NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by first submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication. Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for making, amending, or repealing any rule. (A.R.S. §§ 41-1013 and 41-1022)

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

[R07-417]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-22-101	Amend
R9-22-117	Repeal
R9-22-1406	Amend
R9-22-1408	Amend
R9-22-1410	Repeal
R9-22-1410	New Section
R9-22-1413	Amend
R9-22-1428	Amend
R9-22-1431	Amend
R9-22-1701	Repeal
R9-22-1701	New Section
R9-22-1702	Repeal
R9-22-1702	New Section
R9-22-1703	Repeal
R9-22-1703	New Section
R9-22-1704	Repeal
R9-22-1704	New Section
R9-22-1705	New Section

2. The statutory 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. § 36-2903.01

3. A list of all previous notices appearing in the *Register* addressing the proposed rule:

Notice of Rulemaking Docket Opening: 13 A.A.R. 2853, August 17, 2007

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

Name: Mariaelena Ugarte

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

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

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

Laws 2007, Ch 263, § 7 A.R.S. § 36-2901 has required the Administration to update the eligibility income limit to the Federal Poverty Level (FPL) of 150 percent for a pregnant woman. The Administration is also proposing amendments to the rules to revise, reorganize, and clarify the enrollment requirements as specified in the Section 1115 waiver with CMS.

6. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, 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.

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

Not applicable

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

It is anticipated that the contractors, private sector, members, providers, small businesses, political subdivisions, the Department, and the Administration will be minimally impacted by the changes to the rule language. The areas of rule that describe the SOBRA pregnant woman's federal poverty level will be changed from 133% to 150%. This increase in FPL will allow more uninsured pregnant women to meet the income requirements and qualify for medical assistance. The Administration is proposing amendments to the rules to revise, reorganize, and clarify the enrollment requirements as specified in the Section 1115 waiver. The enrollment rule updates will have minimal to no impact since the changes provide further detail and clarity. Where the member was given 16 days to choose a plan, they now have 30. This increase in time to choose a plan will have a minimal impact to the Administration, where system changes will be required to allow for this change. The members will benefit from the additional time to decide which plan they prefer.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name:	Mariaelena Ugarte
Address:	AHCCCS Office of Legal Assistance 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4693
Fax:	(602) 253-9115
E-mail:	AHCCCSRules@azahcccs.gov

Proposed rule language will be available on the AHCCCS web site www.azahcccs.gov the week of December 3, 2007. Please send written comments to the above address by 12:00 p.m., January 22, 2008. E-mail comments will also be accepted during this time-frame.

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date:	January 22, 2008
Time:	9:30 a.m.
Location:	AHCCCS 701 E. Jefferson Phoenix, AZ 85034
Nature:	Public Hearing
Date:	January 22, 2008
Time:	9:30 a.m.
Location:	ALTCS: Arizona Long-term Care System 110 S. Church, Suite 1360 Tucson, AZ 85701
Nature:	Public Hearing

Date:	January 22, 2008
Time:	9:30 a.m.
Location:	ALTCS: Arizona Long-term Care System 3480 E. Route 66 Flagstaff, AZ 86004
Nature:	Public Hearing

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

None

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

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 1. DEFINITIONS

Section
R9-22-101. Location of Definitions
R9-22-117. ~~Enrollment Related Definitions~~ Repealed

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR FAMILIES AND INDIVIDUALS

Section
R9-22-1406. Application Process
R9-22-1408. Applicant and Member Responsibility
R9-22-1410. ~~Eligibility Interview or Home Visit~~ Department Responsibilities
R9-22-1413. Time-frames, Approval, Discontinuance, or Denial of an Application
R9-22-1428. Eligibility for a Person Not Eligible as a Family
R9-22-1431. Family Planning Services Extension Program (FPEP)

ARTICLE 17. ENROLLMENT

Section
R9-22-1701. ~~Enrollment of a Member with an AHCCCS Contractor~~ Enrollment Related Definitions
R9-22-1702. ~~Effective Date of Enrollment with a Contractor and Notification to the Contractor~~ Enrollment of a Member with an AHCCCS Contractor
R9-22-1703. ~~Newborn Enrollment~~ Effective Date of Enrollment with a Contractor
R9-22-1704. ~~Guaranteed Enrollment Period~~ Newborn Enrollment
R9-22-1705. Guaranteed Enrollment Period

ARTICLE 1. DEFINITIONS

R9-22-101. Location of Definitions

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

Definition	Section or Citation
"Accommodation"	R9-22-701
"Act"	R9-22-101
"ADHS"	R9-22-101
"Administration"	A.R.S. § 36-2901
"Adverse action"	R9-22-101
"Affiliated corporate organization"	R9-22-101
"Aged"	42 U.S.C. 1382c(a)(1)(A) and R9-22-1501

"Aggregate"	R9-22-701
"AHCCCS"	R9-22-101
"AHCCCS inpatient hospital day or days of care"	R9-22-701
"AHCCCS registered provider"	R9-22-101
"Ambulance"	A.R.S. § 36-2201
"Ancillary department"	R9-22-701
"Ancillary service"	R9-22-701
"Anticipatory guidance"	R9-22-201
"Annual enrollment choice"	~~R9-22-117~~ R9-22-1701
"APC"	R9-22-701
"Appellant"	R9-22-101
"Applicant"	R9-22-101
"Application"	R9-22-101
"Assessment"	R9-22-1101
"Assignment"	R9-22-101
"Attending physician"	R9-22-101
"Authorized representative"	R9-22-101
"Authorization"	R9-22-201
"Auto-assignment algorithm"	~~R9-22-117~~ R9-22-1701
"AZ-NBCCEDP"	R9-22-2001
"Baby Arizona"	R9-22-1401
"Behavior management services"	R9-22-1201
"Behavioral health adult therapeutic home"	R9-22-1201
"Behavioral health therapeutic home care services"	R9-22-1201
"Behavioral health evaluation"	R9-22-1201
"Behavioral health medical practitioner"	R9-22-1201
"Behavioral health professional"	R9-22-1201
"Behavioral health recipient"	R9-22-201
"Behavioral health service"	R9-22-1201
"Behavioral health technician"	R9-22-1201
"BHS"	R9-22-1401
"Billed charges"	R9-22-701
"Blind"	R9-22-1501
"Burial plot"	R9-22-1401
"Business agent"	R9-22-701 and R9-22-704
"Calculated inpatient costs"	R9-22-712.07
"Capital costs"	R9-22-701
"Capped fee-for-service"	R9-22-101
"Caretaker relative"	R9-22-1401
"Case management"	R9-22-1201
"Case record"	R9-22-101
"Case review"	R9-22-101
"Cash assistance"	R9-22-1401
"Categorically-eligible"	R9-22-101
"CCR"	R9-22-712
"Certified psychiatric nurse practitioner"	R9-22-1201

"Charge master"	R9-22-712
"Child"	R9-22-1503 and R9-22-1603
"Children's Rehabilitative Services" or "CRS"	~~R9-22-102~~ R9-22-201
"Claim"	R9-22-1101
"Claims paid amount"	R9-22-712.07
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-22-201
"CMDP"	~~R9-22-117~~ R9-22-1701
"CMS"	R9-22-101
"Continuous stay"	R9-22-101
"Contract"	R9-22-101
"Contract year"	R9-22-101
"Contractor"	A.R.S. § 36-2901
"Copayment"	R9-22-701, R9-22-711 and R9-22-1603
"Cost avoid"	R9-22-1201
"Cost-To-Charge Ratio"	R9-22-701
"Covered charges"	R9-22-701
"Covered services"	R9-22-101
"CPT"	R9-22-701
"Creditable coverage"	R9-22-2003 and 42 U.S.C. 300gg(c)
"Critical Access Hospital"	R9-22-701
"CRS"	R9-22-1401
"Cryotherapy"	R9-22-2001
"Customized DME"	R9-22-212
"Day"	R9-22-101 and R9-22-1101
"Date of the Notice of Adverse Action"	R9-22-1441
"DBHS"	R9-22-201
"DCSE"	R9-22-1401
"De novo hearing"	42 CFR 431.201
"Dentures" and "Denture services"	R9-22-201
"Department"	A.R.S. § 36-2901
"Dependent child"	A.R.S. § 46-101
"DES"	R9-22-101
"Diagnostic services"	R9-22-101
"Director"	R9-22-101
"Disabled"	R9-22-1501
"Discussion"	R9-22-101
"Disenrollment"	~~R9-22-117~~ R9-22-1701
"DME"	R9-22-101
"DRI inflation factor"	R9-22-701
"E.P.S.D.T. services"	42 CFR 440.40(b)
"Eligibility posting"	R9-22-701
"Eligible person"	A.R.S. § 36-2901
"Emergency behavioral health condition for the non-FES member"	R9-22-201
"Emergency behavioral health services for the non-FES member"	R9-22-201
"Emergency medical condition for the non-FES member"	R9-22-201

"Emergency medical services for the non-FES member"	R9-22-201
"Emergency medical or behavioral health condition for a FES member"	R9-22-217
"Emergency services costs"	A.R.S. § 36-2903.07
"Encounter"	R9-22-701
"Enrollment"	~~R9-22-117~~ R9-22-1701
"Enumeration"	R9-22-101
"Equity"	R9-22-101
"Experimental services"	R9-22-101
"Existing outpatient service"	R9-22-701
"Expansion funds"	R9-22-701
"FAA"	R9-22-1401
"Facility"	R9-22-101
"Factor"	R9-22-701 and 42 CFR 447.10
"FBR"	R9-22-101
"Federal financial participation" or "FFP"	42 CFR 400.203
"Federal poverty level" or "FPL"	A.R.S. § 36-2981
"Fee-For-Service" or "FFS"	R9-22-101
"FES member"	R9-22-101
"FESP"	R9-22-101
"First-party liability"	R9-22-1001
"File"	R9-22-1101
"Fiscal agent"	R9-22-210
"Fiscal intermediary"	R9-22-701
"Foster care maintenance payment"	42 U.S.C. 675(4)(A)
"FQHC"	R9-22-101
"Free Standing Children's Hospital"	R9-22-701
"Fund"	R9-22-712.07
"Graduate medical education (GME) program"	R9-22-701
"Grievance"	R9-34-202
"GSA"	R9-22-101
"HCPCS"	R9-22-701
"Health care practitioner"	R9-22-1201
"Hearing aid"	R9-22-201
"HIPAA"	R9-22-701
"Home health services"	R9-22-201
"Homebound"	R9-22-1401
"Hospital"	R9-22-101
"In-kind income"	R9-22-1420
"Insured entity"	R9-22-720
"Intermediate Care Facility for the Mentally Retarded" or "ICF-MR"	42 ~~USC~~ U.S.C. 1396d(d)
"ICU"	R9-22-701
"IHS"	~~R9-22-117~~ R9-22-101
"IHS enrolled" or "enrolled with IHS"	R9-22-708
"IMD" or "Institution for Mental Diseases"	42 CFR 435.1010 and R9-22-201
"Income"	R9-22-1401 and R9-22-1603

"Indigent"	R9-22-1401
"Individual"	R9-22-211
"Inmate of a public institution"	42 CFR 435.1010
"Inpatient covered charges"	R9-22-712.07
"Interested party"	R9-22-101
"Intern and Resident Information System"	R9-22-701
"LEEP"	R9-22-2001
"Legal representative"	R9-22-101
"Level I trauma center"	R9-22-2101
"License" or "licensure"	R9-22-101
"Licensee"	R9-22-1201
"Liquid assets"	R9-22-1401
"Mailing date"	R9-22-101
"Medical education costs"	R9-22-701
"Medical expense deduction" or "MED"	R9-22-1401
"Medical record"	R9-22-101
"Medical review"	R9-22-701
"Medical services"	A.R.S. § 36-401
"Medical supplies"	R9-22-201
"Medical support"	R9-22-1401
"Medically necessary"	R9-22-101
"Medicare claim"	R9-22-101
"Medicare HMO"	R9-22-101
"Member"	A.R.S. § 36-2901
"Mental disorder"	A.R.S. § 36-501
"Milliman study"	R9-22-712.07
"Monthly equivalent"	R9-22-1421 and R9-22-1603
"Monthly income"	R9-22-1421 and R9-22-1603
"National Standard code sets"	R9-22-701
"New hospital"	R9-22-701
"NICU"	R9-22-701
"Noncontracting Hospital"	R9-22-718
"Noncontracting provider"	A.R.S. § 36-2901
"Non-FES member"	R9-22-201
"Non-IHS Acute Hospital"	R9-22-701
"Nonparent caretaker relative"	R9-22-1401
"Nursing facility" or "NF"	42 U.S.C. 1396r(a)
"OBHL"	R9-22-1201
"Observation day"	R9-22-701
"Occupational therapy"	R9-22-201
"Offeror"	R9-22-101
"Operating costs"	R9-22-701
"Organized health care delivery system"	R9-22-701
"Outlier"	R9-22-701
"Outpatient hospital service"	R9-22-701
"Ownership change"	R9-22-701

"Ownership interest"	42 CFR 455.101
"Parent"	R9-22-1603
"Partial Care"	R9-22-1201
"Participating institution"	R9-22-701
"Peer group"	R9-22-701
"Peer-reviewed study"	R9-22-2001
"Penalty"	R9-22-1101
"Pharmaceutical service"	R9-22-201
"Physical therapy"	R9-22-201
"Physician"	R9-22-101
"Physician assistant"	R9-22-1201
"Post-stabilization services"	R9-22-201 or 42 CFR 422.113
"PPC"	R9-22-701
"PPS bed"	R9-22-701
"Practitioner"	R9-22-101
"Pre-enrollment process"	R9-22-1401
"Premium"	R9-22-1603
"Prescription"	R9-22-101
"Primary care provider" or "PCP"	R9-22-101
"Primary care provider services"	R9-22-201
"Prior authorization"	R9-22-101
"Prior period coverage" or "PPC"	R9-22-701
"Procedure code"	R9-22-701
"Proposal"	R9-22-101
"Prospective rates"	R9-22-701
"Psychiatrist"	R9-22-1201
"Psychologist"	R9-22-1201
"Psychosocial rehabilitation services"	R9-22-201
"Public hospital"	R9-22-701
"Qualified alien"	A.R.S. § 36-2903.03
"Qualified behavioral health service provider"	R9-22-1201
"Quality management"	R9-22-501
"Radiology"	R9-22-101
"RBHA" or "Regional Behavioral Health Authority"	R9-22-201
"Reason to know"	R9-22-1101
"Rebase"	R9-22-701
"Referral"	R9-22-101
"Rehabilitation services"	R9-22-101
"Reinsurance"	R9-22-701
"Remittance advice"	R9-22-701
"Resident"	R9-22-701
"Residual functional deficit"	R9-22-201
"Resources"	R9-22-1401
"Respiratory therapy"	R9-22-201
"Respite"	R9-22-1201
"Responsible offeror"	R9-22-101

"Responsive offeror"	R9-22-101
"Revenue Code"	R9-22-701
"Review"	R9-22-101
"Review month"	R9-22-101
"RFP"	R9-22-101
"Rural Contractor"	R9-22-718
"Rural Hospital"	R9-22-712.07 and R9-22-718
"Scope of services"	R9-22-201
"Section 1115 Waiver"	A.R.S. § 36-2901
"Service location"	R9-22-101
"Service site"	R9-22-101
"SOBRA"	R9-22-101
"Specialist"	R9-22-101
"Specialty facility"	R9-22-701
"Speech therapy"	R9-22-201
"Spendthrift restriction"	R9-22-1401
"Sponsor"	R9-22-1401
"Sponsor deemed income"	R9-22-1401
"Sponsoring institution"	R9-22-701
"Spouse"	R9-22-101
"SSA"	42 CFR 1000.10
"SSDI Temporary Medical Coverage"	R9-22-1603
"SSI"	42 CFR 435.4
"SSN"	R9-22-101
"Stabilize"	42 U.S.C. 1395dd
"Standard of care"	R9-22-101
"Sterilization"	R9-22-201
"Subcontract"	R9-22-101
"Submitted"	A.R.S. § 36-2904
"Substance abuse"	R9-22-201
"SVES"	R9-22-1401
"Therapeutic foster care services"	R9-22-1201
"Third-party"	R9-22-1001
"Third-party liability"	R9-22-1001
"Tier"	R9-22-701
"Tiered per diem"	R9-22-701
"Title IV-D"	R9-22-1401
"Title IV-E"	R9-22-1401
"Total Inpatient payments"	R9-22-712.07
"Trauma and Emergency Services Fund"	A.R.S. § 36-2903.07
"TRBHA" or "Tribal Regional Behavioral Health Authority"	R9-22-1201
"Treatment"	R9-22-2004
"Tribal Facility"	A.R.S. § 36-2981
"Unrecovered trauma center readiness costs"	R9-22-2101
"Urban Contractor"	R9-22-718
"Urban Hospital"	R9-22-718

"USCIS"	R9-22-1401
"Utilization management"	R9-22-501
"WWHP"	R9-22-2001

B. General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Act" means the Social Security Act.

"ADHS" means the Arizona Department of Health Services.

"Adverse action" means an action taken by the Department or Administration to deny, discontinue, or reduce medical assistance.

"Affiliated corporate organization" means any organization that has ownership or control interests as defined in 42 CFR 455.101, and includes a parent and subsidiary corporation.

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

"AHCCCS registered provider" means a provider or noncontracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A), and

Meets license or certification requirements to provide covered services.

"Appellant" means an applicant or member who is appealing an adverse action by the Department or Administration.

"Applicant" means a person who submits or whose authorized representative submits~~,~~ a written, signed, and dated application for AHCCCS benefits.

"Application" means an official request for AHCCCS medical coverage made under this Chapter.

"Assignment" means enrollment of a member with a contractor by the Administration.

"Attending physician" means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a Fee-For-Service member.

"Authorized representative" means a person who is authorized to apply for medical assistance or act on behalf of another person.

"Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific covered service or equipment provided to a member. A payment is made in accordance with an upper, or capped, limit established by the Director. This capped limit can be either a specific dollar amount or a percentage of billed charges.

"Case record" means an individual or family file retained by the Department that contains all pertinent eligibility information, including electronically stored data.

"Case review" means the Administration's evaluation of an individual's or family's circumstances and case record in a review month.

"Categorically-eligible" means a person who is eligible under A.R.S. §§ 36-2901(6)(a)(i), (ii), or (iii) or 36-2934.

"CMS" means the Centers for Medicare and Medicaid Services.

"Continuous stay" means a period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

"Contract" means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and this Chapter.

"Contract year" means the period beginning on October 1 and continuing until September 30 of the following year.

"Covered services" means the health and medical services described in Articles 2 and 12 of this Chapter as being eligible for reimbursement by AHCCCS.

"Day" means a calendar day unless otherwise specified.

"DES" means the Department of Economic Security.

"Diagnostic services" means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.

"Director" means the Director of the Administration or the Director's designee.

"Discussion" means an oral or written exchange of information or any form of negotiation.

"DME" means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed

to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.

"Enumeration" means the assignment of a nine-digit identification number to a person by the Social Security Administration.

"Equity" means the county assessor full cash value or market value of a resource minus valid liens, encumbrances, or both.

"Experimental services" means services that are associated with treatment or diagnostic evaluation and that are not generally and widely accepted as a standard of care in the practice of medicine in the United States unless:

The weight of the evidence in peer-reviewed articles in medical journals published in the United States supports the safety and effectiveness of the service; or

In the absence of peer-reviewed articles, for services that are rarely used, novel, or relatively unknown in the general professional medical community, the weight of opinions from specialists who provide the service attests to the safety and effectiveness of the service.

"Facility" means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related service.

"FBR" means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.

"Fee-For-Service" or "FFS" means a method of payment by the AHCCCS Administration to a registered provider on an amount-per-service basis for a member not enrolled with a contractor.

"FES member" means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.

"FESP" means the federal emergency services program under R9-22-217 which covers services to treat an emergency medical or behavioral health condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

"FQHC" means federally qualified health center.

"GSA" means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with the contractor.

"Hospital" means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.

"IHS" means Indian Health Service.

"Interested party" means an actual or prospective offeror whose economic interest may be directly affected by the issuance of an RFP, the award of a contract, or by the failure to award a contract.

"Legal representative" means a custodial parent of a child under 18, a guardian, or a conservator.

"License" or "licensure" means a nontransferable authorization that is granted based on established standards in law by a state or a county regulatory agency or board and allows a health care provider to lawfully render a health care service.

"Mailing date" when used in reference to a document sent first class, postage prepaid, through the United States mail, means the date:

Shown on the postmark;

Shown on the postage meter mark of the envelope, if no postmark; or

Entered as the date on the document if there is no legible postmark or postage meter mark.

"Medical record" means a document that relates to medical or behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and is kept at the site of the provider.

"Medically necessary" means a covered service is provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or their progression, or to prolong life.

"Medicare claim" means a claim for Medicare-covered services for a member with Medicare coverage.

"Medicare HMO" means a health maintenance organization that has a current contract with Centers for Medicare and Medicaid Services for participation in the Medicare program under 42 CFR 417 Subpart L.

"Offeror" means an individual or entity that submits a proposal to the Administration in response to an RFP.

"Physician" means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

"Practitioner" means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a registered nurse practitioner certified under A.R.S. Title 32, Chapter 15.

"Prescription" means an order to provide covered services that is signed or transmitted by a provider authorized to prescribe the services.

"Primary care provider" or "PCP" means an individual who meets the requirements of A.R.S. § 36-2901(12) or (13), and who is responsible for the management of a member's health care.

"Prior authorization" means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services contingent on the medical necessity of the services.

"Prior period coverage" means the period prior to the member's enrollment during which a member is eligible for covered services. PPC begins on the first day of the month of application or the first eligible month, whichever is later, and continues until the day the member is enrolled with a contractor.

"Proposal" means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.

"Radiology" means professional and technical services rendered to provide medical imaging, radiation oncology, and radioisotope services.

"Referral" means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

"Rehabilitation services" means physical, occupational, ~~and~~ speech therapies, and items to assist in improving or restoring a person's functional level.

"Responsible offeror" means an individual or entity that has the capability to perform the requirements of a contract and that ensures good faith performance.

"Responsive offeror" means an individual or entity that submits a proposal that conforms in all material respects to an RFP.

"Review" means a review of all factors affecting a member's eligibility.

"Review month" means the month in which the individual's or family's circumstances and case record are reviewed.

"RFP" means Request for Proposals, including all documents, whether attached or incorporated by reference, that are used by the Administration for soliciting a proposal under 9 A.A.C. 22, Article 6.

"Service location" means a location at which a member obtains a covered service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.

"Service site" means a location designated by a contractor as the location at which a member is to receive covered services.

"SOBRA" means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII).

"Specialist" means a Board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.

"Spouse" means a person who has entered into a contract of marriage recognized as valid by this state.

"SSN" means Social Security number.

"Standard of care" means a medical procedure or process that is accepted as treatment for a specific illness, injury, or medical condition through custom, peer review, or consensus by the professional medical community.

"Subcontract" means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member~~;~~,

A marketing organization~~;~~, or

Any other organization or person who agrees to perform any administrative function or service for the contractor specifically related to securing or fulfilling the contractor's obligation to the Administration under the terms of a contract.

R9-22-117. ~~Enrollment Related Definitions~~ Repealed

~~In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:~~

~~"Annual enrollment choice" means the annual opportunity for a person to change contractors.~~

~~"Auto-assignment algorithm" means the mathematical formula used by the Administration to assign persons to the various contractors.~~

~~"CMDP" means Comprehensive Medical and Dental Program.~~

~~"Disenrollment" means the discontinuance of a person's entitlement to receive covered services from a contractor of record.~~

~~"Enrollment" means the process by which an eligible person becomes a member of a contractor's plan.~~

~~"IHS" means Indian Health Service.~~

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR FAMILIES AND INDIVIDUALS

R9-22-1406. Application Process

A. Right to apply. A person ~~identified in subsection (B)~~ may apply for AHCCCS medical coverage by submitting ~~a signed Department approved or~~ an Administration-approved written application to the Administration, an FAA office, or one of the following outstation locations ~~under 42 CFR 435.904~~:

1. A BHS site ~~as provided in A.R.S. § 36-3431~~;
2. ~~A CRS site as provided in A.R.S. § 36-261~~ A facility contracted with CRS Administration;
3. A Baby Arizona-approved provider's office, if the applicant is a pregnant woman;
4. A Federally Qualified Health Center or disproportionate share hospital under 42 U.S.C. 1396r-4; or
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'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 in writing or verbally in the presence of an employee of the Administration or Administration's designee;~~
~~6. An adult who lives with the applicant;~~
~~7. The applicant's adult child; or~~
~~8. Another party if the applicant is:~~
~~a. A child less than 18 years old;~~
~~b. A child who is age 18 and a student; or~~
~~c. An adult who is incapacitated. The Administration or Administration's designee 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.~~

~~C.~~B. Written application. To initiate the application process, ~~a~~ any person ~~listed in subsection (B)~~ may apply but shall submit a written application under 42 CFR 435.907 to one of the sites listed in subsection (A) with the appropriate signatures.

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 who is submitting the application.~~
   a. Applicant's legible name,
   b. Address, or location where the applicant can be reached,
   c. Signature of the person listed in subsection (D)(2) and (D)(3), and
   d. Date the application was signed.
2. The Administration or Administration's designee shall require that a third party witness the signing and attest by signing the application if the individual signing the application signs with a mark.
3. The Administration or Administration's designee shall accept an application for a person who is incapacitated and whose name and address are unknown.

~~D.~~C. Date of application. The date of application is the date a written application is received by the Administration or its designee at a location listed in subsection (A).

~~E.~~D. Complete application form.

1. ~~An applicant or a person applying on behalf of the applicant shall provide all information requested on the application form.~~ The Administration shall consider an application complete when:

a. All questions are answered, and
b. All necessary verification is provided by an applicant or an applicant's representative.

2. The Administration or Administration's 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.
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 the applicant and spouse are not separated;
   d. An adult who lives with an applicant who is less than 18 years old or age 18 and a student;
   e. One of the unmarried partners if living together with a child in common, if the child is the applicant; or
   f. Another party, if the applicant is incapacitated and no one listed in subsections ~~(E)(3)(a)~~ (D)(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.
   ~~g. A person listed in subsection (E)(2) or (E)(3)(a) through (e) may authorize, verbally in the presence of an employee of the Administration or Administration's 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.~~
   g. A person authorized verbally in the presence of an employee of the Administration or Administration's designee or in writing, by a person listed in subsection (D)(2) or (D)(3)(a) through (c) to represent the applicant in the application process. The authorized representative may sign the declaration on the application relating to the applicant's eligibility, under penalty or perjury.
4. Unmarried adults not applying for a child in common shall each sign the application if using the same application form.
5. The application shall be witnessed and signed by a third party if the individual signing the application signs with a mark.
6. If the application is incomplete, the Administration or the Department shall do at least one of the following:
   a. Contact an applicant or an applicant's representative by telephone or electronic medium 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.
   c. Meet with the applicant, representative or household member.

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

R9-22-1408. Applicant and Member Responsibility

A. An applicant and a member shall authorize the Department to obtain verification for initial eligibility or continuation of eligibility.

B. As a condition of eligibility, an applicant or a member shall:
1. Give the Department complete and truthful information. The Department may deny an application or discontinue eligibility if:
   a. The applicant or member fails to provide information necessary for initial or continuing eligibility;
   b. The applicant or member fails to provide the Department with written authorization to permit the Department to obtain necessary initial or continuing eligibility verification;
   c. The applicant or member fails to provide verification under R9-22-1412 after the Department made an effort to obtain the necessary verification but has not obtained the necessary information; or
   d. The applicant or member does not assist the Department in resolving incomplete, inconsistent, or unclear information that is necessary for initial or continuing eligibility;
2. Cooperate with the Division of Child Support Enforcement (DCSE) in establishing paternity and enforcing medical support obligations when requested unless good cause exists for not cooperating under 42 CFR 433.147 as of ~~January 19, 1993~~ October 1, 2006, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol ~~Street~~ St., NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments. The Department shall not deny AHCCCS eligibility to an applicant who would otherwise be eligible, is a minor child, and whose parent or legal representative does not cooperate with the medical support requirements under subsection (E) or first- and third-party liability

requirements under Article 10 of this Chapter; and

3. Provide information concerning third-party coverage for medical care ~~.~~ :
   a. Name of policyholder,
   b. Policyholder's relationship to the applicant or member,
   c. SSN of the policy holder,
   d. Name and address of the insurance company, and
   e. Policy number.

C. A member or an applicant shall:

1. Send to the Department any medical support payments received while the member is eligible resulting from a medical support order;
2. Cooperate with the Administration or Administration's designee regarding any issues arising as a result of the Medicaid Eligibility Quality Control Program ~~under Article 9 of this Chapter~~ described under A.R.S. § 36-2903.01; and
3. Inform the Department of the following changes within 10 days from the date the applicant or member knows of a change:
   a. In address;
   b. In the household's composition;
   c. In income;
   d. In resources, when required under R9-22-1438 for the Medical Expense Deduction (MED) program;
   e. In Arizona state residency;
   f. In citizenship or immigrant status;
   g. In first- or third-party liability that may contribute to the payment of all or a portion of the person's medical costs; or
   h. That may affect the member's or applicant's eligibility including a change in a woman's pregnancy status.

D. As a condition of eligibility, an applicant or a member shall apply for other benefits as required under 42 CFR 435.608 as of ~~November 21, 1990~~ October 1, 2006, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

E. As a condition of eligibility, an applicant or a member shall cooperate with the Assignment of Rights under R9-22-1404. If the applicant or member receives care and services for which a first or third party is liable, the applicant or member shall ~~:~~

~~1.~~ ~~Cooperate~~ cooperate with the Department and the Administration in identifying and providing information to assist the Department and the Administration in pursuing any first or third party who may be liable to pay for medical care and services.

~~2. Except as provided in subsections (E)(3) and (E)(4), a parent, legal representative, or other legally responsible adult who applies for AHCCCS medical coverage on behalf of a child shall cooperate with the Department to establish paternity and obtain medical support or other payments as provided in A.R.S. § 46-292(C).~~

~~3. A pregnant woman under A.R.S. § 36-2901(6)(a)(ii) is not required to provide the Department with information regarding paternity or medical support from a father of a child born out of wedlock.~~

~~4. A parent who is not requesting AHCCCS medical coverage for himself or herself is not required to provide the Department with information regarding paternity or medical support from an absent parent under R9-22-1427(E).~~

~~**F.** At an initial application interview and at any review, the Department shall explain to an applicant or member the following requirements~~

~~1. To cooperate with DCSE in establishing paternity and enforcing medical support, except in circumstances when good cause under 42 CFR 433.147 exists for not cooperating;~~

~~2. To establish good cause for not cooperating with DCSE in establishing paternity and enforcing medical support;~~

~~3. To report a change listed in subsection (C)(3) no later than 10 days from the date the applicant or member knows of the change;~~

~~4. To send to the Department any medical support received through a Title IV-D court order; and~~

~~5. To cooperate with the Department and Administration's assignment of rights and securing payments received from any liable party for a member's medical care.~~

~~**G.** An applicant or member shall provide the following health insurance information, if applicable, at the initial interview, within 10 days of becoming aware of a new source of health insurance, and at any eligibility review:~~

~~1. Name of policyholder,~~

~~2. Policyholder's relationship to the applicant or member,~~

~~3. SSN of the policy holder,~~

~~4. Name and address of the insurance company, and~~

~~5. Policy number.~~

F. As a condition of eligibility for a parent, legal representative, or other legally responsible adult who applies for AHCCCS medical coverage on behalf of a child, that individual shall cooperate with the Department to establish paternity and

obtain medical support or other payments as provided in A.R.S. § 46-292(C). However, a pregnant woman under A.R.S. § 36-2901(6)(a)(ii) is not required to provide the Department with information regarding paternity or medical support from a father of a child born out of wedlock.

R9-22-1410. ~~Eligibility Interview or Home Visit~~ Department Responsibilities

~~**A.** Scheduling an interview or home visit.~~
- ~~1. Upon receipt of an application, the Department shall:~~
  - ~~a. Schedule an initial eligibility interview or a home visit if requested by a homebound applicant or if the Department believes that a home visit may avoid an eligibility error, and~~
  - ~~b. Provide the applicant a written notice of the scheduled interview or home visit.~~
- ~~2. The Department shall not require an initial interview or home visit under subsection (A)(1) unless the application received does not include sufficient information to determine eligibility under this Article for an applicant whose application is received from:~~
  - ~~a. A Baby Arizona provider,~~
  - ~~b. A KidsCare office under 9 A.A.C. 31,~~
  - ~~c. A CRS site,~~
  - ~~d. A BHS site, or~~
  - ~~e. Another agency or entity approved by the Administration to conduct an interview.~~

~~**B.** Attending the interview. As a condition of eligibility, the applicant or the applicant's representative shall attend any required interview.~~

~~**C.** Good cause for failure to attend an interview.~~
- ~~1. Upon request, the Department shall reschedule the initial interview if the applicant or member or the applicant's or member's representative had good cause for missing the interview and a request for a rescheduled interview is made by the 45th day from the date of application. Good cause includes:~~
  - ~~a. Hospitalization,~~
  - ~~b. Illness,~~
  - ~~c. Serious injury or accident involving an applicant or member of the applicant's or member's household that made it impossible to contact the local FAA office, or~~
  - ~~d. Any unanticipated occurrence that made it impossible to contact the local FAA office.~~
- ~~2. Notwithstanding subsection (C)(1), the Department shall deny the applicant's or member's eligibility if the second interview is missed.~~

~~**D.** Department's obligations at the eligibility interview. During the initial interview or eligibility review interview, a Department representative shall:~~
- ~~1. Offer to help the applicant or member to complete the application form and to obtain required verification;~~
- ~~2. Provide the applicant or member with information explaining:~~
  - ~~a. The eligibility and verification requirements for AHCCCS medical coverage,~~
  - ~~b. The requirement that the applicant or member obtain and provide a SSN to the Department,~~
  - ~~c. How the Department uses the SSN,~~
  - ~~d. The Department's practice of exchanging eligibility and income information through the SVES,~~
  - ~~e. The applicant and member's right to appeal an adverse action under R9-22-1441,~~
  - ~~f. The assignment of rights under operation of law as provided in A.R.S. § 36-2903,~~
  - ~~g. That the Department will use information to complete data matches with potentially liable parties,~~
  - ~~h. The eligibility review process,~~
  - ~~i. The program coverage and the types of services available under each program,~~
  - ~~j. The AHCCCS pre-enrollment process,~~
  - ~~k. Availability of continued AHCCCS medical coverage under R9-22-1427,~~
  - ~~l. That the Department shall use the Systematic Alien Verification for Entitlements (SAVE) process to verify eligible alien status, and~~
  - ~~m. That the Department shall help the applicant or member obtain necessary verification if the applicant or member asks for help;~~
- ~~3. Review the penalties for perjury and fraud printed on the application;~~
- ~~4. Review any verification items provided by the applicant or member and give a written list of additional verification items and time-frames within which the applicant or member shall provide information to the Department;~~
- ~~5. Explain the applicant and member's responsibilities under R9-22-1408;~~
- ~~6. Review all reporting requirements and explain that the applicant or member may lose the earned income disregards defined in R9-22-1420 if the applicant or member fails to timely report earned income changes; and~~
- ~~7. Explain the MED program under R9-22-1435 through R9-22-1440~~

A. The Department shall provide the applicant or member with information explaining the following requirements to:
- 1. Cooperate with DCSE in establishing paternity and enforcing medical support, except in circumstances when good

cause under 42 CFR 433.147 exists for not cooperating;
2. Establish good cause for not cooperating with DCSE in establishing paternity and enforcing medical support;
3. Report a change listed in subsection R9-22-1408(C)(3) no later than 10 days from the date the applicant or member knows of the change;
4. Send to the Department any medical support received through a Title IV-D court order; and
5. Cooperate with the Department and Administration's assignment of rights and securing payments received from any liable party for a member's medical care.

B. At initial application, or eligibility review, a Department representative shall:
1. Offer to help the applicant or member to complete the application form and to obtain required verification.
2. Provide the applicant or member with information explaining:
   a. The eligibility and verification requirements for AHCCCS medical coverage,
   b. The requirement that the applicant or member obtain and provide a SSN to the Department,
   c. How the Department uses the SSN,
   d. The Department's practice of exchanging eligibility and income information through the SVES,
   e. The applicant and member's right to appeal an adverse action under R9-22-1441,
   f. The assignment of rights under operation of law as provided in A.R.S. § 36-2903,
   g. That the Department will use information to complete data matches with potentially liable parties,
   h. The eligibility review process,
   i. The program coverage and the types of services available under each program,
   j. The AHCCCS pre-enrollment process,
   k. Availability of continued AHCCCS medical coverage under R9-22-1427,
   l. That the Department shall use the Systematic Alien Verification for Entitlements (SAVE) process to verify eligible alien status, and
   m. That the Department shall help the applicant or member obtain necessary verification if the applicant or member asks for help;
3. Review the penalties for perjury and fraud printed on the application;
4. Review any verification items provided by the applicant or member and inform the member of any additional verification items and time-frames within which the applicant or member shall provide information to the Department;
5. Explain the applicant's and member's responsibilities under R9-22-1408; and
6. Review all reporting requirements and explain that the applicant or member may lose the earned income disregards defined in R9-22-1420 if the applicant or member fails to timely report earned income changes.

R9-22-1413. Time-frames, Approval, Discontinuance, or Denial of an Application

A. Application processing time. The Department shall complete an eligibility determination under 42 CFR 435.911 within 45 days after the application date under R9-22-1406 unless:
1. The applicant is pregnant. The Department shall determine eligibility for a pregnant woman within 20 days after the application date unless additional information is required to determine eligibility; or
2. The applicant is in a hospital as an inpatient at the time of application. Within seven days of the Department's receipt of a signed application the Department shall~~:~~ complete an eligibility determination if the Department does not need additional information or verification to determine eligibility.
   ~~a. Complete an eligibility interview and ask all of the questions on the application, and~~
   ~~b. Complete an eligibility determination if the Department does not need additional information or verification to determine eligibility.~~

B. Approval. If the applicant meets all the eligibility requirements and conditions of eligibility of this Article, the Department shall approve the application and provide the applicant with an approval notice. The approval notice shall contain:
1. The name of each approved applicant,
2. The effective date of eligibility as defined in R9-22-1416 for each approved applicant,
3. The reason and the legal citations if a member is approved for only emergency medical services, and
4. The applicant's right to appeal the decision under R9-22-1441(A).

C. Denial. If an applicant fails to meet the eligibility requirements or conditions of eligibility of this Article, the Department shall deny the application and provide the applicant with a denial notice. The denial notice shall contain:
1. The name of each ineligible applicant,
2. The specific reason why the applicant is ineligible,
3. The income and resource calculations for the applicant compared to the income or resource standards for eligibility when the reason for the denial is due to the applicant's income or resources exceeding the applicable standard,
4. The legal citations supporting the reason for the ineligibility,
5. The location where the applicant can review the legal citations,
6. The date of ~~ineligibility~~ the application being denied, and
7. The applicant's right to appeal the decision and request a hearing.

D. The Department shall reopen an application or reinstate eligibility of a member when any of the following conditions are met:
1. The denial or discontinuance of eligibility was due to an administrative error,
2. The discontinuance of eligibility was due to noncompliance with a condition of eligibility and the applicant or member complies prior to the effective date of the discontinuance,
3. The member informs the Department of a change of circumstances prior to the effective date of the discontinuance, that would allow for continued eligibility, or
4. ~~The~~ Following a discontinuance the member requests and is eligible for continuation of medical coverage pending an appeal under R9-22-1441.

R9-22-1428. Eligibility for a Person Not Eligible as a Family

Income standards. A person who is not approved in a family unit under R9-22-1427 but meets all the eligibility requirements in the Article is eligible for AHCCCS medical coverage if countable income does not exceed the following percentage of the FPL:
1. 150 percent for a pregnant woman,
~~1.~~2. 140 percent for a child under one year of age,
~~2.~~3. 133 percent for a ~~pregnant woman or a~~ child age one through five years of age, or
~~3.~~4. 100 percent for all other persons.

R9-22-1431. Family Planning Services Extension Program (FPEP)

A. A member who loses eligibility for AHCCCS medical coverage under R9-22-1430 due to the postpartum period ending and who has no other creditable coverage, as specified in 42 U.S.C. 300gg(c), may receive up to 24 months of family planning services as provided in this Section and A.R.S. § 36-2907.04.

B. Review of eligibility.
1. The Department shall complete a review of each member's continued eligibility for FPEP at least once every 12 months.
2. If a member continues to meet all eligibility requirements, the Department shall authorize continued eligibility for the FPEP and notify the member of continued eligibility.
3. The Department shall discontinue eligibility and notify the member of the discontinuance under R9-22-1415 if the member:
   a. Has income that exceeds ~~133~~ 150 percent of the FPL at the time of the 12-month review,
   b. Fails to comply with a review of eligibility under this subsection, or
   c. Meets any of the criteria under subsection (D).

C. Changes in the member's income after the initial or review eligibility determination shall not impact the member's eligibility during the following 12-month period.

D. The Administration or its designee shall deny or terminate a member from FPEP under this Section if the member:
1. Voluntarily withdraws from the program;
2. Has whereabouts that are unknown;
3. Fails to provide information to the Administration or Department;
4. Becomes an inmate of a public institution;
5. Moves out-of-state;
6. Has creditable coverage under 42 U.S.C. 300gg(c);
7. Fails to meet the documentation requirements for U.S. citizenship or legal alien status under A.R.S. § 36-2903.03;
8. Becomes eligible under 9 A.A.C. Chapter 22, Chapter 28, or Chapter 31 for full services under Article 2 of this Chapter;
9. Becomes sterile, or
10. Dies.

E. The Administration or its designee shall not reinstate eligibility under this Section after the effective date of a discontinuance of eligibility unless the discontinuance is overturned on appeal or resulted from an administrative error.

R9-22-1701. ~~Enrollment of a Member with an AHCCCS Contractor~~ Enrollment Related Definitions

~~**A.** General Enrollment Requirements.~~
~~1. Except as provided in subsections (A)(3), (A)(4), and (C), a member, determined eligible under this Chapter and residing in an area served by more than one contractor, shall have freedom of choice in the selection of a contractor serving the member's GSA within 16 days from the date of the initial interview. A Native American member may select IHS or another available contractor.~~
~~2. If the member does not make a choice, the Administration shall auto-assign the member to IHS if the member is a Native American living on a reservation, a contractor based on family continuity, or the auto-assignment algorithm.~~
~~3. The Administration shall enroll a member with the member's most recent contractor of record, if available, if the~~

~~member's period of ineligibility and disenrollment from the contractor of record is for a period of less than 90 days except if:~~

~~a. The member no longer resides in the contractor's GSA;~~
~~b. The contractor's contract is suspended or terminated;~~
~~c. The member was previously enrolled with CMDP but at the time of re-enrollment the member is not a foster care child;~~
~~d. The member chooses another contractor or chooses IHS, if available to the member, during the annual enrollment choice period; or~~
~~e. The member was previously enrolled with a contractor but at the time of re-enrollment the member is a foster care child.~~

~~4. The Administration shall not enroll a member with a contractor if a member:~~
~~a. Is eligible for the FESP under R9-22-1418;~~
~~b. Is eligible for a period less than 30 days from the date the Administration receives notification of a member's eligibility, except for a member who is enrolled with CMDP or IHS;~~
~~c. Is eligible only for a retroactive period of eligibility, except for a member who is enrolled with IHS;~~
~~d. Is not a Native American and resides in an area not served by a contractor; or~~
~~e. Is a Native American and resides in an area not served by a contractor or IHS.~~

~~**B.** Fee-for-service coverage. A member not enrolled with a contractor under subsection (A)(4) shall obtain covered medical services from an AHCCCS-registered provider on a fee-for-service basis under Article 7.~~

~~**C.** Foster care child. The Administration shall enroll a member with CMDP if the member is a foster care child under A.R.S. § 8-512.~~

~~**D.** Family Planning Services Extension Program. A member eligible for the Family Planning Services Extension Program, as under R9-22-1424, shall remain enrolled with the member's contractor of record, or IHS.~~

~~**E.** Contractor or IHS enrollment change for a member.~~

~~1. The Administration shall change a member's enrollment if the member requests a change to an available contractor or IHS during an annual enrollment period. A Native American may change from an available contractor to IHS or from IHS to an available contractor at any time.~~
~~2. The Administration shall approve a change for an enrolled member under this Article, or as determined by the Director.~~
~~3. The Administration shall approve a change in enrollment for any member if the change is a result of the final outcome of a grievance under Article 8.~~
~~4. A member may choose a different contractor if the member moves into a GSA not served by the current contractor or if the contractor is no longer available. If the member does not select a contractor, the Administration shall auto-assign the member as provided in subsection (A)(2).~~

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Annual enrollment choice" means the annual opportunity for a person to change contractors.

"Auto-assignment algorithm" or "Algorithm" means a formula used by the Administration to assign a member who did not make a timely choice to the various contractors.

"CMDP" means Comprehensive Medical and Dental Program.

"Disenrollment" means the discontinuance of a person's entitlement to receive covered services from a contractor of record.

"Enrollment" means the process by which an eligible person becomes a member of a contractor's plan.

R9-22-1702. ~~Effective Date of Enrollment with a Contractor and Notification to the Contractor~~ Enrollment of a Member with an AHCCCS Contractor

~~**A.** Effective date of enrollment. A member's date of enrollment is the date enrollment action is taken by the Administration.~~

~~**B.** Financial liability of the contractor. The contractor shall be financially liable for an enrolled member's care as specified in contract.~~

~~**C.** Notice to contractor. The Administration shall notify the contractor of each member's enrollment with the contractor as specified in contract.~~

A. General Enrollment Requirements. The Administration will enroll a member with a contractor as described below, unless the member has pre-selected a contractor on the application:

1. Except as provided in subsections (A)(3), (A)(5), and (C), a member, determined eligible under this Chapter and residing in an area served by more than one contractor, shall have freedom of choice in the selection of a contractor serving the member's GSA within 30 days from the date of notice of enrollment. A Native American member may select IHS or another available contractor.
2. If the member does not make a choice, the Administration shall immediately auto-assign the member to IHS if the

member is a Native American living on a reservation, a contractor based on family continuity, or the auto-assignment algorithm.

3. The Administration shall enroll a member with the member's most recent contractor of record, if available, if the member's period of ineligibility and disenrollment from the contractor of record is for a period of less than 90 days except if:
   a. The member no longer resides in the contractor's GSA;
   b. The contractor's contract is suspended or terminated;
   c. The member was previously enrolled with CMDP but at the time of re-enrollment the member is not a foster care child;
   d. The member chooses another contractor or chooses IHS, if available to the member, during the annual enrollment choice period; or
   e. The member was previously enrolled with a contractor but at the time of re-enrollment the member is a foster care child.
4. When the members disenrollment period is more than 90 days, the member may select a contractor as described in subsection (1).
5. The Administration shall not enroll a member with a contractor if a member:
   a. Is eligible for the FESP under R9-22-1419;
   b. Is eligible for a period less than 30 days from the date the Administration receives notification of a member's eligibility, except for a member who is enrolled with CMDP or IHS;
   c. Is eligible only for a retroactive period of eligibility, except for a member who is enrolled with CMDP or IHS; or
   d. Resides in an area not served by a contractor.

B. Fee-for-service coverage. A member not enrolled with a contractor under subsection (A)(4) shall obtain covered medical services from an AHCCCS-registered provider on a fee-for-service basis under Article 7:

C. Foster care child. The Administration shall enroll a member with CMDP if the member is a foster care child under A.R.S. § 8-512.

D. Family Planning Services Extension Program. A member eligible for the Family Planning Services Extension Program, as under R9-22-1431, shall remain enrolled with the member's contractor of record, or IHS.

E. Contractor or IHS enrollment change for a member.
1. The Administration shall change a member's enrollment if the member requests a change to an available contractor or IHS during an annual enrollment period. A Native American may change from an available contractor to IHS or from IHS to an available contractor at any time.
2. The Administration shall approve a change for an enrolled member under this Article, or as determined by the Director.
3. The Administration shall approve a change in enrollment for any member if the change is a result of the final outcome of a grievance under 9. A.A.C. 34.
4. A member may choose a different contractor if the member moves into a GSA not served by the current contractor or if the contractor is no longer available. If the member does not select a contractor, the Administration shall auto-assign the member as provided in subsection (A)(2).
5. The Administration shall provide the member 60-day advance notice of their option to change plans by their annual enrollment date.
6. A member may disenroll from a plan if:
   a. The member moves out of the GSA;
   b. The plan does not, because of moral or religious objections, cover the service the member seeks.
   c. The member needs related services to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

R9-22-1703. ~~Newborn Enrollment~~ Effective Date of Enrollment with a Contractor

~~**A.** General.~~
1. ~~The Administration shall enroll a newborn child of an AHCCCS eligible mother with a contractor or IHS, based on the mother's enrollment.~~
2. ~~The Administration shall auto-assign a newborn child of an AHCCCS eligible mother who is not enrolled with a contractor or who is enrolled with CMDP.~~
3. ~~The Administration shall notify the mother of the right to choose a different contractor for her child within 16 days from the date of the initial interview.~~

~~**B.** Financial liability for all newborns. The contractor shall be financially liable for the medical care of a newborn as specified in contract.~~

~~**C.** Notification to mother. The Administration shall notify the mother of the newborn's enrollment.~~

~~**D.** Choice. The Administration shall give the mother of the newborn an opportunity to select a different contractor or IHS, if available, for the newborn~~.

A. Effective date of enrollment. A member's date of enrollment is the date enrollment action is taken by the Administration. However, if a plan change occurs for an annual enrollment choice, the effective date is the month of the member's anniversary date.

B. Financial liability of the contractor. The contractor shall be financially liable for an enrolled member's care as specified in contract.

R9-22-1704. ~~Guaranteed Enrollment Period~~ Newborn Enrollment

~~**A.** General. Except for members enrolled with IHS or CMDP, the Administration shall provide a guaranteed enrollment period for a one time period which begins on the effective date of the member's initial enrollment with the contractor and ends on the last day of the fifth full calendar month.~~

~~**B.** Exceptions to guaranteed period. The Administration shall not grant a guaranteed enrollment period or shall terminate a guaranteed enrollment period as provided in subsection (C), if the member:~~

~~1. Was factually ineligible when initially enrolled with the contractor,~~
~~2. Except as provided in 9 A.A.C. 22, Article 12, is an inmate of a public institution as defined in 42 CFR 435.1009,~~
~~3. Dies,~~
~~4. Moves out-of-state,~~
~~5. Voluntarily withdraws from the AHCCCS program, or~~
~~6. Is adopted.~~

~~**C.** Disenrollment effective date. The Administration shall terminate any guaranteed enrollment period to which the member is not entitled effective on:~~

~~1. The date the member is admitted to a public institution under subsection (B);~~
~~2. The member's date of death;~~
~~3. The last day of the month in which the Administration receives notification that a member moved out-of-state;~~
~~4. The date the Administration receives written notification of the member's voluntary withdrawal from the AHCCCS program; or~~
~~5. The date adoption proceedings are initiated through a private party, if known, or on the last day of the month in which the Administration receives notification of the proceedings.~~

~~**D.** Retroactive adjustments. The Administration shall adjust the member's eligibility and enrollment retroactively as under subsection (C).~~

A. General.

1. The Administration shall enroll a newborn child of an AHCCCS eligible mother with a contractor or IHS, based on the mother's enrollment.
2. The Administration shall auto-assign a newborn child of an AHCCCS eligible mother who is not enrolled with a contractor or who is enrolled with CMDP. When a CMDP mother has a newborn, and the newborn is surrendered to Administration on Children, Youth and Families (ACYF), the newborn is then enrolled with CMDP.
3. The Administration shall notify the mother of the right to choose a different contractor for her child. The mother may make her choice within 30 days from the date of notice of enrollment.

B. Financial liability for all newborns. The contractor shall be financially liable for the medical care of a newborn as specified in contract.

R9-22-1705. Guaranteed Enrollment Period

A. General. Except for members enrolled with IHS or CMDP, the Administration shall provide a guaranteed enrollment period for a one time period which begins on the effective date of the member's initial enrollment with any contractor and ends on the last day of the fifth full calendar month.

B. Exceptions to guaranteed period. The Administration shall not grant a guaranteed enrollment period or shall terminate a guaranteed enrollment period as provided in subsection (C), if the member:

1. Was factually ineligible when initially enrolled with the contractor;
2. Except as provided in 9 A.A.C. 22, Article 12, is an inmate of a public institution as defined in 42 CFR 435.1010;
3. Dies;
4. Moves out-of-state;
5. Voluntarily withdraws from the AHCCCS program;
6. Is adopted; or
7. Whereabouts are unknown, or the Administration has lost contact with the member.

C. Disenrollment effective date. The Administration shall terminate any guaranteed enrollment period to which the member is not entitled effective on:

1. The date the member is admitted to a public institution under subsection (B);
2. The member's date of death;

3. The last day of the month in which the Administration receives notification that a member moved out-of-state;
4. The date the Administration receives written notification of the member's voluntary withdrawal from the AHCCCS program; or
5. The date adoption proceedings are initiated through a private party, if known, or on the last day of the month in which the Administration receives notification of the proceedings.
6. The date the Administration establishes that the member's whereabouts are unknown or has lost contact with the member.

D. Retroactive adjustments. The Administration shall adjust the member's eligibility and enrollment retroactively as under subsection (C).

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

[R07-415]

PREAMBLE

1. Sections Affected | **Rulemaking Action**

R9-22-705	Amend
R9-22-712	Amend
R9-22-712.35	Amend
R9-22-712.40	Amend

2. The statutory 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. § 36-2903.01

3. A list of all previous notices appearing in the *Register* addressing the proposed rule:

Notice of Rulemaking Docket Opening: 13 A.A.R. 4331, December 7, 2007

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

Name: Mariaelena Ugarte

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

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

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

The Administration intends to clarify the coverage and reimbursement requirements related to services provided out-of-state or outside the geographical service area (GSA).

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

None

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

Not applicable

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

The Administration anticipates minimal to no impact on small businesses or consumers with the rule changes. These changes provide clarification of how necessary medical services will be reimbursed when received out-of-state or out of the geographical service area.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name:	Mariaelena Ugarte
Address:	AHCCCS Office of Legal Assistance 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4693
Fax:	(602) 253-9115
E-mail:	AHCCCSRules@azahcccs.gov

Proposed rule language will be available on the AHCCCS web site www.azahcccs.gov the week of December 3, 2007. Please send written comments to the above address by 12:00 p.m., January 22, 2008. E-mail comments will also be accepted during this time-frame.

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date:	January 22, 2008
Time:	10:00 a.m.
Location:	AHCCCS 701 E. Jefferson Phoenix, AZ 85034
Nature:	Public Hearing
Date:	January 22, 2008
Time:	10:00 a.m.
Location:	ALTCS: Arizona Long-term Care System 110 S. Church, Suite 1360 Tucson, AZ 85701
Nature:	Public Hearing
Date:	January 22, 2008
Time:	10:00 a.m.
Location:	ALTCS: Arizona Long-term Care System 3480 E. Route 66 Flagstaff, AZ 86004
Nature:	Public Hearing

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

None

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

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-705. Payments by Contractors
R9-22-712. Reimbursement: General
R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees
R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-705. Payments by Contractors

A. General requirements. A contractor shall contract with providers to provide covered services to members enrolled with the contractor. The contractor is responsible for ~~the~~ provider reimbursement and coordination of care provided for services provided to a member. Except as provided in subsection (A)(2), a contractor is not required to reimburse a noncontracting provider for services rendered to a member enrolled with the contractor.

1. Providers. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of March 6, 1992, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol ~~Street~~, St., NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
2. A contractor shall reimburse a noncontracting provider for services rendered to a member enrolled with the contractor ~~at the Administration's capped fee-for-service schedule rate~~ as specified in this Article if:
   a. The contractor referred the member to the provider or authorized the provider to render the services and the claim is otherwise payable under this Chapter, or
   b. The service is emergent under Article 2 of this Chapter.

B. Timely submission of claims.

1. Under A.R.S. § 36-2904, a contractor shall deem a paper or electronic claim as submitted on the date that the claim is received by the contractor. The contractor shall do one or more of the following for each claim the contractor receives:
   a. Place a date stamp on the face of the claim,
   b. Assign a system-generated claim reference number, or
   c. Assign a system-generated date-specific number.
2. Unless a shorter time period is specified in subcontract, a contractor shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
   a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
   b. Six months from the date of eligibility posting.
3. Unless a shorter time period is specified in subcontract, a contractor shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
   a. Twelve months from the date of service or for an inpatient hospital claim, ~~twelve~~ 12 months from the date of discharge; or
   b. Twelve months from the date of eligibility posting.

C. Date of claim. A contractor's date of receipt of an inpatient or an outpatient hospital claim is the date the claim is received by the contractor as indicated by the date stamp on the claim, the system-generated claim reference number, or the system-generated date-specific number assigned by the contractor. A hospital claim is considered paid on the date indicated on the disbursement check. A denied hospital claim is considered adjudicated on the date of the claim's denial. For a claim that is pending for additional supporting documentation specified in A.R.S. §§ 36-2903.01 or 36-2904, the contractor shall assign a new date of receipt upon receipt of the additional documentation. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. §§ 36-2903.01 or 36-2904, the contractor shall not assign a new date of receipt. A contractor and a hospital may, through a contract approved as specified in R9-22-715, adopt a method for identifying, tracking, and adjudicating a claim that is different from the method described in this subsection.

D. Payment for inpatient hospital services. A contractor shall reimburse an in-state provider and a noncontracting provider for inpatient hospital services rendered with an admission date on or after March 1, 1993, at either a rate specified by subcontract or, in absence of the subcontract, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715. This subsection does not apply to an urban contractor as specified in R9-22-718 and A.R.S. § 36-2905.01.

E. Payment for outpatient hospital services.

1. A contractor shall reimburse an in-state provider and a noncontracting provider for outpatient hospital services rendered on or after March 1, 1993 through June 30, 2005, at either a rate specified by a subcontract that complies with R9-22-715(A) or, in absence of a subcontract, as described in R9-22-712 or under A.R.S. § 36-2903.01. Subcontract

rates, terms, and conditions are subject to review, and approval or disapproval, under A.R.S. § 36-2904 and R9-22-715.

2. A contractor shall reimburse an in-state provider and noncontracting provider for outpatient hospital services rendered on or after July 1, 2005, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10, A.R.S. § 36-2903.01 and other sections of this Article. Subcontract rates, terms, and conditions are subject to review, and approval or disapproval, under A.R.S. § 36-2904 and R9-22-715.

~~**F.** Inpatient and outpatient out-of-state hospital payments. A contractor shall reimburse out-of-state hospitals for covered inpatient and outpatient services and associated professional fees provided to an AHCCCS member at the lesser of the negotiated rate, or the rates as described under A.R.S. § 36-2903.01 and this Article.~~

F. Inpatient and outpatient out-of-state hospital payments. A contractor shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b). A contractor shall reimburse out-of-state hospitals for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the claim will be paid by multiplying the covered charges for the outpatient services by the state-wide outpatient cost-to-charge ratio. A contractor and an out-of-state hospital may enter into a written agreement that provides for payment on different terms.

G. Payment for observation days. A contractor shall reimburse a provider and a noncontracting provider for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, as prescribed under R9-22-712, R9-22-712.10, and R9-22-712.45. An "observation day" means a physician-ordered evaluation period of less than 24 hours to determine the need of treatment or the need for admission as an inpatient.

H. Review of claims and coverage for hospital supplies.

1. A contractor may conduct a review of any claims submitted and recoup any payments made in error.
2. A hospital shall obtain prior authorization from the appropriate contractor for nonemergency admissions. When issuing prior authorization, a contractor shall consider the medical necessity of the service, and the availability and cost effectiveness of an alternative treatment. Failure to obtain prior authorization when required is cause for nonpayment or denial of a claim. A contractor shall not require prior authorization for medically necessary services provided during any prior period for which the contractor is responsible. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of the subcontract regarding utilization control activities. A hospital shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and shall make the hospital's medical records pertaining to a member enrolled with a contractor available for review.
3. Regardless of prior authorization or concurrent review activities, a contractor may make prepayment or post payment review of all claims, including but not limited to a hospital claim. A contractor may recoup an erroneously paid claim. If prior authorization was given for a specific level of care, but medical review of a claim indicates that a different level of care was medically appropriate, a contractor shall adjust the claim to pay for the cost for the appropriate level of care. An adjustment in payment for a different level of care is effective on the date when the different level of care is medically appropriate.
4. A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures if the subcontract meets the requirements of R9-22-715.
5. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
   a. Patient care kit,
   b. Toothbrush,
   c. Toothpaste,
   d. Petroleum jelly,
   e. Deodorant,
   f. Septi soap,
   g. Razor or disposable razor,
   h. Shaving cream,
   i. Slippers,
   j. Mouthwash,
   k. Disposable razor,
   l. Shampoo,
   m. Powder,
   n. Lotion,
   o. Comb, and
   p. Patient gown.
6. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
   a. Arm board,
   b. Diaper,
   c. Underpad,

d. Special mattress and special bed,
e. Gloves,
f. Wrist restraint,
g. Limb holder,
h. Disposable item used instead of a durable item,
i. Universal precaution,
j. Stat charge, and
k. Portable charge.

7. The contractor shall determine in a hospital claims review whether services rendered were:
   a. Covered services as defined in R9-22-102;
   b. Medically necessary;
   c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
   d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2904.
8. If a contractor adjudicates a claim or recoups payment for a claim, a person may file a claim dispute challenging the adjudication or recoupment as described under 9 A.A.C. 34.

I. Non-hospital claims. A contractor shall pay claims for non-hospital services in accordance with contract, or in the absence of a contract, at a rate not less than the Administration's capped fee-for-service schedule or at a lower rate if negotiated between the two parties.

J. Payments to hospitals. A contractor shall pay for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and as described in A.R.S. § 36-2904:
1. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
2. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
3. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a fee of ~~1~~ one percent penalty of the rate for each month or portion of the month following the 60th day of receipt of the bill until date of payment.

K. Interest payment. In addition to the requirements in subsection (J), a contractor shall pay interest for late claims as defined by contract.

R9-22-712. Reimbursement: General

A. Inpatient and outpatient discounts and penalties. If a claim is pended for additional documentation required under A.R.S. § 36-2903.01(H)(4), the period during which the claim is pended is not used in the calculation of the quick-pay discounts and slow-pay penalties under A.R.S. § 36-2903.01(H)(5).

~~**B.** Inpatient and outpatient out-of-state hospital payments. AHCCCS shall reimburse out-of-state hospitals for covered inpatient and outpatient services provided to a member at the lesser of the negotiated rate or the AHCCCS FFS rate as described in A.R.S. § 36-2903.01 and this Article.~~

B. Inpatient and outpatient out-of-state hospital payments. AHCCCS shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b). AHCCCS shall reimburse out-of-state hospitals for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the claim will be paid by multiplying the covered charges for the outpatient services by the state-wide outpatient cost-to-charge ratio. AHCCCS and an out-of-state hospital may enter into a written agreement that provides for payment on different terms.

C. Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall allow the Administration access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or the Administration's designated representative in performance of the Administration's utilization control activities. The Administration shall deny a claim for failure to cooperate.

D. Prior authorization. The Administration shall deny a claim for failure to obtain prior authorization as required in R9-22-210.

E. Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers to prepayment medical review or post-payment review, or both. The Administration shall conduct post-payment reviews consistent with A.R.S. § 36-2903.01 and may recoup erroneously paid claims. If prior authorization was given for a specific level of care but medical review of the claim indicates that a different level of care was appropriate, the Administration may adjust the claim to reflect the more appropriate level of care, effective on the date when the different level of care was medically appropriate.

F. Claim receipt. The Administration's date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the system-generated claim reference number or system-generated date-specific number. Hospital claims are considered paid on the date indicated on disbursement checks. Denied claims are considered adjudicated on the date of their denial. Claims that are denied and are resub-

mitted are assigned new receipt dates. For a claim that is pending for additional supporting documentation specified in A.R.S. §§ 36-2903.01 or 36-2904, the Administration shall assign a new date of receipt upon receipt of the additional documentation. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. §§ 36-2903.01 or 36-2904, the Administration shall not assign a new date of receipt.

G. Outpatient hospital reimbursement. The Administration shall pay for covered outpatient hospital services provided to eligible persons with dates of service from March 1, 1993 through June 30, 2005, at the AHCCCS outpatient hospital cost-to-charge ratio, multiplied by the amount of the covered charges.

1. Computation of outpatient hospital reimbursement. The Administration shall compute the cost-to-charge ratio on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient operating and capital costs are included in the computation but outpatient medical education costs that are included in the inpatient medical education component are excluded. To calculate the outpatient hospital cost-to-charge ratio annually for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in R9-22-712.01. The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:
   a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters for outpatient hospital services by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.
   b. Cost-to-charge limit. To comply with 42 CFR 447.325, the Administration may limit cost-to-charge ratios to 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are non-covered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.
2. New hospitals. The Administration shall reimburse new hospitals at the weighted statewide average outpatient hospital cost-to-charge ratio multiplied by covered charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for a new hospital until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing.
3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in a specialty facility. ~~For purposes of this subsection, "specialty facility" means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.~~
4. Reimbursement requirements. To receive payment from the Administration, a hospital shall submit claims that are legible, accurate, error free, and have a covered charge greater than ~~0~~ zero. The Administration shall not reimburse hospitals for emergency room treatment, observation hours or days, or other outpatient hospital services performed on an outpatient basis, if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation area, or other outpatient department. Services provided in the emergency room, observation area, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment.
5. Rebasing. The Administration shall rebase the outpatient hospital cost-to-charge ratios at least every four years but no more than once a year using updated Medicare Cost Reports and claim and encounter data.
6. If a hospital files an increase in its charge master for an existing outpatient service provided on or after July 1, 2004, and on or before June 30, 2005, which represents an aggregate increase in charges of more than 4.7 percent, the Administration shall adjust the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (G)(5) by applying the following formula: CCR*[1.047/(1+ % increase)]
   Where "CCR" means the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (G)(5) and "% increase" means the aggregate percentage increase in charges for outpatient services shown on the hospital charge master.
   "Charge master" means the schedule of rates and charges as described under A.R.S. § 36-436 and the rules that relate to those rates and charges that are filed with the Director of the Arizona Department of Health Services.
   "Existing outpatient services" means a service provided by the hospital prior to the hospital filing an increase in its charge master, regardless of whether the service was explicitly described in the hospital charge master before filing the increase, or how the service was described in the charge master before filing the increase.

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

A. AHCCCS shall increase the fees established under R9-22-712.20 (except for laboratory services and out-of-state hospital services) for the following hospitals submitting any claims:

1. By 48 percent for public hospitals on July 1, 2005, as well as hospitals that were public in calendar year 2004.

2. By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the year in which the rates are effective.
3. By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the year in which the rates are effective.
4. By 115 percent for hospitals designated as Critical Access Hospitals, or for hospitals that have not been designated as Critical Access Hospitals, but meet the criteria.
5. By 113 percent for a freestanding children's hospital with at least 110 pediatric beds.
6. By 14 percent for a University Affiliated Hospital defined as those hospitals that have a majority of the member of its board of directors appointed by the Board of Regents.

B. In addition to subsection (A) the following increase may be established: A 50 percent adjustment for a Level 2 and 3 emergency department procedures billed by a ~~level~~ Level 1 Trauma center as defined by R9-22-2101.

C. Fee adjustments in subsection (A) are available with the AHCCCS Outpatient Capped Fee-For Service Schedule on file and online with AHCCCS.

R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update

A. Procedure Codes. AHCCCS shall add new procedure codes for covered outpatient services and shall either assign the default CCR, the Medicare rate, or calculate an appropriate fee when procedure codes are issued by CMS or the Current Procedural Terminology published by the American Medical Association.

B. APC Changes. AHCCCS may reassign procedure codes to new or different APC groups when APC groups are revised by Medicare. AHCCCS may reassign procedure codes to a different APC group than Medicare. If AHCCCS determines that utilization of the code within the Medicare program is substantially different from the AHCCCS program, AHCCCS may not assign any APC. For procedure codes not grouped into an APC by Medicare, AHCCCS may assign the code to an APC group when AHCCCS determines that the cost and resources associated with the non-assigned code are substantially similar to those in a particular APC group.

C. Annual Update for Outpatient Hospital Fee Schedule. Beginning October 1, 2006, AHCCCS shall adjust outpatient fee schedule rates:
1. On an annual basis by multiplying the rates effective during the prior year by the Global Insight Prospective Hospital Market Basket Inflation Index; or
2. In any given year the director may substitute the increases in (B)(1) by calculating the dollar value associated with the inflationary increase in (B)(1), and applying that dollar value to adjust rates at varying levels.

D. Rebase. AHCCCS shall rebase the outpatient fees every five years.

E. Statewide CCR. The statewide CCR calculated in R9-22-712.30 shall be recalculated at the time of rebasing, at which time AHCCCS may consider recalculating the statewide CCR based on the costs and charges for those services excluded from the outpatient hospital fee schedule.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R07-416]

PREAMBLE

1. Sections Affected	Rulemaking Action
R9-28-101	Amend
R9-28-104	Repeal
R9-28-401	Repeal
R9-28-401	New Section
R9-28-401.01	New Section
R9-28-407	Amend
R9-28-408	Amend
R9-28-410	Amend
R9-28-412	Amend
R9-28-415	Amend
R9-28-418	Amend

2. The statutory 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. § 36-2903.01

3. A list of all previous notices appearing in the *Register* addressing the proposed rule:

Notice of Rulemaking Docket Opening: 13 A.A.R. 2853, August 17, 2007

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

Name:	Mariaelena Ugarte
Address:	AHCCCS Office of Legal Assistance 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4693
Fax:	(602) 253-9115
E-mail:	AHCCCSRules@azahcccs.gov

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

Laws 2007, Ch 263, § 7 A.R.S. § 36-2901 has required the Administration to update the eligibility income limit to the Federal Poverty Level (FPL) of 150 percent for a pregnant woman. The Administration is also proposing amendments to the rules to revise, reorganize, and clarify the enrollment requirements as specified in the Section 1115 waiver with CMS.

6. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, 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.

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

Not applicable

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

It is anticipated that the contractors, private sector, members, providers, small businesses, political subdivisions, the Department, and the Administration will be minimally impacted by the changes to the rule language. The areas of rule that describe the SOBRA pregnant woman's federal poverty level will be changed from 133% to 150%. This increase in FPL will allow more uninsured pregnant women to meet the income requirements and qualify for medical assistance.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name:	Mariaelena Ugarte
Address:	AHCCCS Office of Legal Assistance 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4693
Fax:	(602) 253-9115
E-mail:	AHCCCSRules@azahcccs.gov

Proposed rule language will be available on the AHCCCS web site www.azahcccs.gov the week of December 3, 2007. Please send written comments to the above address by 12:00 p.m., January 22, 2008. E-mail comments will also be accepted during this time-frame.

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date:	January 22, 2008
Time:	9:30 a.m.
Location:	AHCCCS 701 E. Jefferson

	Phoenix, AZ 85034
Nature:	Public Hearing
Date:	January 22, 2008
Time:	9:30 a.m.
Location:	ALTCS: Arizona Long-term Care System 110 S. Church, Suite 1360 Tucson, AZ 85701
Nature:	Public Hearing
Date:	January 22, 2008
Time:	9:30 a.m.
Location:	ALTCS: Arizona Long-term Care System 3480 E. Route 66 Flagstaff, AZ 86004
Nature:	Public Hearing

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

None

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

None

13. 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 1. DEFINITIONS

Section
R9-28-101. General Definitions
R9-28-104. ~~Eligibility and Enrollment Related Definitions~~ Repealed

ARTICLE 4. ELIGIBILITY AND ENROLLMENT

Section
R9-28-401. ~~General~~ Eligibility and Enrollment Related Definitions
R9-28-401.01. General
R9-28-407. Resource Criteria for Eligibility
R9-28-408. Income Criteria for Eligibility
R9-28-410. Community Spouse
R9-28-412. General Enrollment
R9-28-415. Enrollment with a Tribal Program Contractor
R9-28-418. Disenrollment

ARTICLE 1. DEFINITIONS

R9-28-101. General Definitions

A. Location of definitions. Definitions applicable to Chapter 28 are found in the following:

Definition	Section or Citation
"210"	R9-28-401
"217"	R9-28-401

"236"	R9-28-401
"Acute"	R9-28-301
"ADHS"	~~R9-22-102~~ R9-22-101
"ADL"	R9-28-101
"Administration"	A.R.S. § 36-2931
"Advance notice"	R9-28-411
"Aged"	R9-28-402
"Aggregate"	R9-22-701
"Aggression"	R9-28-301
"AHCCCS"	R9-22-101
"AHCCCS registered provider"	R9-22-101
~~"Algorithm"~~	~~R9-28-104~~
"ALTCS"	R9-28-101
"ALTCS acute care services"	~~R9-28-104~~ R9-28-401
"ALTCS transitional program"	R9-28-307
"Alternative HCBS setting"	R9-28-101
"Ambulance"	A.R.S. § 36-2201
"Ambulation"	R9-28-301
"Applicant"	R9-22-101
"Assessor"	R9-28-301
"Associating time with an event and an action"	R9-28-301
"Auto-assignment algorithm" or "Algorithm"	R9-22-1701
"Bathing"	R9-28-301
"Bathing or showering"	R9-28-301
"Bed hold"	R9-28-102
"Behavior intervention"	R9-28-102
"Behavior management services"	R9-22-1201
"Behavioral health evaluation"	R9-22-1201
"Behavioral health medical practitioner"	R9-22-1201
"Behavioral health professional"	R9-20-101
"Behavioral health service"	R9-20-101
"Behavioral health technician"	R9-20-101
"Billed charges"	R9-22-701
"Blind"	42 U.S.C. 1382c(a)(2)
"Capped fee-for-service"	R9-22-101
"Caregiver training"	R9-28-301
"Case management plan"	R9-28-101
"Case management"	R9-28-1101
"Case manager"	R9-28-101
"Case record"	R9-22-101
"Categorically-eligible"	R9-22-101
"Certification"	R9-28-501
"Certified psychiatric nurse practitioner"	R9-22-1201
"CFR"	R9-28-101
"Child"	R9-22-1420
"Chronic"	R9-28-301

"Clarity of communication"	R9-28-301
"Clean claim"	A.R.S. § 36-2904
"Climbing stairs or a ramp"	R9-28-301
"Clinical supervision"	~~R9-22-102~~ R9-22-201
"CMS"	R9-22-101
"Community mobility"	R9-28-301
"Community spouse"	~~R9-28-104~~ R9-28-401
"Consecutive days"	R9-28-901
"Continence"	R9-28-301
"Contract"	R9-22-101
"Contract year"	~~R9-28-101~~ R9-22-101
"Contractor"	A.R.S. § 36-2901
"Cost avoid"	R9-22-1201
"County of fiscal responsibility"	R9-28-701
"Covered services"	R9-28-101
"CPT"	R9-22-701
"Crawling and standing"	R9-28-301
"CSRD"	~~R9-28-104~~ R9-28-401
"Current"	R9-28-301
"Day"	R9-22-101
"De novo hearing"	42 CFR 431.201
"Department"	A.R.S. § 36-2901
"Developmental disability" or "DD"	A.R.S. § 36-551
"Developmental milestone"	R9-28-301
"Diagnostic services"	~~R9-22-102~~ R9-22-101
"Director"	R9-22-101
"Disabled"	R9-28-402
"Disenrollment"	~~R9-22-117~~ R9-22-1701
"Disruptive behavior"	R9-28-301
"DME"	~~R9-22-102~~ R9-22-201
"Dressing"	R9-28-301
"Eating"	R9-28-301
"Eating or drinking"	R9-28-301
"Elderly"	R9-28-301
"Emergency medical services for the non-FES member"	~~R9-22-102~~ R9-22-201
"Emotional and cognitive functioning"	R9-28-301
"Employed"	R9-28-1320
"Encounter"	R9-22-701
"Enrollment"	~~R9-22-117~~ R9-22-1701
"EPD"	R9-28-301
"E.P.S.D.T. services"	~~R9-22-101~~ 42 CFR 440.40(b)
"Estate"	A.R.S. § 14-1201
"Experimental services"	R9-22-101
"Expressive verbal communication"	R9-28-301
"Facility"	R9-22-101
"Factor"	42 CFR 447.10

"Fair consideration"	~~R9-28-104~~ R9-28-401
"FBR"	R9-22-101
"Federal financial participation" or "FFP"	42 CFR 400.203
"Fee-For-Service" or "FFS"	~~R9-28-102~~ R9-22-101
"File"	R9-28-901
"Food preparation"	R9-28-301
"Frequency"	R9-28-301
"Functional assessment"	R9-28-301
"Grievance"	R9-34-202
"Grooming"	R9-28-301
"GSA"	R9-22-101
"Guardian"	A.R.S. § 14-5311
"Hand use"	R9-28-301
"HCBS" or "Home and community based services"	A.R.S. §~~§~~ 36-2931 ~~and 36-2939~~
"Health care practitioner"	R9-22-1201
"History"	R9-28-301
"Home"	R9-28-101 and R9-28-901
"Home health services"	~~R9-22-102~~ R9-22-201
"Hospice"	A.R.S. § 36-401
"Hospital"	R9-22-101
"ICF-MR" or "Intermediate care facility for the mentally retarded"	42 U.S.C. 1396d(d)
~~"Intergovernmental agreement"~~	~~R9-28-1101~~
"IADL"	R9-28-101
"IHS"	~~R9-28-101~~ R9-22-101
"IMD" or "Institution for mental diseases"	42 CFR 435.1010
"Immediate risk of institutionalization"	R9-28-301
"Institutionalized"	~~R9-28-104~~ R9-28-401
"Institutionalized spouse"	R9-28-101
"Interested Party"	R9-28-106
"Intergovernmental agreement" or "IGA"	R9-28-1101
"Intervention"	R9-28-301
"JCAHO"	R9-28-101
"License" or "licensure"	R9-22-101
"Limited or occasional"	R9-28-301
"Medical assessment"	R9-28-301
"Medical or nursing services and treatments" or "services and treatments"	R9-28-301
"Medical record"	R9-22-101
"Medical services"	A.R.S. § 36-401
"Medical supplies"	~~R9-22-102~~ R9-22-201
"Medically eligible"	~~R9-28-104~~ R9-28-401
"Medically necessary"	R9-22-101
"Member"	A.R.S. § 36-2931 and R9-28-901
"Mental disorder"	A.R.S. § 36-501
"MMMNA"	~~R9-28-104~~ R9-28-401
"Mobility"	R9-28-301

"Noncontracting provider"	A.R.S. § 36-2931
"Nursing facility" or "NF"	42 U.S.C. 1396r(a)
"Occupational therapy"	~~R9-22-102~~ R9-22-201
"Orientation"	R9-28-301
"Partial care"	R9-22-1201
"PAS"	R9-28-103
"Personal hygiene"	R9-28-301
"Pharmaceutical service"	~~R9-22-102~~ R9-22-201
"Physical interruption"	R9-28-301
"Physical participation"	R9-28-301
"Physical therapy"	~~R9-22-102~~ R9-22-201
"Physically disabled"	R9-28-301
"Physically lift"	R9-28-301
"Physician"	~~R9-22-102~~ R9-22-201
"Physician consultant"	R9-28-301
"Place"	R9-28-901
"Post-stabilization care services"	42 CFR 438.114
"Practitioner"	~~R9-22-102~~ R9-22-201
"Primary care provider (PCP)"	~~R9-22-102~~ R9-22-201
"Primary care provider services"	~~R9-22-102~~ R9-22-201
"Prior authorization"	~~R9-22-102~~ R9-22-201
"Prior period coverage" or "PPC"	R9-22-101
"Program contractor"	A.R.S. § 36-2931
"Provider"	A.R.S. § 36-2931
"Psychiatrist"	R9-22-1201
"Psychologist"	R9-22-1201
"Psychosocial rehabilitation services"	~~R9-22-102~~ R9-22-201
"Qualified behavioral health service provider"	R9-28-1101
"Quality management"	R9-22-501
"Radiology"	~~R9-22-102~~ R9-22-201
"Reassessment"	R9-28-103
"Recover"	R9-28-901
"Redetermination"	~~R9-28-104~~ R9-28-401
"Referral"	R9-22-101
"Regional behavioral health authority" or "RBHA"	A.R.S. § 36-3401
"Reinsurance"	R9-22-701
"Remembering an instruction and demonstration"	R9-28-301
"Representative"	~~R9-28-104~~ R9-28-401
"Resistiveness"	R9-28-301
"Resistiveness or rebelliousness"	R9-28-301
"Respiratory therapy"	~~R9-22-102~~ R9-22-201
"Respite care"	R9-28-102
"RFP"	R9-22-106
"Room and board"	R9-28-102
"Rolling and sitting"	R9-28-301
"Running or wandering away"	R9-28-301

"Scope of services"	R9-28-102
"Section 1115 Waiver"	A.R.S. § 36-2901
"Self-injurious behavior"	R9-28-301
"Sensory"	R9-28-301
"Seriously mentally ill" or "SMI"	A.R.S. § 36-550
"Social worker"	R9-28-301
"Special diet"	R9-28-301
"Speech therapy"	~~R9-22-102~~ R9-22-201
"Spouse"	~~R9-28-104~~ R9-28-401
"SSA"	42 CFR 1000.10
"SSI"	42 CFR 435.4
"Subcontract"	R9-22-101
"TEFRA lien"	R9-28-901
"Therapeutic Leave"	R9-28-501
"Toileting"	R9-28-301
"Transferring"	R9-28-301
"TRBHA"	~~R9-28-101~~ R9-22-1201
"Tribal contractor"	R9-28-1101
"Tribal facility	A.R.S. § 36-2981
"Utilization management"	R9-22-501
"Ventilator dependent"	R9-28-102
"Verbal or physical threatening"	R9-28-301
"Vision"	R9-28-301
"Wandering"	R9-28-301
"Wheelchair mobility"	R9-28-301

B. General definitions. In addition to definitions contained in A.R.S. §§ 36-551, 36-2901, 36-2931, and 9 A.A.C. 22, Article 1, the following words and phrases have the following meanings unless the context of the Chapter explicitly requires another meaning:

"ADL" or "Activities of Daily Living" mean activities a member must perform daily for the member's regular day to day necessities, including but not limited to mobility, transferring, bathing, dressing, grooming, eating, and toileting.

"ALTCS" means the Arizona Long-term Care System as authorized by A.R.S. § 36-2932.

"Alternative HCBS setting" means a living arrangement approved by the Director and licensed or certified by a regulatory agency of the state, where a member may reside and receive HCBS including:

For a person with a developmental disability specified in A.R.S. § 36-551:

Community residential setting defined in A.R.S. § 36-551;

Group home defined in A.R.S. § 36-551;

State-operated group home under A.R.S. § 36-591;

Group foster home under A.A.C. R6-5-5903;

Licensed residential facility for a person with traumatic brain injury under A.R.S. § 36-2939;

Behavioral health adult therapeutic home under 9 A.A.C 20, Articles 1 and 15;

Level 2 and Level 3 behavioral health residential agencies under 9 A.A.C. 20, Articles 1, 4, 5, and 6; and

Rural substance abuse transitional centers under 9 A.A.C. 20, Articles 1 and 14; and

For a person who is EPD under R9-28-301, and the facility, setting, or institution is registered with AHCCCS:

Adult foster care defined in A.R.S. § 36-401 and as authorized in A.R.S. § 36-2939;

Assisted living home or assisted living center, units only, under A.R.S. § 36-401, and as authorized in A.R.S. § 36-2939;

Licensed residential facility for a person with a traumatic brain injury specified in A.R.S. § 36-2939;

Behavioral health adult therapeutic home under 9 A.A.C. 20, Articles 1 and 15;

Level 2 and Level 3 behavioral health residential agencies under 9 A.A.C. 20, Articles 1, 4, 5, and 6; and

Rural substance abuse transitional centers under 9 A.A.C. 20, Articles 1 and 14~~; and~~.

~~Alzheimer's treatment assistive living facility as specified in Laws 1999, Ch. 313, § 35 as amended by Laws 2001, Ch. 140, § 1 and Laws 2003, Ch. 76, § 1, and Laws 1999, Chapter 313, § 41, as amended by Laws 2001, Chapter 140, § 2.~~

"Case management plan" means a service plan developed by a case manager that involves the overall management of a member's care, and the continued monitoring and reassessment of the member's need for services.

"Case manager" means a person who is either a degreed social worker, a licensed registered nurse, or a person with a minimum of two years of experience in providing case management services to a person who is EPD.

"CFR" means Code of Federal Regulations, unless otherwise specified in this Chapter.

"Covered services" means the health and medical services described in Articles 2 and 11 of this Chapter as being eligible for reimbursement by AHCCCS.

"Home" means a residential dwelling that is owned, rented, leased, or occupied by a member, at no cost to the member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a:

Health care institution under A.R.S. § 36-401;

Residential care institution under A.R.S. § 36-401;

Community residential setting under A.R.S. § 36-551; or

Behavioral health facility under 9 A.A.C. 20, Articles 1, 4, 5, and 6.

"IADL" or "Instrumental Activities of Daily Living" mean activities related to independent living that a member must perform, including but not limited to:

Preparing meals,

Managing money,

Shopping for groceries or personal items,

Performing light or heavy housework, and

Use of the telephone.

"IHS" means the Indian Health Service.

"Institutionalized spouse" means a husband or wife of a community spouse as defined in U.S.C. 1396r-5.

"JCAHO" means the Joint Commission on Accreditation of Healthcare Organizations.

~~"TRBHA" means the same as in A.A.C. R9-22-1201.~~

R9-28-104. ~~Eligibility and Enrollment Related Definitions~~ Repealed

~~Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:~~

~~"211" is defined in 42 CFR 435.211.~~

~~"217" is defined in 42 CFR 435.217.~~

~~"236" is defined in 42 CFR 435.236.~~

~~"Algorithm" means a mathematical formula used by the Administration to assign a member to an EPD program contractor when the member does not make a choice and does not meet the assignment decision process.~~

~~"ALTCS acute care services" means services, under 9 A.A.C. 22, Articles 2 and 12, that are provided to a person who meets ALTCS eligibility requirements in 9 A.A.C. 28, Article 4 but who lives in an acute care living arrangement described in R9-28-406 or who is not eligible for long term care benefits, described in R9-28-409, due to a transfer under R9-28-409 without receiving fair consideration.~~

~~"Community spouse" means the husband or wife of an institutionalized person who has entered into a contract of marriage, recognized as valid by Arizona, and who does not live in a medical institution.~~

~~"CSRD" means Community Spouse Resource Deduction, the amount of a married couple's resources that are excluded in the eligibility determination to prevent impoverishment of the community spouse, determined under R9-28-410.~~

~~"Fair consideration" means income, real or personal property, services, or support and maintenance equal to the fair market value of the income or resources that were transferred.~~

~~"Institutionalized" means residing in a medical institution or receiving or expecting to receive HCBS that prevent the person from being placed in a medical institution determined by the PAS under R9-28-103.~~

~~"Medically eligible" means meeting the ALTCS medical eligibility criteria under 9 A.A.C. 28, Article 3.~~

~~"MMMNA" means Minimum Monthly Maintenance Needs Allowance.~~

~~"Redetermination" means a periodic review of all eligibility factors for a recipient.~~

~~"Representative" means a person other than a spouse or a parent of a dependent child, who applies for ALTCS on behalf of another person.~~

~~"Spouse" means a person legally married under Arizona law, a person eligible for Social Security benefits as the spouse of another person, or a person living with another person of the opposite sex and the couple represents themselves in the community as husband and wife.~~

ARTICLE 4. ELIGIBILITY AND ENROLLMENT

R9-28-401. ~~General~~ Eligibility and Enrollment Related Definitions

~~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. A person listed in A.A.C. R9-22-1405(B) shall submit the application.~~
  - ~~c. 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 the application if an applicant signs the application with a mark.~~
  - ~~e. The date of application is the date the application is received at any ALTCS eligibility office.~~
- ~~4. Except as provided in R9-22-1501(C)(5), the Administration shall determine eligibility within 45 days from the date of application.~~
- ~~5. An applicant or representative who files 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. 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, if the application is filed in the month of the person's death.~~

~~B.~~ ~~Conditions of ALTCS eligibility. Except for persons identified in subsection (C), the Administration shall approve a person 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. 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 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.~~

Definitions. For purposes of this Article the following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

"210" is defined in 42 CFR 435.211.

"217" is defined in 42 CFR 435.217.

"236" is defined in 42 CFR 435.236.

"ALTCS acute care services" means services, under 9 A.A.C. 22, Articles 2 and 12, that are provided to a person who meets ALTCS eligibility requirements in 9 A.A.C. 28, Article 4 but who lives in an acute care living arrangement described in R9-28-406 or who is not eligible for long-term care benefits, described in R9-28-409, due to a transfer under R9-28-409 without receiving fair consideration, or who has refused institutionalized or HCBS services.

"Community spouse" means the husband or wife of an institutionalized person who has entered into a contract of marriage, recognized as valid by Arizona, and who does not live in a medical institution.

"CSRD" means Community Spouse Resource Deduction, the amount of a married couple's resources that are excluded in the eligibility determination to prevent impoverishment of the community spouse, determined under R9-28-410.

"Fair consideration" means income, real or personal property, services, or support and maintenance equal to the fair market value of the income or resources that were transferred.

"Institutionalized" means residing in a medical institution or receiving or expecting to receive HCBS that prevent the person from being placed in a medical institution determined by the PAS under R9-28-103.

"Medically eligible" means meeting the ALTCS medical eligibility criteria under 9 A.A.C. 28, Article 3.

"MMMNA" means Minimum Monthly Maintenance Needs Allowance.

"Redetermination" means a periodic review of all eligibility factors for a recipient.

"Representative" means a person other than a spouse or a parent of a dependent child, who applies for ALTCS on behalf of another person.

"Spouse" means a person legally married under Arizona law, a person eligible for Social Security benefits as the spouse of another person, or a person living with another person of the opposite sex and the couple represents themselves in the community as husband and wife.

R9-28-401.01. 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 an application to an ALTCS eligibility office.
   a. The application shall contain the applicant's name and address.
   b. Before the application is approved a person listed in A.A.C. R9-22-1406(D) shall sign the application.
   c. A witness shall also sign the application if an applicant signs the application with a mark.
   d. The date of application is the date the application is received by the Administration or Department as described in A.A.C. R9-22-1406(A)(5).
4. Except as provided in A.A.C. R9-22-1501(D)(5), the Administration shall determine eligibility within 45 days from the date of application.
5. An applicant or representative who files 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. 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, if the application is filed in the month of the person's death.

B. Conditions of ALTCS eligibility. Except for persons identified in subsection (C), the Administration shall approve a person 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. 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 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 as specified in 9 A.A.C. 34 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.

R9-28-407. Resource Criteria for Eligibility

A. The following Medicaid-eligible persons shall be deemed to meet the resource requirements for ALTCS eligibility unless ineligible due to federal and state laws regarding trusts.
1. A person receiving Supplemental Security Income (SSI);
2. A person receiving Title IV-E Foster Care Maintenance payment; or
3. A person receiving a Title IV-E Adoption Assistance.

B. Except as provided in subsection ~~(D)~~ (C), if a person's ALTCS eligibility is most closely related to SSI and is not included in subsection (A), the Administration shall determine eligibility using resource criteria in 42 U.S.C. 1382(a)(3), 42 U.S.C. 1382b, and 20 CFR 416 Subpart L.

~~**C.** If a person's ALTCS eligibility is determined as a member of a family group including a dependent child, the Administration shall use the resource criteria in Section 2 of the AFDC State Plan as it existed on July 16, 1996 to determine eligibility.~~

~~**D.**~~**C.** The Administration permits exceptions to the resource criteria for a person identified in subsection (B):
1. Resources of a responsible relative (spouse or parent) are disregarded beginning the first day in the month the person is institutionalized.
2. The value of household goods and personal effects is excluded.
3. The value of oil, timber, and mineral rights is excluded.
4. The value of all of the following shall be disregarded:
   a. Term insurance;
   b. Burial insurance;
   c. Assets that a person has irrevocably assigned to fund the expense of a burial;
   d. The cash value of all life insurance if the face value does not exceed $1,500 total per insured person and the policy has not been assigned to fund a pre-need burial plan or declaratively designated as a burial fund;
   e. The value of any burial space held for the purpose of providing a place for the burial of the person, a spouse, or any other member of the immediate family;
   f. At the time of eligibility determination, $1,500 of the equity value of an asset declaratively designated as a burial fund or a revocable burial arrangement if there is no irrevocable burial arrangement; and
   g. If the person remains continuously eligible, all appreciation in the value of the assets in subsection ~~(D)(4)(f)~~

(C)(4)(f) will be disregarded;

h. The value of a payment refunded by a nursing facility after ALTCS approval for six months beginning with the month of receipt. The Administration shall evaluate the refund in accordance with R9-28-409 if transferred without receiving something of equal value.

~~E.~~**D.** For an institutionalized spouse, a resource disregard is allowed under 42 U.S.C. 1396r-5(h)(1), ~~September 30, 1989~~ January 3, 2005, and 42 U.S.C. 1396r-5(c).

~~F.~~**E.** Trusts are evaluated in accordance with federal and state laws to determine eligibility.

~~G.~~**F.** A person is not eligible for long-term care services if countable resources exceed the following limits:

1. For a SSI-related person identified in subsection (B), the limit is $2,000 or $3,000 per couple under 20 CFR 416.1205.
2. ~~For a person described in subsection (C), the limit is $2,000; and~~
3. ~~2.~~ For a person eligible under 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII), there is no resource limit.

~~H.~~**G.** A person shall provide information and verification necessary to determine the countable value of resources.

R9-28-408. Income Criteria for Eligibility

A. The following Medicaid-eligible persons shall be deemed to meet the income requirements for eligibility unless ineligible due to a trust in accordance with federal and state law.

1. A person receiving Supplemental Security Income (SSI);
2. A person receiving Title IV-E Foster Care Maintenance Payments; or
3. A person receiving ~~a~~ Title IV-E Adoption Assistance.

B. If a person's ALTCS eligibility is most closely related to SSI and the person is not included in subsection (A), the Administration shall count the income described in 42 U.S.C. 1382a and 20 CFR 416 Subpart K to determine eligibility with the following exceptions:

1. Income types excluded by 42 U.S.C. 1382a(b) for determining net income are also excluded in determining gross income to determine eligibility;
2. Income of a responsible relative (parent or spouse) is counted as part of income under 42 CFR 435.602, except that the income of a responsible relative is disregarded the month the person is institutionalized;
3. In-kind support and maintenance, under 42 U.S.C. 1382a(a)(2)(A), are excluded for both net and gross income tests;
4. The income exceptions under A.A.C. ~~R9-22-1503(A)(2)~~ R9-22-1503(B) apply to the net income test; and
5. Income described in subsection ~~(E)~~(D).

~~C. If a person's ALTCS eligibility is determined as a member of a family with a dependent child, the Administration shall use the methodology in Section 2 of the AFDC State Plan as it existed on July 16, 1996 to determine eligibility.~~

~~D.~~**C.** For a person whose eligibility is determined under 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), or 42 U.S.C. 1396a(a)(10)(A)(i)(VII), the methodology in A.A.C. ~~R9-22-1403~~ R9-22-1420 through R9-22-1426 is used to determine eligibility in accordance with 42 CFR 435.602. Income standards are then applied as described in A.A.C. R9-22-1428.

~~E.~~**D.** The following are income exceptions.

1. Disbursements from a trust are considered in accordance with federal and state law;
2. For a person defined in 42 U.S.C. 1396r-5(h)(1) income is calculated for the institutionalized spouse in accordance with 42 U.S.C. 1396r-5(b).

~~F.~~**E.** As a condition of eligibility for ALTCS, countable income shall be less than or equal to the following limits:

1. For a person in either the 217 or 236 coverage group specified in R9-28-402(B), 300 percent of the FBR;
2. For a person or a couple in the SSI-related 210 coverage group specified in R9-28-402(B), 100 percent of the FBR;
3. For a person who is under 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII) and is:
   a. A child who is at least age 6 but less than age 19; 100 percent of the FPL, adjusted by household size;
   b. A child age 1 through 5, 133 percent of the FPL, adjusted by household size; ~~or~~
   c. A child less than age 1 ~~or a pregnant woman~~, 140 percent of the FPL, adjusted by household size; or
   d. A pregnant woman, 150 percent of the FPL, adjusted by household size.
4. ~~For a person who is a member of a family with a dependent child, the standards specified in Section 2 of the AFDC State Plan as it existed on July 16, 1996 shall apply.~~

~~G.~~**F.** The Director shall determine the amount a person shall pay for the cost of ALTCS services and the post-eligibility treatment of income (share-of-cost) under A.R.S. § 36-2932(L) and 42 CFR 435.725 or 42 CFR 435.726. The Director shall consider the following in determining the share-of-cost:

1. Income types excluded by 42 U.S.C. 1382a(b) for determining net income are excluded in determining share-of-cost;
2. SSI benefits paid under 42 U.S.C. 1382(e)(1)(E) and (G) to a person who receives care in a hospital or nursing facility are not included in calculating the share-of-cost;
3. The share-of-cost of a person with a spouse is calculated as follows:

a. If an institutionalized person has a community spouse under 42 U.S.C. 1396r-5(h), share-of-cost is calculated under R9-28-410 and 42 U.S.C. 1396r-5(b) and (d); and
b. ~~If an institutionalized person has a spouse who does not live at home but is absent due to marital estrangement, or who resides in a medical institution or in an approved~~ a setting specified in R9-28-504, ~~only the institutionalized person's income is used for the share-of-cost. The spousal deduction under subsection (F)(5)(b) is not allowed; and~~
b. If an institutionalized person does not have a community spouse, share of cost is calculated solely on the income of the institutionalized person.
c. ~~For all other persons, the share-of-cost is calculated by dividing the combined income of the spouses in half;~~

4. Income assigned to a trust is considered in accordance with federal and state law.
5. The following expenses are deducted from the share-of-cost of an eligible person to calculate ~~their~~ the person's share-of-cost:
   a. A personal-needs allowance equal to 15 percent of the FBR for a person residing in a medical institution for a full calendar month. A personal-needs allowance equal to 300 percent of the FBR for a person who receives or intends to receive HCBS or who resides in a medical institution for less than the full calendar month;
   b. A spousal allowance, equal to the FBR minus the income of the spouse, if a spouse but no children remain at home;
   c. A family allowance equal to the standard specified in Section 2 of the AFDC State Plan as it existed on July 16, 1996 for the number of family members minus the income of the family members if a spouse and children remain at home;
   d. Expenses for the medical and remedial care services listed in subsection (6) if these expenses have not been paid or are not subject to payment by a third-party, but the person still has the obligation to pay the expense, and one of the following conditions is met:
      i. The expense represents a current payment (that is, a payment made and reported to the Administration during the application period or a payment reported to the Administration no later than the end of the month following the month in which the payment occurred) and the expense has not previously been allowed a share-of-cost deduction; or
      ii. The expense represents the unpaid balance of an allowed, noncovered medical or remedial expense, and the expense has not been previously deducted from the share-of-cost;
   e. An amount determined by the Director for the maintenance of a single person's home for not longer than six months if a physician certifies that the person is likely to return home within that period; or
   f. An amount for Medicare and other health insurance premiums, deductibles, or coinsurance not subject to third-party reimbursement; and
6. In the post-eligibility calculation of income, the Administration recognizes the following medical and remedial care services are not covered under the Title XIX State Plan, nor covered by a program contractor to a person determined to need institutional services under this Article when the medical or remedial care services are medically necessary for a person:
   a. Nonemergency dental services for a person who is age 21 or older;
   b. Hearing aids and hearing aid batteries for a person who is age 21 or older;
   c. Nonemergency eye care and prescriptive lenses for a person who is age 21 or older;
   d. Chiropractic services, including treatment for subluxation of the spine, demonstrated by x-ray;
   e. Orthognathic surgery for a person 21 years of age or older; and
   f. On a case-by-case basis, other noncovered medically necessary services that a person petitions the Administration for and the Director approves.

~~H.~~**G.** A person shall provide information and verification of income under A.R.S. § 36-2934(G) and 20 CFR 416.203.

R9-28-410. Community Spouse

A. The methodology in this Section applies to an institutionalized person who ~~is legally married and~~ has a community spouse who resides in the community.

B. If the institutionalized person's most current period of continuous institutionalization began on or after September 30, 1989, the Administration shall use the methodology for the treatment of resources under 42 U.S.C. 1396r-5(c), ~~September 30, 1989~~ January 3, 2005, incorporated by reference and on file with the Administration ~~and the Secretary of State~~. This incorporation by reference contains no future editions or amendments.
   1. The following resource criteria shall be used in addition to the criteria specified in R9-28-407:
      a. Resources owned by a couple at the beginning of the first continuous period of institutionalization from and after September 30, 1989, shall be computed from the first day of institutionalization. The total value of resources owned by the institutionalized spouse and the community spouse, and a spousal share equal to ~~1/2~~ half of the total value, are computed under 42 U.S.C. 1396r-5(c)(1), ~~September 30, 1989~~ January 3, 2005, incorporated by reference and on file with the Administration ~~and the Secretary of State~~. This incorporation contains no future

editions or amendments.

b. The Community Spouse Resource Reduction (CSRD) is calculated under 42 U.S.C. 1396r-5(f)(2), ~~September 30, 1989~~ January 3, 2005, incorporated by reference and on file with the Administration ~~and the Secretary of State~~. This incorporation by reference contains no future editions or amendments.

c. The CSRD is subtracted from the total resources of the couple to determine the amount of the couple's resources considered available to the institutionalized spouse at the time of application under 42 U.S.C. 1396r-5(c)(2), ~~September 30, 1989~~ January 3, 2005, incorporated by reference and on file with the Administration ~~and the Secretary of State~~. This incorporation by reference contains no future editions or amendments.

i. Resources in excess of the CSRD must be equal to or less than the standard for a person specified in R9-28-407.

ii. The CSRD is allowed as a deduction for 12 consecutive months beginning with the first month in which the institutionalized spouse is eligible for ALTCS benefits. Beginning with the 13th month, the separate property of the institutionalized spouse must be within the resource standard for a person specified in R9-28-407.

iii. If a person, previously eligible for ALTCS using the community spouse policy, reapplies for ALTCS after a break in institutionalization of more than 30 days, the CSRD will be allowed as a deduction from resources for another 12-month period.

2. Resources are excluded as specified in R9-28-407, except that one vehicle is totally excluded regardless of its value, and any additional vehicles are included using equity value.

3. The Director may grant eligibility if the Administration determines a denial of eligibility would create an undue hardship.

C. The community spouse policy applies to the income eligibility and post-eligibility treatment of income beginning September 30, 1989, regardless of when the first period of institutionalization began.

1. Income payments are attributed to the institutionalized spouse and the community spouse under 42 U.S.C. 1396r-5(b)(2), ~~October 1, 1993~~ January 3, 2005, incorporated by reference and on file with the Administration ~~and the Secretary of State~~. This incorporation by reference contains no future editions or amendments.

2. Income is excluded specified in R9-28-408.

3. The institutionalized spouse's income eligibility is determined under community property rules in which the income of the spouse is combined and divided by ~~2~~ two. Income eligibility shall be based on the income received in the person's name if the person is not eligible using community property rules.

4. The items described in 42 U.S.C. 1396r-5(d)(1) and (2) are allowed as deductions from the institutionalized spouse's income in determining share-of-cost and 42 U.S.C. 1396r-5(d)(1) and (2), September 30, 1989, are incorporated by reference and on file with the Administration and the Secretary of State and contain no future editions or amendments:

a. A personal-needs allowance specified in R9-28-408(f)(5)(a);

b. A community spouse monthly income allowance, but only to the extent that the institutionalized spouse's income is made available to or for the benefit of the community spouse;

c. A family allowance for each family member equal to 1/3 of the amount remaining after deducting the countable income of the family member from a minimum monthly-needs allowance;

d. An amount for medical or remedial services specified in R9-28-408; and

e. An amount for Medicare and other health insurance premiums, deductibles, or coinsurance not subject to third-party reimbursement.

D. Transfers.

1. The institutionalized spouse may transfer to any of the following an amount of resources equal to the CSRD without affecting eligibility under 42 U.S.C. 1396r-5(f), ~~September 30, 1989~~ January 3, 2005, incorporated by reference and on file with the Administration ~~and the Secretary of State~~. This incorporation by reference contains no future editions or amendments. The institutionalized spouse may transfer resources to:

a. The community spouse; or

b. Someone other than the community spouse if the resources are for the sole benefit of the community spouse.

2. The institutionalized spouse is allowed a period of 12 consecutive months, beginning with the first month of eligibility, to transfer resources in excess of the resource standard in R9-28-407(E)(2) to the persons listed in subsection (D)(1).

3. All other transfers by the institutionalized person or transfers by the community spouse are treated under the provisions in R9-28-409.

E. Specific hearing rights apply to a person whose eligibility is determined under this Section.

1. The institutionalized spouse or the community spouse is entitled to a fair hearing if dissatisfied with the determination of any of the following:

a. The community spouse monthly income allowance~~;~~,

b. The amount of monthly income allocated to the community spouse~~;~~,

c. The computation of the spousal share of resources~~;~~,

d. The attribution of resources~~;~~, or
e. The CSRD.

2. The hearing officer may increase the amount of the MMMNA if either the community spouse or institutionalized spouse establishes that the community spouse needs income above the established MMMNA due to exceptional circumstances.
3. The hearing officer may increase the amount of the CSRD to allow the community spouse to retain enough resources to generate income to meet the MMMNA. The community spouse may be allowed to retain an amount of resources necessary to purchase a single premium life annuity that would furnish monthly income sufficient to bring the community spouse's total monthly income up to the MMMNA.

R9-28-412. General Enrollment

A. Program contractors. The Administration shall enroll each ALTCS member with one of the following ALTCS program contractors or the FFS program as specified in A.R.S. § 36-2933:
1. An elderly and physically disabled (EPD) program contractor,
2. The developmentally disabled (DD) program contractor,
3. A tribal program contractor, or
4. The AHCCCS fee-for-service program.

B. Annual enrollment. If an ALTCS member is elderly or physically disabled and lives in a GSA served by more than one program contractor, a member may change program contractors during the annual enrollment choice period ~~or as permitted as specified in R9-28-507~~.

C. Enrollment choice. An ALTCS member may choose a program contractor:
1. At the time of application, or
2. If the ALTCS member establishes a home outside of the GSA.

D. A program contractor is responsible for the enrolled ALTCS member as described by the County of Fiscal Responsibility Section R9-28-712.

R9-28-415. Enrollment with a Tribal Program Contractor

A. On-reservation. ~~The~~ Notwithstanding Section R9-28-412, the Administration shall enroll an Indian ALTCS member who is elderly or physically disabled with the ALTCS tribal program contractor as specified in A.R.S. § 36-2932 if a person:
1. Lives on-reservation of a tribe participating as an ALTCS tribal program contractor, or
2. Lived on-reservation of a tribe participating as an ALTCS tribal program contractor immediately prior to placement in an off-reservation NF or alternative HCBS setting.

B. Off-reservation. The Administration shall enroll an Indian ALTCS member who is elderly or physically disabled with an EPD program contractor under R9-28-413, if a member lives off-reservation, and has no on-reservation status as specified in subsection (A)(2).

R9-28 418. Disenrollment

The Administration shall disenroll an ALTCS member the last day of the month following receipt of appropriate notification under R9-28-411 except under the following situations:
1. The Administration shall disenroll an ALTCS member who dies. A member's last day of enrollment shall be the date of death.
2. The Administration may disenroll a member immediately if requested.
3. The Administration shall disenroll a member effective the date of the hearing decision if ALTCS benefits have been continued pending an eligibility appeal decision and the discontinuance is upheld, as specified in ~~9 A.A.C. 28, Article 8~~ 9 A.A.C. 34.