee shall exclude an unusual variation in income, except for a month in which the variation is anticipated to occur.

B. Unconverted income.

1. Description. Unconverted income is the actual amount of income received or projected to be received during a month.
2. Calculation. The Administration or designee shall sum the actual amount of income received or projected to be received during a month.

C. Converted income.
1. Description. Converted income is income received weekly or biweekly that is changed to a monthly equivalent.
2. Calculation.
   a. To convert income, the Administration or designee shall determine the average weekly or bi-weekly income amount before converting to the monthly equivalent if the person's past income fluctuates and the fluctuation is expected to recur.
   b. To convert income paid weekly to a monthly equivalent, the Administration or designee shall multiply the weekly average by 4.3 weeks.
   c. To convert income paid bi-weekly to a monthly equivalent, the Administration or designee shall multiply the bi-weekly average by 2.15 weeks.

D. Averaged income.
1. Description. Averaging income proportionally distributes the person's income received on a regular basis.
2. Calculation. To average income, the Administration or designee shall add the amount of the income and divide by the total number of pay periods. If the amount of income received per pay period fluctuates, and the fluctuation is expected to continue, the Administration or designee shall:
   a. Use the averaged weekly or bi-weekly amounts to convert weekly or bi-weekly income to a monthly equivalent;
   b. Use the averaged monthly or semi-monthly amounts to project monthly income; and
   c. Use the averaged hours worked and multiply the average by the current rate of pay. If there is a change in the rate of pay; use the new rate of pay when calculating projected income under subsection (A).

E. Prorated income.
1. Description. Prorated income evenly distributes a person's income over the period the income is intended to cover to calculate a monthly equivalent.
2. Calculation. To prorate income, the Administration or designee shall divide the total amount of the person's income received during the period by the number of months that the income is intended to cover.

R9-22-1419.03. Calculations and Use of Methods Listed in R9-22-1419.02 Based on Frequency of Income

A. Monthly income. If income is received monthly or in a lump sum, the Administration or designee shall use the unconverted method for calculating monthly income. Lump sum means a non-recurring payment that serves as a complete payment. Lump sum payments include but are not limited to: rebates or credits; inheritances; insurance settlements; and payments for prior months from such sources as Social Security, Veterans Administration, Railroad Retirement, child support arrearages, or other benefits. A lump sum payment may include a portion intended for the current month.

B. Weekly income. If income is received weekly the Administration or designee shall convert the income to a monthly equivalent.

C. Bi-weekly income. If income is received bi-weekly the Administration or designee shall convert the income to a monthly equivalent.

D. Semi-monthly or daily income. If income is received semi-monthly or daily, the Administration or designee shall use the unconverted method for calculating monthly income.

E. Bimonthly, quarterly, semi-annual, or annual income. If income is received bimonthly, quarterly, semi-annually or annually, the Administration or designee shall prorate the income received or projected to be received.

R9-22-1419.04. Exceptions to R9-22-1419.03

A. New income.
1. Description. New income is income received from a new source during the first calendar month that the income is received from the source.
2. Calculating monthly income.
   a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1419.03 to calculate the monthly income.
   b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.

B. Terminated income.
1. Description. Terminated income is income received during the last calendar month that income is received from a source when no more income is expected to be received.
2. Calculating monthly income.
   a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1419.03 to calculate the monthly income.
   b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.

C. Break in income.
1. Description. A break in income is:

a. Income received from a previous source in the first calendar month following a break in established frequency of income from the source of one calendar month or more, or
b. Income received from a source in the last calendar month before a break in established frequency of income of one calendar month or more.

2. Calculating monthly income.
a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1419.03 to calculate the monthly income.
b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.

D. Contract income.
1. Description. Contract income is income a person earns under a contract or other legal document that specifies a length of time the contract or legal document covers, the amount of income to be paid, and the frequency of payment.
2. Calculating monthly income.
a. The Administration or designee shall calculate the monthly income based on the frequency of payment if income is paid more frequently than monthly.
b. The Administration or designee shall prorate over the period of time specified by the contract if income is paid monthly or less frequently.

E. Unusual variation in the amount of income.
1. Description. Unusual variation is an amount of income that is different from the established amount received and is not projected to continue or recur.
2. Calculating monthly income.
a. When calculating income for the month in which an unusual variation in income occurs, the Administration or designee shall include the unusual variation in the income calculation.
b. When an unusual variation in income occurs during the month, the Administration or its designee shall use the converted method for calculating monthly income if income is received weekly or bi-weekly.
c. When projecting income for the months following the month in which the unusual variation occurs, the Administration or designee shall exclude the unusual variation in income from the income calculation.

ARTICLE 15. AHCCCS MEDICAL COVERAGE FOR PEOPLE WHO ARE AGED, BLIND, OR DISABLED

R9-22-1501. General Information

A. General. The Administration shall determine eligibility for AHCCCS medical coverage for the following applicants or members using the eligibility criteria and requirements in this Article~~.~~:
1. A person who is aged, blind, or disabled and does not receive SSI cash under 42 CFR 435.210~~.~~; and
2. A person terminated from the SSI cash program ~~and~~ under R9-22-1505.

B. Confidentiality. The Administration shall maintain the confidentiality of the person's records and shall not disclose the person's financial, medical, or other confidential information except under Article 5 of this Chapter.

C. Application ~~Process~~ process.
1. A person may apply for AHCCCS medical coverage by submitting a signed application to any Administration office or outstation location under R9-22-1405.
2. ~~The applicant, a minor applicant's parent, the applicant's legal or authorized representative, or if the applicant is incompetent or incapacitated, someone acting responsibly on behalf of the applicant may file the application. An application shall be witnessed and signed by a third party if an applicant signs an application with a mark.~~ The provisions in A.A.C. R9-22-1405(B), (C), and (E) apply to this Section.
3. The application date is the date a signed application is received at any Administration office or outstation location approved by the Director.
4. ~~The~~ An applicant who files an application may withdraw the application, either orally or in writing. If an applicant withdraws an application, the Administration shall send the applicant a denial notice under subsection (F).
5. Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 90 days for an applicant applying on the basis of disability and 45 days for all other applicants.
6. If an applicant dies while an application is pending, the Administration shall complete an eligibility determination for the deceased applicant.
7. The Administration shall complete an eligibility determination on an application filed on behalf of a deceased applicant, if the application is filed in the month of the ~~person's~~ applicant's death.

D. Redetermination of eligibility for a person terminated from the SSI cash program.
1. Continuation of AHCCCS medical coverage. The Administration shall continue AHCCCS medical coverage for a person terminated from the SSI cash program until a redetermination of eligibility under subsection (D)(2) is completed.
2. Coverage group screening. The Administration shall screen for eligibility under any coverage group under A.R.S. §§ 36-2901(6)(a)(i) and (ii) and 36-2934.

a. If an applicant ~~has filed~~ files an application for Arizona Long-term Care System (ALTCS) coverage, the Administration shall determine eligibility under 9 A.A.C. 28, Article 4.
b. If an applicant or member is aged, blind, or disabled, but not in need of long-term care services, the Administration shall determine eligibility under this Article.
c. For all other persons, the Administration shall refer the applicant's case to the Department for an eligibility decision under Article 14.

3. Eligibility decision.
a. If ~~the~~ an applicant is eligible under this Article or 9 A.A.C. 28, Article 4, the Administration shall send a notice as under subsection (F) informing the applicant that AHCCCS medical coverage shall continue.
b. If ~~the~~ an applicant is ineligible, the Administration shall send a notice as under subsection (F) to discontinue AHCCCS medical coverage.

E. Eligibility effective date. Eligibility ~~shall be~~ is effective on the first day of the month that all eligibility requirements are met, but no earlier than the month of application.

F. Notice for ~~Approval or Denial~~ approval or denial. The Administration shall send an applicant a written notice of the decision regarding the application. This notice shall include a statement of the intended action, and:
1. If approved, the notice shall contain the effective date of eligibility.
2. If approved under FESP, the notice shall also contain:
a. The emergency services certification end date~~;~~,
b. A statement detailing the reason for the denial of full services~~;~~,
c. The legal authority supporting the decision~~;~~,
d. Where the legal authority supporting the decision can be found~~;~~,
e. An explanation of the right to request a hearing~~;~~, and
f. The date by which a request for hearing shall be received by the Administration.
3. If denied, the notice shall contain:
a. The effective date of the denial;
b. The reason for the denial, including specific financial calculations and the financial eligibility standard, if applicable;
c. Legal authority supporting the decision;
d. Where the legal authority supporting the decision can be found;
e. An explanation of the right to request a hearing; and
f. The date by which a request for hearing shall be received by the Administration.

G. Reporting and verifying changes.
1. ~~Under 42 CFR 435.916, a~~ A member shall report to the Administration the following changes for an applicant or a member, an ~~applicant~~ applicant's or member's spouse, and an applicant or member's dependent children:
a. Change of address;
b. Change in the household's members;
c. Change in income;
d. Change in resources, when applicable;
e. Determination of eligibility for other coverage;
f. Death;
g. Change in marital status;
h. Change in school attendance;
i. Change in Arizona state residency; and
j. Any other change that may affect the ~~member~~ member's or applicant's eligibility.
2. ~~Under 42 CFR 435.916, a~~ A member shall report to the Administration the following changes for an applicant or a member:
a. Admission to a penal institution,
b. Change in U.S. citizenship or immigrant status,
c. Receipt of a Social Security ~~Number~~ number, and
d. Change in first- or third-party liability which may contribute to the payment of all or a portion of the person's medical costs.
3. A person ~~may~~ shall report a change to the Administration either orally or in writing and shall include the:
a. Name of the affected applicant or member;
b. Description of the change;
c. Date the change occurred;
d. Name of the person reporting the change; and
e. Social Security or case number of the applicant or member, if known.
4. A person shall provide verification of changes ~~upon request of~~ if requested by the Administration.

5. A person shall report anticipated changes in eligibility to the Administration as soon as the ~~future event becomes known~~ person knows that the change will occur.
6. A person shall report an unanticipated change to the Administration within 10 days following the date the change occurred.

H. Processing of changes and redeterminations. If a person receives AHCCCS medical coverage under subsection (A), the Administration shall redetermine the member's eligibility ~~shall be redetermined~~ at least once every 12 months or more frequently when changes occur ~~under 42 CFR 435.916 which~~ that may affect eligibility.

I. Actions that may result from a redetermination or change. The processing of a redetermination or change shall result in one of the following actions:
1. No change in eligibility,
2. Discontinuance of eligibility if a condition of eligibility is no longer met, or
3. A change in the program under which a person receives AHCCCS medical coverage.

J. Notice of ~~Discontinuance~~ discontinuance.
1. Contents of notice. The Administration shall issue a notice whenever it takes an adverse action to discontinue a member's eligibility. The notice shall contain the following information:
   a. A statement of the action that is being taken;
   b. The effective date of the action;
   c. The reason for the discontinuance, including specific financial calculations and the financial eligibility standard if applicable;
   d. The legal authority that supports the action proposed by the Administration;
   e. Where the legal authority supporting the decision can be found;
   f. An explanation of the right to request a hearing; and
   g. The date by which a hearing request shall be received by the Administration and the right to continue medical coverage pending appeal.
2. Advance notice of changes in eligibility. Advance notice means a notice of proposed action that is issued to the member at least 10 days before the effective date of the proposed action. Except under subsection (J)(3), advance notice shall be issued whenever an adverse action is taken to discontinue eligibility.
3. Exceptions from advance notice. ~~Under 42 CFR 431.213, a~~ A notice shall be issued to ~~the~~ a member to discontinue eligibility no later than the effective date of the action if:
   a. ~~A~~ The member provides to the Administration a clearly written statement, signed by that member, that:
      i. Services are no longer wanted; or
      ii. Gives information that requires termination or reduction of services and indicates that the member understands that this ~~shall be~~ is the result of supplying that information;
   b. ~~A~~ The member provides information to the Administration that requires termination of eligibility and a member signs a written statement waiving advance notice;
   c. ~~A~~ The member cannot be located and mail sent to the member's last known address has been returned as undeliverable subject to reinstatement of discontinued services under 42 CFR 231(d);
   d. ~~A~~ The member has been admitted to a public institution where a person is ineligible for coverage;
   e. ~~A~~ The member has been approved for Medicaid in another state; or
   f. The Administration receives information confirming the death of ~~a~~ the member.

K. Request ~~For Hearing~~ for hearing. An applicant or member may request a hearing under Article 8 of this Chapter for any of the following adverse actions:
1. Complete or partial denial of eligibility;
2. Termination or reduction of AHCCCS medical coverage; or
3. Delay in the eligibility determination beyond the time-frames listed in R9-22-1501(C).

L. Assignment of ~~Rights~~ rights. A person determined eligible assigns rights to all types of medical benefits to which the person is entitled under operation of law under A.R.S. § 36-2903.

M. ~~Title VI Compliance. The Administration shall determine eligibility under the provisions of this Article. The Administration shall not discriminate against an eligible person or member because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, or physical or mental disability in accordance with Title VI of the U.S. Civil Rights Act of 1964, 42 U.S.C. 2000d, and rules and regulations promulgated according to, or as otherwise provided by law.~~

ARTICLE 19. FREEDOM TO WORK

R9-22-1903. Application for Coverage

A. A person may apply by submitting a signed application to an Administration office.

B. The application date is the date the application is received at an Administration office or outstation location approved by the Director.

C. ~~The applicant, a minor applicant's parent, the applicant's legal or authorized representative, or if the applicant is incapacitated, someone acting responsibly on behalf of the applicant may file the application. An application shall be witnessed and signed by a third party if an applicant signs an application with a mark.~~ The provisions in A.A.C. R9-22-1405(B), (C), and (E) apply to this Section.

D. The applicant or representative who files the application may withdraw the application for coverage either orally or in writing. An applicant withdrawing an application shall receive a denial notice under R9-22-1904.

E. Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 45 days.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

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

PREAMBLE

1. Sections Affected | **Rulemaking Action**

R9-28-401	Amend
R9-28-1303	Amend

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

Authorizing statutes: A.R.S. §§ 36-2932 and 36-2950

Implementing statutes: A.R.S. §§ 36-2932 and 36-2950

3. The effective date of the rules:

January 3, 2004

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

Notice of Rulemaking Docket Opening: 9 A.A.R. 3061, July 11, 2003

Notice of Proposed Rulemaking: 9 A.A.R. 3466, August 8, 2003

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

Name: Barbara Ledder

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4580

Fax: (602) 253-9115

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

The Administration is making amendments to the rules to clarify and align certain application processes for its programs. The Administration is also adding cross references to new provisions in Chapter 22 to set forth clear, uniform terminology and methodology for determining income eligibility for the long-term care program.

7. A reference to any study relevant to the rules that the agency reviewed and either relied on in its evaluation of or justification for the rules or did not rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The Administration did not review any study relevant to these rules.

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

Not applicable

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

It is anticipated that the contractors, members, providers, and the Administration will be nominally impacted by the changes to the rule language. These rules clarify and align certain application processes for the Acute Care program, SSI-MAO program and Freedom to Work program. Several cross-references to new Sections in Chapter 22 have been

added to clarify the processes for determining income eligibility for these programs. The income eligibility provisions were added to establish clear, uniform terminology and methodology for determining income eligibility.

It is anticipated that the private sector, including small businesses and political subdivisions, will not be impacted since the proposed rule language changes are intended to align and clarify the existing rules. The Administration, contractors, providers, and members will benefit from the increased clarity of the rule language and the establishment of rules governing methodology for determining income eligibility.

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

Location	Description	Comment
R9-28-401(A)(3)(c)	Corrected the cross-reference to R9-22-1405.	The reference became incorrect when R9-22-1405(C)(3) through (C)(6) was moved to R9-22-1405(E).
R9-28-1303(C)	Corrected the cross-reference to R9-22-1405.	The reference became incorrect when R9-22-1405(C)(3) through (C)(6) was moved to R9-22-1405(E).
General	Other minor technical and grammatical changes were made at the suggestion of G.R.R.C. staff.	

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

The Administration did not receive any comments.

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

Not applicable

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

Not applicable

14. Were these rules previously adopted as emergency rules?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

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

ARTICLE 4. ELIGIBILITY AND ENROLLMENT

Section
R9-28-401. General

ARTICLE 13. FREEDOM TO WORK

Section
R9-28-1303. Application for Coverage

ARTICLE 4. ELIGIBILITY AND ENROLLMENT

R9-28-401. General

A. Application for ALTCS coverage.
1. The Administration shall provide a person the opportunity to apply for ALTCS without delay.
2. A person may be accompanied, assisted, or represented by another in the application process.
3. To apply for ALTCS, a person shall submit a written application to an ALTCS eligibility office.
   a. The application shall contain the applicant's name and address.
   b. ~~The application may be submitted by the applicant's representative.~~ A person listed in A.A.C. R9-22-1405(B) shall submit the application.
   c. ~~The application shall be signed by the person requesting ALTCS coverage or by a representative.~~ Before the application is approved a person listed in A.A.C. R9-22-1405(E) shall sign the application.
   d. A witness shall also sign ~~an~~ the application if an applicant signs ~~an~~ the application with a mark.

e. The date of application is the date the application is received at any ALTCS eligibility office.

4. ~~Except when there is an emergency beyond the Administration's control, the Administration shall not delay the eligibility determination beyond the following time-frames when information necessary to make the determination has been provided or obtained:~~
   ~~a. 90 days for an applicant applying on the basis of disability; or~~
   ~~b. 45 days for all other applicants.~~
   Except as provided in R9-22-1501(C)(5), the Administration shall determine eligibility within 45 days from the date of application.
5. ~~The~~ An applicant or representative who files ~~the~~ an ALTCS application may withdraw the application for ALTCS coverage either orally or in writing to the ALTCS eligibility office where the application was filed. ~~An applicant withdrawing an ALTCS application shall receive~~ The Administration shall provide the applicant with a denial notice under subsection (G).
6. If an applicant dies while an application is pending, the Administration shall complete an eligibility determination for the deceased applicant.
7. The Administration shall complete an eligibility determination on an application filed on behalf of a deceased applicant, ~~provided~~ if the application is filed in the month of the person's death ~~or earlier~~.

B. Conditions of ALTCS eligibility. Except for persons identified in subsection (C), the Administration shall approve a person ~~shall be approved~~ for ALTCS if all conditions of eligibility for one of the ALTCS coverage groups listed in R9-28-402(B) are met. The conditions of eligibility are:

1. Categorical requirements under R9-28-402;
2. Citizenship and alien status under R9-28-404;
3. SSN under R9-28-405;
4. Living arrangements under R9-28-406;
5. Resources under R9-28-407;
6. Income under R9-28-408;
7. Transfers under R9-28-409;
8. A legally authorized person shall assign rights to the Administration for medical support and for payment of medical care from any first- and third-parties and shall cooperate by:
   a. ~~Establishing paternity and obtaining~~ Obtaining medical support and payments and establishing paternity for a child born out of wedlock, except for pregnant women under A.A.C. R9-22-1421, unless the person establishes good cause under 42 CFR 433.147 for not cooperating; and
   b. Identifying and providing information to assist the Administration in pursuing first-and third-parties who may be liable to pay for care and services unless the person establishes good cause for not cooperating;
9. A person shall take all necessary steps to obtain annuity, pension, retirement, and disability benefits for which a person may be entitled unless the person establishes good cause for not doing so;
10. State residency under R9-28-403;
11. Medical eligibility specified in Article 3 of this Chapter; and
12. Providing information and verification specified in Section (D).

C. Persons eligible for Title IV-E or Title XVI. To be determined eligible for ALTCS, a person eligible for benefits under Title IV-E or Title XVI of the Social Security Act shall provide information to allow the Administration to determine:

1. Medical eligibility specified in Article 3 of this Chapter;
2. Post-eligibility treatment of income specified in R9-28-408;
3. Trusts in accordance with federal and state law; and
4. Transfer of property specified in R9-28-409.

D. Verification. If requested by the Administration, a person shall provide information and documentation to verify the following criteria or shall authorize the Administration to verify the following criteria:

1. Categorical requirements under R9-28-402,
2. SSN under R9-28-405,
3. Living arrangements under R9-28-406,
4. Resources under R9-28-407,
5. Transfers of assets under R9-28-409,
6. Income under R9-28-408,
7. Citizenship and alien status under R9-28-404,
8. First-and third-party liability under subsection (B)(8),
9. Application for potential benefits under subsection (B)(9),
10. State residency under R9-28-403,
11. Medical conditions under Article 3 of this Chapter, and
12. Other individual circumstances necessary to determine a person's eligibility and post-eligibility treatment of income (share-of-cost).

E. Documentation of the eligibility decision. The ALTCS eligibility interviewer shall include facts in a person's case record to support the decision on the person's application.

F. Eligibility effective date. Eligibility ~~shall be~~ is effective the first day of the month that all eligibility requirements are met but no earlier than the month of application.

G. Notice. The Administration shall send a person a written notice of the decision regarding the person's application. The notice shall include a statement of the action and an explanation of the person's hearing rights specified in Article 8 of this Chapter and:

1. If the applicant's eligibility is approved, the notice shall contain:
   a. The effective date of eligibility; and
   b. Post-eligibility treatment of income (share-of-cost) information, which is the amount the person shall pay toward the cost of care.
2. If the applicant's eligibility is denied, the notice shall contain:
   a. The effective date of the denial;
   b. A statement detailing the reason for the person's denial, including specific financial calculations and the financial eligibility standard if applicable; and
   c. The legal authority supporting the decision.

H. Confidentiality. The Administration shall maintain the confidentiality of a person's record and shall not disclose the person's financial, medical, or other privacy interests except under A.A.C. R9-22-512.

I. ~~Title VI Compliance. The Administration shall determine eligibility under the provisions of this Article. The Administration shall not discriminate against an eligible person or member because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, or physical or mental disability in accordance with Title VI of the U.S. Civil Rights Act of 1964, 42 U.S.C. 2000d, and rules and regulations promulgated according to, or as otherwise provided by law.~~

ARTICLE 13. FREEDOM TO WORK

R9-28-1303. Application for Coverage

A. A person may apply by submitting a signed application to an Administration office.

B. The application date is the date the application is received at an Administration office.

C. ~~The applicant, a minor applicant's parent, the applicant's legal or authorized representative, or if the applicant is incapacitated, someone acting responsibly on behalf of the applicant may file the application. An application shall be witnessed and signed by a third party if an applicant signs an application with a mark.~~ The provisions of A.A.C. R9-22-1405(B), (C), and (E) apply to this Section.

D. ~~The~~ An applicant or representative who files ~~the~~ an application may withdraw the application for coverage either orally or in writing. ~~An~~ The Administration shall send an applicant withdrawing an application ~~shall receive~~ a denial notice under R9-28-1304.

E. Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 45 days.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 29. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM MEDICARE COST SHARING PROGRAM

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-29-101	Amend
R9-29-102	New Section
Article 2	Amend
R9-29-201	Amend
R9-29-202	Repeal
R9-29-202	New Section
R9-29-203	Repeal
R9-29-203	New Section
R9-29-204	New Section
R9-29-205	New Section
R9-29-206	New Section
R9-29-207	New Section
R9-29-208	New Section
R9-29-209	New Section
R9-29-210	New Section
R9-29-211	New Section
R9-29-212	New Section
R9-29-213	New Section
R9-29-214	New Section
R9-29-215	New Section
R9-29-216	New Section
R9-29-217	New Section
R9-29-218	New Section
R9-29-219	New Section
R9-29-220	New Section
R9-29-221	New Section
R9-29-222	New Section
R9-29-223	New Section
R9-29-224	New Section
Article 3	Amend
R9-29-301	Amend
R9-29-302	Amend
R9-29-303	New Section
Article 4	Amend
R9-29-401	Amend
Article 5	Amend
R9-29-501	Amend
R9-29-502	Repeal
R9-29-503	Amend
Article 6	Amend
R9-29-601	Amend
R9-29-602	Repeal

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

Implementing statute: A.R.S. § 36-2972

3. The effective date of the rules:

January 3, 2004

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

Notice of Rulemaking Docket Opening: 9 A.A.R. 1471, May 16, 2003

Notice of Proposed Rulemaking: 9 A.A.R. 3470, August 8, 2003

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

Name: Barbara Ledder

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4580

Fax: (602) 253-9115

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

Consistent with the changes proposed in the Agency's Five-year Rule Review Report approved by the G.R.R.C. in January 2003, AHCCCS proposes to amend this Chapter by making it more clear, concise, and understandable. Other changes include the addition of provisions from federal regulations that make the Chapter easier to read and consistent with other AHCCCS related Chapters in describing the eligibility determination criteria and process.

7. A reference to any study relevant to the rules that the agency reviewed and either relied on in its evaluation of or justification for the rules or did not rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

AHCCCS did not review any study relevant to these rules.

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

Not applicable

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

The Agency has determined that the AHCCCS members, contractors, the Arizona Office of Administrative Hearings (AOAH), as well as AHCCCS' eligibility offices would benefit from amending the entire Chapter, making it clearer and more concise. The proposed language includes provisions required through federal and state laws and regulations.

The only effect on AHCCCS is that replacement pages will need to be issued for the Legal Reference Binders used by AHCCCS field offices. AHCCCS field offices use these binders to provide applicants or recipients with the statute or regulatory basis for an eligibility decision or adverse action. Adverse actions can include a denial of eligibility, termination of eligibility, and a decrease in benefits.

AHCCCS expects that a few system changes will need to be made to update existing system tables with the new rule citations that are input on program notices. The cost to AHCCCS is nominal in that to incorporate these amendments into our existing processes for notification of eligibility determinations require minimal system changes resulting in no more than 40 staff hours and less than $150 in copying charges. No other entity, private or public, will absorb any cost in relation to this proposed rulemaking.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules:

In addition to the changes identified below, AHCCCS made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules.

Location	Description
Chapter Heading	Changed the Chapter heading from Qualified Medicare Beneficiaries (QMB) to Medicare Cost Sharing.
Table of Contents	Index- ARTICLE 5- original language was reinserted and struck "AND REQUEST FOR HEARING" (Note that the Article did not have this language, but instead had "AND APPEALS PROCESS" which is what we have in the proposed/final. Added "Member" to Section heading of Section 302.
R9-29-101(A)	Added "Medicare" to "SLMB" acronym.
R9-29-102	Changed order of language.
R9-29-203(A)	Added "…approved by AHCCCS."
R9-29-204	Added the following language: "…approved by AHCCCS" to identify outstation location.
R9-29-207	Added word "benefits" after QMB.
R9-29-213	The term "equal to" was deleted in reference to the SLMB and QI-1's income, in relation to the federal poverty level.

R9-29-218	Clarified language regarding Medicare Part A.
R9-29-301(A)	The language regarding copayments was removed to be consistent with federal law.
R9-29-301(B)	Reduced duplications by grouping together what AHCCCS shall pay and shall not pay. Removed "and/or" from (1)(b), kept "and."
R9-29-302	Added subsection headings.
R9-29-302	Added "Member" to heading.
R9-29-302(B)	Removed the term "copayment."
R9-29-401(A)	Changed language to read "…benefits and services specified in R9-29-302(B) and **either** 9 A.A.C. 22 or 9 A.A.C. 28 for dually eligible members."
R9-29-401(B)	Language was amended to clarify that if a dually eligible member is referred to a primary care physician or primary care practitioner, the contractor shall pay a copayment for services provided.
R9-29-401(D)	Reinserted and struck language.
Chapter 29	Other technical and grammatical changes were made at the suggestion of G.R.R.C. staff

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

The Agency received no comments.

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

None

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

None

14. Were these rules previously adopted as emergency rules?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 29. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
~~QUALIFIED MEDICARE BENEFICIARY (QMB)~~ MEDICARE COST SHARING PROGRAM

ARTICLE 1. DEFINITIONS

Section
R9-29-101. Location of Definitions
R9-29-102. Dually Eligible

ARTICLE 2. ELIGIBILITY ~~AND ENROLLMENT~~

Section
R9-29-201. General ~~Provisions of QMB Eligibility~~
R9-29-202. ~~QMB Enrollment~~ Opportunity to Apply
R9-29-203. ~~QMB Discontinuance~~ How to File an Application
R9-29-204. ~~Repealed~~ Date of Application
R9-29-205. Complete Application
R9-29-206. Assistance with Application
R9-29-207. Assignment of Rights
R9-29-208. Medical Support Obligation
R9-29-209. Social Security Number (SSN)
R9-29-210. Citizenship
R9-29-211. Residency
R9-29-212. Income Calculation
R9-29-213. Income Standards
R9-29-214. Application for Other Benefits
R9-29-215. Institutionalized Person
R9-29-216. Resources
R9-29-217. Verification

ARTICLE 3. ~~COVERED~~ BENEFITS AND SERVICES

ARTICLE 4. CONTRACTOR, PROVIDER, ~~NONPROVIDER,~~ AND NONCONTRACTING PROVIDER REQUIREMENTS

ARTICLE 5. GRIEVANCE AND ~~REQUEST FOR HEARING~~ APPEAL PROCESS

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

ARTICLE 1. DEFINITIONS

R9-29-101. Location of Definitions

~~A.~~ ~~Location of definitions. Definitions applicable to Chapter 29 are found in the following:~~

~~Definition~~	~~Section or Citation~~
~~"AHCCCS"~~	~~R9-22-101~~
~~"ALTCS"~~	~~A.R.S. § 36-2932~~
~~"CFR"~~	~~R9-29-101~~
~~"Contractor"~~	~~A.R.S. § 36-2971~~
~~"Director"~~	~~R9-22-101~~
~~"Dual eligible"~~	~~A.R.S. § 36-2971~~
~~"Enrollment"~~	~~R9-22-117~~
~~"First-party liability"~~	~~R9-22-110~~
~~"Grievance"~~	~~R9-22-108~~
~~"Hearing"~~	~~R9-22-108~~
~~"Program contractor"~~	~~A.R.S. § 36-2971~~
~~"QMB only"~~	~~R9-29-101~~
~~"Third-party"~~	~~R9-22-110~~
~~"Third-party liability"~~	~~R9-22-110~~

~~B.~~ ~~General 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:~~

~~"AHCCCS" is defined in 9 A.A.C. 22, Article 1.~~

~~"ALTCS" means the Arizona Long-Term Care System as authorized by A.R.S. § 36-2931 et seq.~~

~~"CFR" means the Code of Federal Regulations.~~

~~"Director" is defined in 9 A.A.C. 22, Article 1.~~

~~"Dual eligible" is defined in A.R.S. § 36-2971.~~

~~"Enrollment" is defined in 9 A.A.C. 22, Article 1.~~

~~"Grievance" is defined in 9 A.A.C. 22, Article 1.~~

~~"Hearing" is defined in 9 A.A.C. 22, Article 1.~~

~~"Program contractor" is defined in A.R.S. § 36-2971.~~

~~"QMB-only" means Qualified Medicare Beneficiary only and is defined in A.R.S. § 36-2971.~~

~~"Third-party" is defined in 9 A.A.C. 22, Article 1.~~

~~"Third-party liability" is defined in 9 A.A.C. 22, Article 1.~~

A. Location of definitions. Definitions for this Chapter are contained in A.R.S. § 36-2971. Definitions include "Qualified Medicare Beneficiary only" (QMB), "Specified Low Income Medicare Beneficiary" (SLMB), and "Qualified Individual-1" (QI-1). For the purpose of Article 2 of this Chapter, QMB includes members defined in A.R.S. § 36-2971(5).

B. "AHCCCS" means the Arizona Health Care Cost Containment System.

C. "Medicare Cost Sharing" (MCS). The MCS Program is administered by the Administration and provides help to Medicare beneficiaries with costs related to Medicare services. MCS is also referred to as the "Medicare Savings Programs."

R9-29-102. Dually Eligible

Under A.R.S. § 36-2971, a person determined eligible under Article 2 of this Chapter for QMB, may also be eligible for Acute Care services provided for in 9 A.A.C. 22 or ALTCS services provided for in 9 A.A.C. 28.

ARTICLE 2. ELIGIBILITY ~~AND ENROLLMENT~~

R9-29-201. General ~~Provisions of QMB Eligibility~~

~~**A.** 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, 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.** Eligibility for QMB 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 QMB benefits.~~

~~**D.** All QMB 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.~~

A. Eligibility determination. AHCCCS shall determine eligibility for a QMB, SLMB, or QI-1 under this Article.

B. Confidentiality. AHCCCS shall maintain the confidentiality of a person's financial information except as provided under Article 5.

R9-29-202. ~~QMB Enrollment~~ Opportunity to Apply

~~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.~~

The Administration shall provide the opportunity to apply without delay.

R9-29-203. ~~QMB Discontinuance~~ How to File an Application

~~**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 QMB eligibility due to death; discontinuance shall be effective the day after the date of death.~~

~~**C.** A member shall lose QMB eligibility due to incarceration and shall be discontinued the date the Administration is notified.~~

A. Written application. To apply for the MCS Program, a person shall submit a written application form prescribed by AHCCCS to any AHCCCS office or outstation location approved by AHCCCS.

B. Who shall submit. An application shall be submitted by a person listed in A.A.C. R9-22-1405(B).

R9-29-204. ~~Repealed~~ Date of Application

The date of application is the date a signed application is received at an AHCCCS office or outstation location approved by AHCCCS.

R9-29-205. Complete Application

AHCCCS shall determine whether an application is complete under A.A.C. R9-22-1405(E).

R9-29-206. Assistance with Application

A. Applicant's representative. AHCCCS shall allow a person of an applicant's choice to accompany, assist, and represent the applicant in the application process.

B. Assistance by AHCCCS. If requested, AHCCCS shall help a person complete an application.

R9-29-207. Assignment of Rights

A person determined eligible for QMB benefits assigns rights to medical benefits to which the person is entitled under operation of law to AHCCCS, under A.R.S. §§ 36-2903 and 36-2972.

R9-29-208. Medical Support Obligation

To be eligible for QMB, a person shall provide information necessary to establish paternity and enforce medical support obligations, when requested by AHCCCS.

R9-29-209. Social Security Number (SSN)

To be eligible for MCS a person shall furnish a SSN or apply for a SSN.

R9-29-210. Citizenship

To be eligible for MCS, a person shall be a United States citizen or a qualified alien under A.R.S. § 36-2903.03.

R9-29-211. Residency

To be eligible for MCS, a person shall be a current resident of this state.

R9-29-212. Income Calculation

AHCCCS shall calculate income under A.A.C. R9-22-1503.

R9-29-213. Income Standards

To be eligible, a person's income shall meet the following federal poverty levels (FPL), adjusted annually:

1. QMB. Income is equal to or less than 100 percent of the FPL.
2. SLMB. Income is greater than 100 percent but less than 120 percent of the FPL.
3. QI-1. Income is at least 120 percent but less than 135 percent of the FPL.

R9-29-214. Application for Other Benefits

To be eligible for MCS, a person shall apply for other benefits, if requested by AHCCCS.

R9-29-215. Institutionalized Person

The provisions in A.A.C. R9-22-1402 apply to this Article for an institutionalized person.

R9-29-216. Resources

Resources mean property that a person owns including, but not limited to cash, financial accounts, real property, vehicles, trusts, and life insurance. Resources are not considered in determining a person's MCS eligibility.

R9-29-217. Verification

To be eligible for MCS, a person shall provide verification, or authorize the release of verification, for all information necessary to complete the determination of eligibility.

R9-29-218. Medicare Requirements

To be eligible for MCS, a person shall either be receiving Medicare Part A benefits or determined conditionally entitled to Medicare Part A benefits by the Social Security Administration. A person may request that the Social Security Administration determine the person to be conditionally entitled to Medicare Part A if the person is required to pay a Part A premium. A person who is conditionally entitled to Medicare Part A is not enrolled in Part A unless approved for QMB.

R9-29-219. Eligibility Determination

AHCCCS shall make an eligibility determination within 45 days of the date of application.

R9-29-220. Notice of Eligibility Determination

A. Notice. AHCCCS shall send an applicant written notice of the eligibility decision. The notice shall include a statement of the action and an explanation of the person's hearing rights specified in Article 5.

B. Approval. If AHCCCS determines that the applicant is eligible, the notice shall contain the effective date of eligibility.

C. Denial. If AHCCCS determines that the applicant is not eligible, the notice shall contain:

1. The effective date of the decision;
2. A statement detailing the reason for the decision, including specific financial calculations and the financial eligibility standard if applicable; and
3. The legal authority supporting the decision.

R9-29-221. Effective Date of Eligibility

A. QMB. The effective date of eligibility is the first day of the month following the month in which AHCCCS makes the eligibility decision.

B. SLMB and QI-1. The effective date of eligibility is the first day of the first month AHCCCS determines the person is eligible under this Article, but no earlier then the first day of the month of application.

R9-29-222. Discontinuance

A. Discontinuance. AHCCCS shall discontinue a person's eligibility if any of the conditions of eligibility under this Article are not met.

B. Notice. AHCCCS shall follow the discontinuance notice requirements under R9-22-1413.

R9-29-223. Redetermination

A. QMB and SLMB. AHCCCS shall redetermine a person's eligibility for QMB or SLMB at least one time every 12 months.

B. QI-1. A person receiving QI-1 benefits shall reapply each calendar year.

R9-29-224. Reporting Changes

A person eligible under this Article shall report to an ALTCS or Social Security Insurance Medical Assistance Only office the following changes for the person, the person's spouse, or the person's dependent children:

1. A change of address;
2. An admission to, or discharge from, a public institution, as specified in R9-22-1402;
3. A change in household composition;
4. A change in income;
5. A determination of eligibility for other benefits;
6. A death;
7. A change in marital status;
8. A change in Arizona state residency;
9. A change in citizenship or alien status;
10. Receipt of a SSN;
11. A change in Medicare receipt or eligibility; and
12. For QMB recipients, a change in first- or third-party liability that may be responsible for payment of all or a portion of the person's medical costs.

ARTICLE 3. ~~COVERED~~ BENEFITS AND SERVICES

R9-29-301. ~~Qualified Medicare Beneficiary~~ QMB Only

A. ~~A person determined eligible as a QMB-only 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.~~

QMB benefits. A person determined eligible as a QMB only member shall receive payment of:

1. Medicare Part A premium,
2. Medicare Part B premium, and
3. Medicare coinsurance and Medicare deductible for Medicare covered services under Title XVIII of the Act.

B. ~~A person determined eligible as a QMB-only who receives covered services from a provider that does not accept Medicare assignment is entitled to coverage of the coinsurance and deductible up to and not exceeding the Medicare-approved amount. The AHCCCS Administration shall make payment of the coinsurance and deductible for a QMB-only member only to the provider. Under no circumstances shall the AHCCCS Administration make a coinsurance or deductible payment to a QMB-only member. 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. The AHCCCS Administration shall have no liability for any balance.~~

Payment of QMB only benefits.

1. The Administration shall:
   a. Pay Medicare Part A and Part B premiums, and
   b. Pay the coinsurance and deductible to the provider.
2. The Administration shall not pay:
   a. More than the Medicare-approved amounts, or
   b. Coinsurance or deductible to a member.

R9-29-302. ~~Qualified Medicare Beneficiary with Dual Eligibility~~ Dually Eligible Member

~~**A.** A person determined dual eligible may shall receive the following benefits and services:~~

~~1. The benefits and services described in R9-29-301; and~~

~~2. Medical services and provisions in 9 A.A.C. 22, Article 2, subject to the specified limitations and exclusions or services and provisions in 9 A.A.C. 28, Article 2, subject to the specified limitations and exclusions.~~

~~**B.** The AHCCCS Administration may deny shall deny payment for covered benefits and services if:~~

~~1. The services are not obtained within the member's health plan, or program contractor or fee-for-service network; or~~

~~2. The services are not provided in conformance with the provisions in 9 A.A.C. 22 or 9 A.A.C. 28.~~

A. Covered services. A person determined to be a dually eligible member shall receive medical services and provisions under 9 A.A.C. 22, Article 2, or services and provisions under 9 A.A.C. 28, Article 2, in addition to the Medicare covered services under R9-29-301(A).

B. Payment responsibilities. AHCCCS shall pay the Medicare Part A and Part B premiums. The contractor shall pay the coinsurance and deductibles in accordance with the contract with AHCCCS.

C. Member responsibilities. A ~~person determined dual~~ dually eligible member who receives ~~covered~~ services in 9 A.A.C. 22, Article 2 or 9 A.A.C. 28, Article 2 from a provider within the ~~health plan, program contractor~~ contractor's network ~~or fee-for-service network shall not be~~ is not liable for any Medicare coinsurance~~, or~~ deductible, or copayment associated with those services and is not liable for any balance.

R9-29-303. SLMB and QI-1

AHCCCS shall pay Medicare Part B premiums.

ARTICLE 4. CONTRACTOR, PROVIDER, ~~NONPROVIDER,~~ AND NONCONTRACTING PROVIDER REQUIREMENTS

R9-29-401. Contractor, Provider, ~~Nonprovider,~~ and Noncontracting Provider Requirements

A. ~~Contractors and other providers shall be responsible for providing the covered services specified in R9-29-302 to dual eligible and QMB-only members as specified in 9 A.A.C. 22.~~

For dually eligible members, a contractor is responsible for benefits and services under R9-29-302(B) and either 9 A.A.C. 22 or 9 A.A.C. 28, as applicable.

B. ~~Program contractors and other providers shall be responsible for providing the covered services specified in R9-29-302 to dual eligible and QMB-only members as specified in 9 A.A.C. 28.~~

A contractor shall pay a copayment for services provided to a dually eligible member by or under referral from the member's primary care physician or primary care practitioner, under A.R.S. § 36-2974.

C. ~~Nonproviders and noncontracting providers~~ Providers and noncontracting providers shall submit all claims for copayments, deductibles, and coinsurance for services rendered to a ~~dual eligible and~~ QMB-only member ~~including claims for copayments, as specified in~~ under 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.~~

ARTICLE 5. GRIEVANCE AND ~~REQUEST FOR HEARING~~ APPEAL PROCESS

R9-29-501. General Provisions for a Grievance and a Request for Hearing

A ~~grievance and a~~ request for hearing under this Chapter shall comply with R9-22-801 and R9-22-802. For the purposes of this Article, "hearing" means an administrative hearing under Title 41, Chapter 6, Article 10.

R9-29-502. ~~Grievance~~ Repealed

~~A grievance and request for hearing under this Chapter shall comply with R9-22-802.~~

R9-29-503. Eligibility Hearing for an Applicant or a Member ~~under 9 A.A.C. 29, Article 2~~

An eligibility hearing for a member or an applicant under this Chapter shall comply with R9-22-803.

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

R9-29-601. ~~1st- and 3rd-~~ First- and Third-Party Liability and ~~Coordination of Benefits~~ Recoveries

A. The provisions specified in 9 A.A.C. ~~R9-22-1001~~ 22, Article 10 apply to this Section. For the purposes of this Article, "third-party liability" means the resources available from a person, entity, or program that is or may be, by agreement, circumstance, or otherwise, liable to pay all or part of the medical expenses incurred by an applicant or member.

B. ~~The Administration~~ AHCCCS shall not be liable for payment of coinsurance and deductibles when Medicare denies payment.

R9-29-602. ~~1st and 3rd Party Liability Monitoring and Compliance~~ Repealed

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

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM CHILDREN'S HEALTH INSURANCE PROGRAM

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-31-302	Amend
R9-31-303	Amend
R9-31-304	Amend
R9-31-1702	Amend

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

Authorizing statutes: A.R.S. §§ 36-2903.01, 36-2982, and 36-2986

Implementing statutes: A.R.S. §§ 36-2981.01, 36-2982, and 36-2983

3. The effective date of the rules:

January 3, 2004

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

Notice of Rulemaking Docket Opening: 9 A.A.R. 3061, July 11, 2003

Notice of Proposed Rulemaking: 9 A.A.R. 3478, August 8, 2003

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

Name: Barbara Ledder

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4580

Fax: (602) 253-9115

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

The Administration is making amendments to the rules to clarify and align certain application processes for its programs. The Administration is also adding provisions to set forth clear, uniform terminology and methodology for determining income eligibility.

7. A reference to any study relevant to the rules that the agency reviewed and either relied on in its evaluation of or justification for the rules or did not rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The Administration did not review any study relevant to these rules.

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

Not applicable

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

It is anticipated that the contractors, members, providers, and the Administration will be nominally impacted by the changes to the rule language. These rules clarify and align certain application processes for the Acute Care program, SSI-MAO program and Freedom to Work program. Several cross-references to new Sections in Chapter 22 have been added to clarify the processes for determining income eligibility for these programs. Income eligibility provisions were added to establish clear, uniform terminology and methodology for determining income eligibility.

It is anticipated that the private sector, including small businesses and political subdivisions, will not be impacted since the proposed rule language changes are intended to align and clarify the existing rules. The Administration, contractors, providers, and members will benefit from the increased clarity of the rule language and the establishment of rules governing methodology for determining income eligibility.

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

Location	Description	Comment
R9-31-302(A) (R9-31-302(C))	Moved the reference to Chapter 22 to subsection (A).	Is more properly housed in subsection (A).
R9-31-302(D)	Corrected the cross-reference to R9-22-1405.	The reference became incorrect when R9-22-1405(C)(3) through (C)(6) was moved to R9-22-1405(E).
R9-31-1702	Corrected the cross-reference to R9-22-1405.	The reference became incorrect when R9-22-1405(C)(3) through (C)(6) was moved to R9-22-1405(E).
General	Other minor technical and grammatical changes were made at the suggestion of G.R.R.C. staff.	

11. A summary of the principal comments and the agency response to them:
The Administration did not receive any comments.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
Not applicable

13. Incorporations by reference and their location in the rules:
None

14. Were these rules previously adopted as emergency rules?
No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM CHILDREN'S HEALTH INSURANCE PROGRAM

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

Section
R9-31-302. Applications
R9-31-303. Eligibility Criteria
R9-31-304. Income Eligibility

ARTICLE 17. ELIGIBILITY AND ENROLLMENT FOR A PARENT

Section
R9-31-1702. Application

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-31-302. Applications

A. Availability. The provisions in A.A.C. R9-22-1405(B) apply to this Section. The Administration shall make available program applications. Any person may request a program application.

B. Submission of applications. An application is completed and submitted to the Administration:
1. In person,
2. By mail,
3. By fax, or
4. By other form approved by the Administration.

C. Date of application. The date of application is the date the Administration or its designee receives an application that:
1. Is signed by the person making the application,
2. Includes the name of the person for whom assistance is requested, and
3. Includes the address and telephone number of the person submitting the application.

D. Completed application.
1. The provisions in A.A.C. R9-22-1405(E) apply to this Section.
~~1.~~2. The Administration shall consider an application complete when:
   a. All questions are answered,
   b. An enrollment choice is included, and
   c. All necessary verification is provided by an applicant or an applicant's representative.
~~2.~~3. If the application is incomplete, the Administration shall do one or both of the following:
   a. Contact an applicant or an applicant's representative by telephone to obtain the missing information required for an eligibility determination;
   b. Mail a request for additional information to an applicant or an applicant's representative, allowing 10 days from the date of the request to provide the required additional information.

E. Eligibility determination processing time.
1. When an application is complete, the Administration shall mail ~~the~~ notification to the applicant regarding the eligibility determination no more than 30 days from the date of application except when there is an emergency beyond the Administration's control.
2. An applicant shall provide the Administration with all requested information within 10 days from the date of the written request for the information. If an applicant fails to provide the requested information and fails to request an extension of the 10 day period or the request for extension is denied, the Administration shall deny eligibility.

F. Waiting list. If the Administration stops processing an application because the monies are insufficient as specified in R9-31-301(C)(1), the Administration shall place an applicant on a waiting list and notify the applicant. When sufficient funding becomes available, the Administration shall contact an applicant on the waiting list and ask the applicant to submit a new application if the original application is more than 60 days old. ~~Spaces shall be filled as a completed~~ The Administration shall fill spaces in the order that an application is received and approved.

R9-31-303. Eligibility Criteria

Eligibility. To be eligible for the program, an applicant shall meet all the following eligibility requirements:
1. Age. Is ~~under~~ less than 19 years of age. A child's coverage shall continue through the month in which a child turns age 19 if the child is otherwise eligible;
2. Citizenship. Is a United States citizen or a qualified alien under A.R.S. § 36-2983;
3. Residency. Is a resident of the state of Arizona under A.R.S. § 36-2983. An Arizona resident is a person who currently lives in Arizona and intends to remain in Arizona indefinitely;
4. Income. Meets the income requirements in R9-31-304;
5. Cost sharing. Pays the cost sharing premium amount when premiums are required as specified in A.R.S. § 36-2982 and 2903.01;
6. Social security number (SSN). ~~The Administration shall not deny eligibility for Title XXI if an applicant does not provide or apply for a social security number except as specified under A.R.S. § 36-2983.~~ Provides a SSN or applies for a SSN within 30 days after submitting an application.
7. Assignment. Assigns rights to any first- or third-party coverage of medical care as specified in 9 A.A.C. 31, Article 10;
8. Other federal program. Is not eligible for ~~Title XIX~~ Medicaid or other federally operated or financed health care insurance program, except the Indian Health Service as specified in A.R.S. § 36-2983;
9. Inmate of a public institution. Is not an inmate of a public institution, as specified in A.R.S. § 36-2983;
10. Patient in an institution for mental disease. Is not a patient in an institution for mental disease at the time of application, or at the time of redetermination, as specified in A.R.S. § 36-2983;
11. Other health coverage. Is not covered under:
    a. An employer's group health insurance plan,
    b. Family or individual health insurance, or
    c. Other health insurance;
12. State health benefits. Is not a member of a family that is eligible for health benefits coverage under a state health benefit plan based on a family member's employment with a public agency in the state of Arizona;
13. Prior health insurance coverage. Has not been covered by health insurance during the previous three months unless that health insurance was discontinued due to the involuntary loss of employment or other involuntary reason as specified in A.R.S. § 36-2983. The three months of ineligibility due to previous insurance coverage shall not apply to:
    a. A newborn as defined in R9-31-309;
    b. A Title XIX member as specified in 9 A.A.C. 22, Article 1;
    c. An applicant who is seriously ill under R9-31-101 or chronically ill under A.R.S. § 36-2983;
    d. A ~~Title XXI~~ member under this Article who loses insurance coverage;
    e. A CRS member; or
    f. A Native American member receiving services from IHS or a Tribal Facility.

R9-31-304. Income Eligibility

A. Income standard. The combined gross income of the household income group members as specified in subsection (C) shall not exceed the percentage of the appropriate FPL under A.R.S. § 36-2981 for the Title XXI household income group size ~~as specified in A.R.S. § 36-2981~~.

B. ~~Countable income. The Administration shall count all income received during a month by the household income group members as specified in subsection (C) except income that is specified in subsections (D) and (E).~~ Calculating monthly income. The Administration shall calculate monthly income under A.A.C. R9-22-1419.01(B) through 1419.04.

C. Title XXI household income group.

1. For this Section:
   a. "Child" means a person ~~under~~ less than 19 years of age or an unborn child.
   b. "Parent" means a biological, adoptive, or step parent.
2. The following related persons, when residing together, constitute a Title XXI household income group:
   a. A married couple and children of either one or both;
   b. An unmarried couple with a common child and at least one other child of either ~~1~~ one or both;
   c. A married couple when one or both are under age 19 with no child;
   d. A single parent and the single parent's child;
   e. A child who does not live with a parent; and
   f. The following persons, when living with a child:
      i. A spouse of the child;
      ii. A child of the spouse child;
      iii. A child of the child; and
      iv. The other parent of a child of the child.
3. A ~~person~~ member of the household income group who is absent from a household shall be included in the child's household income group if absent:
   a. For 30 days or less,
   b. For the purpose of seeking employment or to maintain a job,
   c. For serving in the military, or
   d. For an educational purpose and the child's parent claims the child as a dependent on the parent's income tax return.

D. Income disregards. When determining gross income of the household, the Administration shall disregard the following:

1. Income specified in 20 CFR 416, Appendix to subpart K as of June 6, 1997, which is incorporated by reference and on file with the Office of the Secretary of State and the Administration. This incorporation by reference contains no future editions or amendments;
2. Income paid according to federal law that prohibits the use of the income when determining eligibility for public benefits;
3. Money received as the result of the conversion of an asset;
4. Income tax refunds; and
5. ~~For a income, the Administration shall count only the net income of that self-employment, after deducting the expenses of producing that income, but not deducting income taxes or capital investments~~ An amount equal to the expenses of producing self-employment income from the gross self-employment income.

~~**E.** Regular infrequent income. Income that is received regularly but less often than monthly shall be pro-rated over the number of months between payments.~~

ARTICLE 17. ELIGIBILITY AND ENROLLMENT FOR A PARENT

R9-31-1702. Application

A. Application form. A parent who wants to apply for eligibility under this Article shall apply using an application approved by the Administration.

B. Application process. For a parent of a child under R9-31-1701(C)(1)(a), the Administration shall process an application ~~shall be processed~~ under A.A.C. R9-22-1405(A) through ~~(C)(2), (D) and (E)~~ (F), A.A.C. R9-22-1411(A) and (C), and A.A.C. R9-22-1407. For a parent of a child under R9-31-1701(C)(1)(b), the Administration shall process an application ~~shall be processed~~ under R9-31-302(A) through (E).