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 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 23. BOARD OF PHARMACY

[R08-100]

PREAMBLE

1. Sections Affected **Rulemaking Action**
R4-23-415 Amend

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rule is implementing (specific):
Authorizing statute: A.R.S. § 32-1904(A)(8)

Implementing statute: A.R.S. § 32-1932.01

3. A list of all previous notices appearing in the *Register* addressing the proposed rule:
Notice of Rulemaking Docket Opening: 14 A.A.R. 845, March 21, 2008

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

Name:	Dean Wright, Compliance Officer
Address:	Board of Pharmacy 1700 W. Washington St., Suite 250 Phoenix, AZ 85007
Telephone:	(602) 771-2727
Fax:	(602) 771-2749
E-mail:	dwright@azpharmacy.gov

5. An explanation of the rule, including the agency's reasons for initiating the rule:
During the 46th Legislative Session in 2003, the Legislature made changes to A.R.S. § 32-1932.01 by taking the words "pharmacists and interns" out and inserting the word "licensees," A.R.S § 32-1932.01 deals with the substance abuse treatment and rehabilitation program. The Board staff has determined that the R4-23-415 (Impaired Licensees - Treatment and Rehabilitation) still contains the phrase "pharmacists and interns" and therefore needs to be updated to conform to the statute.

R4-23-415 will be amended by replacing the words "pharmacists and interns" with the word "licensees" in subsections (A), and (C)(4) and (5). The rule will include format, style, and grammar necessary to comply with the current rules of the Secretary of State and the Governor's Regulatory Review Council.

The Board believes that amending this rule will benefit the public health and safety by establishing clear standards governing treatment and rehabilitation programs for Board licensees.

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 agency did not review or rely on any study relevant to the rule.

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 rule has no economic impact except the cost to the Board for the usual rulemaking-related costs, which are minimal. The treatment and rehabilitation program has been in operation for many years. The rule is necessary to comply with statutory mandate. The rule is necessary to correct the inconsistency created during the 46th Legislative Session in 2003, when the Legislature made changes to A.R.S. § 32-1932.01 by taking the words "pharmacists and interns" out and inserting the word "licensees," The rule does not impose any costs on small business or consumers.

The public, Board, pharmacists interns, pharmacy technicians, and pharmacies benefit from rules that are clear, concise, and understandable. The rule benefits the public health and safety by establishing clear standards governing treatment and rehabilitation programs for Board licensees.

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:	Dean Wright, Compliance Officer
Address:	Board of Pharmacy 1700 W. Washington St., Suite 250 Phoenix, AZ 85007
Telephone:	(602) 771-2727
Fax:	(602) 771-2749
E-mail:	dwright@azpharmacy.gov

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:

Comments may be written or presented orally. Written comments must be received by 5:00 p.m., Monday, May 19, 2008. An oral proceeding is scheduled for:

Date:	May 19, 2008
Time:	11:00 a.m.
Location:	1700 W. Washington St., 3rd Floor Board Room Phoenix, AZ 85007

A person may request information about the oral proceeding by contacting the person listed above.

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

Not applicable

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

None

13. The full text of the rule follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 23. BOARD OF PHARMACY

ARTICLE 4. PROFESSIONAL PRACTICES

Section
R4-23-415. Impaired Licensees – Treatment and Rehabilitation

ARTICLE 4. PROFESSIONAL PRACTICES

R4-23-415. Impaired Licensees – Treatment and Rehabilitation

A. The Board may contract with qualified organizations to operate a program for the treatment and rehabilitation of ~~pharmacists and interns~~ licensees impaired as the result of alcohol or other drug abuse, pursuant to A.R.S. § 32-1932.01.

B. No change

C. No change

1. No change
2. No change
3. No change
   a. No change
      i. No change
      ii. No change
   b. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
4. The program administrator shall report immediately to the Board the name of any impaired ~~pharmacist or pharmacy intern~~ licensee who poses a danger to ~~the public or himself~~ self or others.
5. The program administrator shall report to the Board, as soon as possible, the name of any impaired ~~pharmacist or pharmacy intern~~ licensee:
   a. Who refuses to submit to treatment~~;~~,
   b. Whose impairment is not substantially alleviated through treatment~~;~~, or
   c. No change
6. No change

D. ~~Pursuant to~~ Under A.R.S. § 32-1903(F), the Board may publish the names of participants under current Board orders.

E. ~~A majority of the~~ The Board or its executive director may request the treatment records for any participant. The program administrator shall provide treatment records within 10 working days of receiving a written request from the Board or its executive director for such records. Upon request of the program administrator or the Board or its executive director, a program participant shall authorize a drug and alcohol treatment facility or program or a private practitioner or treatment program to release the participant's records to the program administrator or the Board or its executive director.

F. No change

NOTICE OF PROPOSED RULEMAKING

TITLE 9: HEALTH SERVICES

CHAPTER 7: DEPARTMENT OF HEALTH SERVICES
CHILDREN'S REHABILITATIVE SERVICES

[R08-102]

PREAMBLE

1. Sections Affected	Rulemaking Action
R9-7-101	Amend
R9-7-201	Amend
R9-7-202	Amend
R9-7-203	Amend
Article 3	Amend
R9-7-301	Amend
R9-7-302	Amend
R9-7-303	Repeal
R9-7-303	New Section
R9-7-304	Repeal
R9-7-304	Renumber
R9-7-304	Amend
R9-7-305	Renumber
R9-7-305	Amend
R9-7-306	Renumber
R9-7-306	Amend
R9-7-307	Renumber
R9-7-307	Amend
R9-7-308	Renumber
R9-7-308	Amend

R9-7-401	Amend
R9-7-402	Repeal
R9-7-402	Renumber
R9-7-402	Amend
R9-7-403	Renumber
R9-7-403	Amend
R9-7-404	Renumber
R9-7-404	Amend
R9-7-405	Renumber
R9-7-405	Amend
R9-7-406	Renumber
R9-7-406	Amend
R9-7-407	Renumber
R9-7-407	Amend
R9-7-408	Renumber
R9-7-408	Amend
R9-7-409	Renumber
R9-7-409	Amend
R9-7-410	Renumber
R9-7-410	Amend
R9-7-411	Renumber
R9-7-411	Amend
R9-7-412	Renumber
R9-7-412	Amend
R9-7-413	Renumber
R9-7-413	Amend
R9-7-414	Renumber
R9-7-414	Amend
R9-7-415	Renumber
R9-7-415	Amend
R9-7-416	Renumber
R9-7-416	Amend
R9-7-417	Renumber
R9-7-417	Amend
R9-7-418	Renumber
R9-7-418	Amend
R9-7-419	Renumber
R9-7-419	Amend
R9-7-420	Renumber
R9-7-420	Amend
R9-7-421	Renumber
R9-7-501	Repeal
R9-7-501	Renumber
R9-7-501	Amend
R9-7-502	Renumber
R9-7-503	Renumber
R9-7-503	Amend
R9-7-504	Renumber
R9-7-504	Amend
R9-7-505	Renumber
Article 6	Repeal
R9-7-601	Repeal
R9-7-602	Renumber
R9-7-603	Renumber
R9-7-604	Renumber
R9-7-701	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. §§ 36-104(3), 36-132(A), and 36-136(F)

Implementing Statute: A.R.S. §§ 36-143, 36-261 through 36-265, 36-797.43, and 36-797.44

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

Notice of Rulemaking Docket Opening: 14 A.A.R. 718, February 29, 2008

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

Name: Kathleen Phillips, Esq.
Rules Administrator and Administrative Counsel

Address: Department of Health Services
Office of Administrative Rules and Counsel
1740 W. Adams St., Suite 200
Phoenix, AZ 85007

Telephone: (602) 542-1264

Fax: (602) 364-1150

E-mail: phillik@azdhs.gov

or

Name: Joan Agostinelli
Office Chief and CRS Administrator

Address: Department of Health Services
Division of Behavioral Health Services
Office for Children with Special Health Care Needs
150 N. 18th Ave., Suite 330
Phoenix, AZ 85007

Telephone: (602) 542-1860

Fax: (602) 542-2589

E-mail: agostij@azdhs.gov

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

The Arizona Department of Health Services (Department) administers the Children's Rehabilitative Services program (CRS) to provide covered medical services and support services to eligible individuals and their families. A.R.S. Title 36, Chapter 2, Article 3, Children's Rehabilitative Services was added by Laws 1975, Ch. 21 § 1, effective May 12, 1975.

A.R.S. § 36-261(5) requires the Department to establish and administer a program to provide care and services to children who are crippled or who are suffering from conditions that lead to crippling. The Department has entered into intergovernmental agreements with the Department of Economic Security (DES) and the Arizona Health Care Cost Containment System (AHCCCS) to ensure a continuum of cost-effective care for children enrolled with more than one agency. The Department does not provide services directly to children, but instead contracts with a network of hospitals, health professionals, and related entities to serve as providers of covered medical and support services on the Department's behalf and under the Department's authority. The Department provides administration, coordination, and oversight functions for the CRS program and CRS providers.

A.R.S. § 36-261(3) requires the Department to adopt rules and policies for the operation of the CRS program. *Arizona Administrative Code*, Title 9, Chapter 7, was adopted by final rulemaking at 10 A.A.R. 691, and was effective April 3, 2004, except 9 A.A.C. 7, Article 7, which was adopted by final rulemaking at 10 A.A.R. 3001, effective July 13, 2004. Because the rules no longer reflect Department policy and practice, the Department is amending 9 A.A.C. 7. The proposed rules conform to current Department policy and practice, industry standards, and rulemaking format and style requirements of the Governor's Regulatory Review Council and the Office of the Secretary of State.

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:

Annual cost/revenue changes are designated as minimal when less than $25,000, moderate when between $25,000 and $250,000, and substantial when greater than $250,000 in additional costs or revenues. Costs are listed as significant when meaningful or important but not readily subject to quantification. Benefits are listed as "cost savings" when quantifiable and as "benefits" when not readily subject to quantification.

Cost bearers are identified as the Department, AHCCCS, AHCCCS health plans, CRS contractors, CRS providers, CRS applicants, CRS members, and third-party health insurance providers. Beneficiaries are identified as the Depart-

ment, AHCCCS, AHCCCS health plans, CRS contractors, CRS providers, CRS members, and third-party health insurance providers.

The Department

The Department administers CRS and is identified in this rulemaking as the Arizona Department of Health Services or, as context requires, its designee.

The Department expects to incur a minimal-to-moderate cost to provide training regarding implementation of the proposed rules. The Department may experience a significant benefit from the amendments to 9 A.A.C. 7 that revise outdated language and update definitions make the rules clearer and easier to use. The more clear, concise, and understandable the rules are, the more the costs of training, administration, and enforcement may be reduced.

The Department may experience a moderate-to-substantial cost savings from conducting initial evaluations based on a designated physician's determination after review of an applicant's complete history of test results and medical records instead of conducting an initial evaluation for every applicant. Currently, the Department conducts an initial evaluation for all applicants at no charge to the applicant. In 2007, 3,462 of the 3,476 initial evaluations conducted for applicants confirmed the applicant's existing diagnosis. Under the proposed rules, the Department would only conduct an initial evaluation if the applicant's complete history of test results and medical records did not provide sufficient information for the designated physician to confirm or deny the applicant's diagnosis. The Department projects that it will conduct initial evaluations for about 10% of all applicants under the proposed rules.

The Department may experience a moderate cost savings from accepting an applicant's current AHCCCS enrollment to prove citizenship, age, or residence. The current rules require all CRS applicants to provide proof of citizenship, age, and residence. About 56% of all CRS applicants are already enrolled in AHCCCS. Applicants to AHCCCS are required to prove citizenship or qualified alien status by submitting a birth certificate, naturalization certificate, U.S. passport, visa, or legally equivalent document. All documents AHCCCS accepts to prove citizenship or qualified alien status also contain the applicant's birth date and place of residence. Accordingly, CRS can determine that an applicant meets the citizenship, age, and residence requirements in R9-7-201(A) simply by verifying that the applicant is currently enrolled in AHCCCS. The proposed rules allow the Department to do so. The proposed rules still require all applicants not enrolled in AHCCCS to provide documents establishing proof of citizenship, age, and residence.

The Department may experience a minimal cost savings from reduced administrative costs from no longer collecting AHCCCS applications from applicants who are not eligible for Title XIX or Title XXI health care insurance. Under the current rules, any applicant not already enrolled in AHCCCS is required to apply to AHCCCS, including applicants who are not eligible for Title XIX or Title XXI health care insurance. In 2007, 209 applicants were determined by AHCCCS to be ineligible for Title XIX or Title XXI health care insurance, and had 100% payment responsibility with CRS. The Department screens applicants to determine whether an applicant's household income is likely to be low enough to qualify for AHCCCS. The Department does not know how many of the 209 members had household income well above the AHCCCS threshold and how many were within a close margin of qualifying. The proposed rules do not require an applicant to apply for AHCCCS if the CRS preliminary screening indicates that the applicant is not eligible for Title XIX or Title XXI health care insurance, but the applicant may still choose to apply for AHCCCS so that an applicant who is within a close margin of qualifying can apply and may be enrolled in AHCCCS if eligible.

The Department may experience a significant benefit from the clarification of language describing the income deduction allowances for child support payments and medical expenses. The Department determines a member's payment responsibility based on the net income of the member's household, which is calculated from earned income, unearned income, and income deduction allowances. The Department does not know if the payment responsibility of any members was determined incorrectly as a result of the language in the current rules, but the Department believes that a small number of members, if any, would have been so affected.

The Department may experience a substantial cost savings from determining the payment responsibility of applicants based on a variable percentage of the Federal Poverty Level (FPL) instead of a fixed percentage of 200%, because the Department will be able to manage the size of the state-0%-pay member population in order to prevent the costs of services to that population from exceeding the amount appropriated to pay those costs.

The Department does not expect a cost or benefit from the changes in Article 4 that remove session limits, duration limits, and categorical limits from specified services. The current rules limit physical therapy, occupational therapy, and speech/language pathology to 24 sessions and home health services and nutrition services to 30 days in duration. The current rules place categorical limits on laboratory services and on treatment of conditions secondary to a member's qualifying CRS medical condition. The approval of a regional medical director is required for a member to receive services beyond the limits. The proposed rules remove the session, duration, and categorical limits from those services, leaving those services subject to the general requirements in R9-7-401, including utilization management. The Department's records for 2007 indicate that the limits were never reached or exceeded and the regional medical director never approved services beyond the limits. In a clear majority of cases, on services limited to 24 sessions, actual utilization did not exceed one session, and on services limited to 30 days in duration, actual utilization was less

than 10 days. Categorical limits on laboratory services and on treatment of secondary conditions no longer reflect Department policy and practice, so the removal of those limits is not expected to cause economic impact.

The Department may incur a moderate-to-substantial cost from providing cochlear implants and motorized wheelchairs to members who are appropriate candidates. Depending on the candidate's payment responsibility, the cost for these services may be offset. Federal and state funds are paid through AHCCCS for AHCCCS-eligible members, and third-party health insurance providers pay for 100%-pay-insured members. The Department will incur the cost to provide these services to state-0%-pay members with no corresponding offset reimbursement. It is not possible to know in advance the payment responsibility of members who could become candidates for these services in the future, but the Department expects the composition of that population to be similar to the composition of the CRS member population overall. About 17 members are projected to be candidates for cochlear implantation surgery, out of about 70 total members who are projected to receive cochlear implant services in the next year. About 13% of all CRS members are state-0%-pay members, so about 13% of the 17 candidates, or about three members, are expected to be state-0%-pay members. The Department may incur moderate-to-substantial costs to provide cochlear implants for those members, depending on physician's costs and other variables beyond the base costs of the procedure. Applying the same projection bases, the Department may incur moderate-to-substantial costs to provide motorized wheelchairs to appropriate candidates as well.

The Department could experience a none-to-substantial cost savings from providing repairs to medical equipment and of prosthetic or orthotic devices regardless of where or how a member acquired the medical equipment or prosthetic or orthotic devices instead of providing new or like-new equipment or devices as replacement. Currently, the Department provides repairs of medical equipment and of prosthetic or orthotic devices instead of providing new or like-new equipment or devices when the equipment or devices were originally provided by the Department and are determined safe and medically appropriate to repair. An exception to this is wheelchairs, which the Department repairs under the same conditions regardless of where or how the member acquired his or her wheelchair. The proposed rule eliminates the provenance requirement entirely, allowing the Department to repair any equipment or devices when appropriate instead of incurring the cost of providing new or like-new equipment or devices. The Department cannot project how many repair requests it will receive in the future, but expects that there will be more than a small number of requests. A repair could be simple or expensive to perform, but no repair would cost more than replacement with a new or like-new equipment or device.

AHCCCS and the AHCCCS health plans

AHCCCS and the AHCCCS health plans are distinguished in this economic impact summary because applicable changes in the proposed rules may cause different economic impact to each. CRS provides an AHCCCS-eligible member with services related to the member's qualifying medical condition, but CRS does not provide the member's primary care services or unrelated medical treatment. An AHCCCS-eligible member's AHCCCS health plan provides the member all services not related to the member's CRS condition. AHCCCS is the funding source for CRS and for the AHCCCS health plans, paying state-appropriated and federal-appropriated funding for services for AHCCCS-eligible members regardless of whether CRS or the AHCCCS health plans provide the services. For example, CRS does not currently provide cochlear implants, so AHCCCS pays for a cochlear implant through the member's AHCCCS health plan. Under the proposed rules, CRS will provide cochlear implants to appropriate members, so AHCCCS will pay CRS for a cochlear implant. The source of the funding to pay for the services is unchanged, so there is no resulting economic impact to AHCCCS.

Under the current rules, any applicant not already enrolled in AHCCCS is required to apply to AHCCCS, including applicants who are not eligible for Title XIX or Title XXI health care insurance. In 2007, 209 applicants were determined by AHCCCS to be ineligible for Title XIX or Title XXI health care insurance, and had 100% payment responsibility with CRS. The Department screens applicants to determine whether an applicant's household income is likely to be low enough to qualify for AHCCCS. The Department does not know how many of the 209 members had household income well above the AHCCCS threshold and how many were within a close margin of qualifying. The proposed rules do not require an applicant to apply for AHCCCS if the CRS preliminary screening indicates that the applicant is not eligible for Title XIX or Title XXI health care insurance, but the applicant may still choose to apply for AHCCCS so that an applicant who is within a close margin of qualifying can apply and may be enrolled in AHCCCS if eligible. Accordingly, AHCCCS may experience a significant benefit from reduced administrative costs, because AHCCCS will not be forced to expend time and staff resources reviewing applications from individuals who are not eligible.

The Department does not expect a cost or benefit to AHCCCS health plans from the changes in Article 4 that remove session limits, duration limits, and categorical limits from specified services. The current rules limit physical therapy, occupational therapy, and speech/language pathology to 24 sessions and home health services and nutrition services to 30 days in duration. The current rules place categorical limits on laboratory services and on treatment of conditions secondary to a member's qualifying CRS medical condition. The approval of a regional medical director is required for a member to receive services beyond the limits. The proposed rules remove the session, duration, and categorical limits from those services, leaving those services subject to the general requirements in R9-7-401, including utilization management. The Department's records for 2007 indicate that the limits were never reached or exceeded and the regional medical director never approved services beyond the limits. In a clear majority of cases, on services limited

to 24 sessions, actual utilization did not exceed one session, and on services limited to 30 days in duration, actual utilization was less than 10 days. Categorical limits on laboratory services and on treatment of secondary conditions no longer reflect Department policy and practice, so the removal of those limits is not expected to cause economic impact.

AHCCCS health plans may experience a substantial cost savings from CRS providing cochlear implants and motorized wheelchairs to members who are appropriate candidates. Currently, these services are provided by AHCCCS health plans and not CRS. It is not possible to know in advance the payment responsibility of members who could become candidates for these services in the future, but the Department expects the composition of that population to be similar to the composition of the CRS member population overall. About 17 members are projected to be candidates for cochlear implantation surgery, out of about 70 total members who are projected to receive cochlear implant services in the next year. About 81% of all CRS members are AHCCCS-eligible members, so about 81% of the 17 candidates, or about 13 members, are expected to be AHCCCS-eligible members. AHCCCS health plans may experience a substantial cost savings from CRS providing cochlear implants for those members, depending on physician's costs and other variables beyond the base costs of the procedure. Applying the same projection bases, AHCCCS health plans may experience a substantial cost savings from CRS providing motorized wheelchairs to appropriate candidates as well.

The Department could experience a none-to-substantial cost savings from providing repairs to medical equipment and of prosthetic or orthotic devices regardless of where or how a member acquired the medical equipment or prosthetic or orthotic devices instead of providing new or like-new equipment or devices as replacement, and that cost savings will apply to AHCCCS health plans whenever the Department provides repair services for an AHCCCS-eligible member. Currently, the Department provides repairs of medical equipment and of prosthetic or orthotic devices instead of providing new or like-new equipment or devices when the equipment or devices were originally provided by the Department and are determined safe and medically appropriate to repair. An exception to this is wheelchairs, which the Department repairs under the same conditions regardless of where or how the member acquired his or her wheelchair. The proposed rule eliminates the provenance requirement entirely, allowing the Department to repair any equipment or devices when appropriate instead of incurring the cost of providing new or like-new equipment or devices. The Department cannot project how many repair requests it will receive in the future, but expects that there will be more than a small number of requests. A repair could be simple or expensive to perform, but no repair would cost more than replacement with a new or like-new equipment or device.

CRS contractors

CRS contractors are identified as the health plans and hospital networks that furnish services to CRS members. Currently, the Department contracts with four "regional clinics" to serve as CRS contractors: St. Joseph's Hospital in Phoenix, Children's Clinics at Tucson Regional Medical Center and University of Arizona Medical Center in Tucson, Flagstaff Regional Medical Center, and Yuma Regional Medical Center. These entities are considered "CRS providers" as well as "CRS contractors," but the EIS associated with this rulemaking identifies them as "CRS contractors" in order to distinguish them from individual health professionals employed or contracted to serve the CRS member population.

CRS contractors may experience a moderate-to-substantial cost savings from conducting initial evaluations based on a designated physician's determination after review of an applicant's complete history of test results and medical records instead of conducting an initial evaluation for every applicant. Currently, the CRS contractors conduct an initial evaluation for all applicants at no charge to the applicant. In 2007, 3,462 of the 3,476 initial evaluations conducted for applicants confirmed the applicant's existing diagnosis. Under the proposed rules, the CRS contractor would only conduct an initial evaluation if the applicant's complete history of test results and medical records did not provide sufficient information for the designated physician to confirm or deny the applicant's diagnosis. The Department projects that it will conduct initial evaluations for about 10% of all applicants under the proposed rules.

CRS contractors may experience a moderate cost savings from accepting an applicant's current AHCCCS enrollment to prove citizenship, age, or residence. The current rules require all CRS applicants to provide proof of citizenship, age, and residence. About 56% of all CRS applicants are already enrolled in AHCCCS. Applicants to AHCCCS are required to prove citizenship or qualified alien status by submitting a birth certificate, naturalization certificate, U.S. passport, visa, or legally equivalent document. All documents AHCCCS accepts to prove citizenship or qualified alien status also contain the applicant's birth date and place of residence. Accordingly, CRS can determine that an applicant meets the citizenship, age, and residence requirements in R9-7-201(A) simply by verifying that the applicant is currently enrolled in AHCCCS. The proposed rules allow the CRS contractors to do so. The proposed rules still require all applicants not enrolled in AHCCCS to provide documents establishing proof of citizenship, age, and residence. The administrative cost savings from this change may benefit CRS contractors proportionately according to each CRS contractor's volume of applicants served.

CRS contractors may experience a substantial cost savings from determining the payment responsibility of applicants based on a variable percentage of the FPL instead of a fixed percentage of 200%, because the Department will be able to manage the size of the state-0%-pay member population in order to prevent the costs of services to that population from exceeding the amount the Department pays CRS contractors to cover those costs.

The Department does not expect a cost or benefit to CRS contractors from the changes in Article 4 that remove session limits, duration limits, and categorical limits from specified services. The current rules limit physical therapy, occupational therapy, and speech/language pathology to 24 sessions and home health services and nutrition services to 30 days in duration. The current rules place categorical limits on laboratory services and on treatment of conditions secondary to a member's qualifying CRS medical condition. The approval of a regional medical director is required for a member to receive services beyond the limits. The proposed rules remove the session, duration, and categorical limits from those services, leaving those services subject to the general requirements in R9-7-401, including utilization management. The Department's records for 2007 indicate that the limits were never reached or exceeded and the regional medical director never approved services beyond the limits. In a clear majority of cases, on services limited to 24 sessions, actual utilization did not exceed one session, and on services limited to 30 days in duration, actual utilization was less than 10 days. Categorical limits on laboratory services and on treatment of secondary conditions no longer reflect Department policy and practice, so the removal of those limits is not expected to cause economic impact.

CRS contractors may incur a significant cost from CRS providing cochlear implants and motorized wheelchairs to members who are appropriate candidates. Though the CRS contractors are not the payors for those services, administrative infrastructure and support staff are necessary to provide them. For example, a CRS contractor may need to hire additional audiologists or speech/language pathologists in order to provide support services for members who receive cochlear implants. Infrastructure and staff needs will vary among CRS contractors because some CRS contractors may already possess the necessary resources and be currently providing cochlear implants or motorized wheelchairs to members as covered by AHCCCS health plans or third-party health insurance providers.

CRS contractors may experience a significant benefit from the proposed rules allowing CRS providers to treat members in settings other than CRS clinics. The term "CRS clinic" refers not to a fixed physical location but a multidisciplinary framework of treatment to CRS members who have complex medical conditions. Currently, a regional clinic such as St. Joseph's Hospital might schedule a CRS clinic for a specific medical condition, such as cystic fibrosis, for one day at a time scheduled periodically throughout the year, and every CRS member with that condition would have an appointment on one of the CRS clinic days. At the appointment, the member would be seen by pediatric physicians in multiple specialties related to cystic fibrosis, who could then collaborate to discuss the member's treatment plan and optimize the plan for effective integrated care for the member. Without the care coordination CRS clinics offer, treatment for complex medical conditions can be less effective. Because CRS clinic days at the regional clinic sites must be allocated for many different complex medical conditions that require different pediatric specialist physicians, and because of the high volume of members seeking treatment and the time and space available for each, it is not uncommon for members to wait four to six months for a CRS clinic appointment. Some CRS conditions; however, do not require multidisciplinary care at every appointment, and can be treated by a single provider in a specialized non-CRS-clinic setting for certain procedures or simple check-up visits that do not require a full array of physicians to examine the member. In either case, those members could be treated at a local hospital campus or private physician's office rather than waiting in a queue for a CRS clinic appointment. Approximately 57% of CRS members attended at least one appointment in 2007 where they were seen by more than one CRS provider. Approximately 43% of CRS members did not see more than one provider at a time during 2007. A reduction in patient volume by up to 43% for the CRS clinics could significantly reduce the queue and allow CRS providers to more effectively serve members with complex medical conditions in the CRS clinic framework. Accordingly, the Department expects the reduction in patient volume for CRS clinics to be primarily a benefit and not a cost to CRS contractors.

CRS providers

CRS providers are identified in this rulemaking as individual health professionals employed or contracted by CRS contractors to serve the CRS member population at the point-of-encounter. The subgroups within the classification of CRS providers that could experience economic impact are physicians, physician assistants, registered nurse practitioners, physical therapists, occupational therapists, speech/language pathologists, and audiologists.

The Department does not expect a cost or benefit to CRS providers from the changes in Article 4 that remove session limits, duration limits, and categorical limits from specified services. The current rules limit physical therapy, occupational therapy, and speech/language pathology to 24 sessions and home health services and nutrition services to 30 days in duration. The current rules place categorical limits on laboratory services and on treatment of conditions secondary to a member's qualifying CRS medical condition. The approval of a regional medical director is required for a member to receive services beyond the limits. The proposed rules remove the session, duration, and categorical limits from those services, leaving those services subject to the general requirements in R9-7-401, including utilization management. The Department's records for 2007 indicate that the limits were never reached or exceeded and the regional medical director never approved services beyond the limits. In a clear majority of cases, on services limited to 24 sessions, actual utilization did not exceed one session, and on services limited to 30 days in duration, actual utilization was less than 10 days. Categorical limits on laboratory services and on treatment of secondary conditions no longer reflect Department policy and practice, so the removal of those limits is not expected to cause economic impact.

CRS providers may experience a significant benefit from CRS providing cochlear implants and motorized wheelchairs to members who are appropriate candidates. Though the CRS providers are not the payors for those services, CRS contractors are required to have administrative infrastructure and support staff to provide them. For example, a CRS contractor may need to hire additional audiologists or speech/language pathologists in order to provide support services for members who receive cochlear implants. Accordingly, CRS providers who are audiologists or speech/language pathologists would benefit from being hired by a CRS contractor. Infrastructure and staff needs will vary among CRS contractors because some CRS contractors may already possess the necessary resources and be currently providing cochlear implants or motorized wheelchairs to members as covered by AHCCCS health plans or third-party health insurance providers.

CRS providers may experience a significant benefit from the proposed rules allowing CRS providers to treat members in settings other than CRS clinics. The term "CRS clinic" refers not to a fixed physical location but a multidisciplinary framework of treatment to CRS members who have complex medical conditions. Currently, a regional clinic such as St. Joseph's Hospital might schedule a CRS clinic for a specific medical condition, such as cystic fibrosis, for one day at a time scheduled periodically throughout the year, and every CRS member with that condition would have an appointment on one of the CRS clinic days. At the appointment, the member would be seen by pediatric physicians in multiple specialties related to cystic fibrosis, who could then collaborate to discuss the member's treatment plan and optimize the plan for effective integrated care for the member. Without the care coordination CRS clinics offer, treatment for complex medical conditions can be less effective. CRS providers have reported that they may see only one or two patients at a CRS clinic in the same time they would see up to 10 patients at an office, at a hospital campus, or their own private physician's office. In addition, some CRS conditions do not require multidisciplinary care at every appointment, and can be treated by a single provider in a specialized non-CRS-clinic setting for certain procedures or simple check-up visits that do not require a full array of physicians to examine the member. In either case, those members could be treated at a local hospital campus or private physician's office rather than waiting in a queue for a CRS clinic appointment. Approximately 57% of CRS members attended at least one appointment in 2007 where they were seen by more than one CRS provider. Approximately 43% of CRS members did not see more than one provider at a time during 2007. CRS providers serving members in a non-CRS-clinic setting may be able to serve more members each day, improving the convenience for those members and concordantly relieving the strain on CRS clinic queues by reducing the CRS clinic patient volume. Accordingly, the Department expects the change to be primarily a benefit and not a cost to CRS providers.

CRS members

CRS members are identified aggregately and according to several subgroups, each of which could experience differing economic impact from this rulemaking. During fiscal year 2007, CRS had 23,156 enrolled members. Of that total, approximately 81% were enrolled in AHCCCS, identified in this EIS as "AHCCCS-eligible members." Approximately 13% were funded entirely by state appropriations and have a 0% payment responsibility, identified here as "state-0%-pay members." The remaining approximately 5% of CRS members have a 100% payment responsibility and either have health care insurance other than AHCCCS or self-fund their services, and are identified as "100%-pay-insured members" and "100%-pay-self-funded members," respectively. In 2007, CRS also provided limited information and referral services to adults with sickle-cell anemia pursuant to A.R.S. § 36-797.44 and other limited services to adults with cystic fibrosis pursuant to A.R.S. § 36-143, but CRS provisions for adults are not affected by this rulemaking.

CRS members may experience a significant benefit from the changes in Article 4 that remove session limits, duration limits, and categorical limits from specified services. Though the limits were never reached in or exceeded in 2007, under the current rules, a member reaching a session, duration, or categorical limit on services would need to arrange for a different provider to furnish those services and, depending on the member's payment responsibility, the member may have needed to self-fund further services or arrange for other insurance coverage. A member could thereby incur costs for medical services, transit or fuel, time, and other resources, as well as experiencing inconvenience and confusion over treatment. It is not possible to know how many members might require services in the future that would have reached or exceeded the limits under the current rules, but under the proposed rules those members will be able to obtain those services from CRS as long as the general requirements in R9-7-401 are met.

CRS members could experience a significant benefit from changes allowing CRS providers to treat members at locations other than CRS clinics. About 25% of the CRS member population lives more than 25 miles away from the closest of the four current regional clinics. About 53% of members live more than 10 miles away from a regional clinic. About 58% of the CRS member population lives in the Phoenix metropolitan area. For example, one member lives in the eastern part of Mesa and is being treated by a pediatric neurologist. Under the current rules, the member has to travel 35 miles to the CRS clinic at St. Joseph's Hospital in Phoenix for an appointment. The neurologist has a branch office in Mesa only 15 miles away from the member's residence. If the member is treated at the branch office, the member's travel distance, time, and the cost of fuel or transit could be cut by more than half.

CRS applicants

A CRS applicant is identified as an individual who potentially or actually fulfills the eligibility requirements for CRS and who is referred to CRS or requests enrollment by applying to CRS. Past and present CRS applicants will not be affected by this rulemaking, but future applicants could potentially incur none-to-substantial costs if the change from

a 200% FPL threshold for eligibility for state funding is reduced under the variable provision to a lower percentage. For example, if the new FPL percentage becomes 150%, future applicants whose household net income is 150% to 199% of the FPL will not qualify for state funding, though they would have qualified under the previous rules. Those applicants, if enrolled, will have 100% payment responsibility instead of being state-0%-pay members. Accordingly, they will be responsible for the cost of obtaining third-party health insurance or paying for services by self-funding.

Third-party health insurance providers

Third-party health insurance providers are identified as primarily private businesses who are the payors for 100%-pay-insured members. The Department does not expect third-party health insurance providers to experience costs or benefits from the changes in Article 4 that remove session limits, duration limits, and categorical limits from specified services, the provision of cochlear implants, or the provision of motorized wheelchairs, because 100%-pay-insured members have always been able to obtain those services and equipment, if covered, through their primary care provider and associated medical network outside CRS, and a 100%-pay-insured member's payor would have been the third-party health insurance provider. The only difference to the third-party health insurance provider would have been the payee for those services: a CRS provider or another provider. Third-party health insurance providers could experience a none-to-minimal benefit from administrative savings from no longer having to account for the change in payee from CRS to another provider once session and duration limits, if applicable, were reached. Third-party health insurance providers could experience a none-to-substantial benefit from cost savings from providing repairs of medical equipment and of prosthetic or orthotic devices for 100%-pay-insured members regardless of the provenance of the equipment or devices when the equipment or devices would otherwise have been provided new or like-new by CRS.

The Department has determined that the requirements in the rules are the least intrusive and least costly manner to administer the CRS program while accomplishing the legislative objective underlying A.R.S. §§ 36-261 through 36-265 of serving the population of children with special health care needs and disabling medical conditions.

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:	Kathleen Phillips, Esq. Rules Administrator and Administrative Counsel
Address:	Department of Health Services Office of Administrative Rules and Counsel 1740 W. Adams St., Suite 200 Phoenix, AZ 85007
Telephone:	(602) 542-1264
Fax:	(602) 364-1150
E-mail:	phillik@azdhs.gov
or	
Name:	Joan Agostinelli Office Chief and CRS Administrator
Address:	Department of Health Services Division of Behavioral Health Services Office for Children with Special Health Care Needs 150 N. 18th Ave., Suite 330 Phoenix, AZ 85007
Telephone:	(602) 542-1860
Fax:	(602) 542-2589
E-mail:	agostij@azdhs.gov

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:

The Department has scheduled the following oral proceeding:

Date:	May 21, 2008
Time:	3:00 p.m.
Location:	Department of Health Services Room 411-A 1740 W. Adams St. Phoenix, AZ 85007

Written comments on the proposed rulemaking or the preliminary economic, small business, and consumer impact summary may be submitted to either individual listed in items 4 and 9 until the close of record at 4:00 p.m. on May 21, 2008.

Individuals with a disability may request a reasonable accommodation by contacting Michael Bahr at (602) 364-0793 or bahrm@azdhs.gov. A request should be made as early as possible to allow time to arrange the accommodation.

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 7. DEPARTMENT OF HEALTH SERVICES
CHILDREN'S REHABILITATIVE SERVICES

ARTICLE 1. DEFINITIONS

Section
R9-7-101. Definitions

ARTICLE 2. ELIGIBILITY

Section
R9-7-201. Eligibility Requirements
R9-7-202. Medical Conditions
R9-7-203. Medical Ineligibility

ARTICLE 3. REFERRAL; ENROLLMENT; ~~APPLICATION;~~ FINANCIAL DETERMINATION; REDETERMINATION; TERMINATION

Section
R9-7-301. Referral
R9-7-302. Enrollment
R9-7-303. ~~Initial Evaluation; Further Diagnostic Testing~~ Financial Screening
~~R9-7-304. Enrollment Application~~
~~R9-7-604.~~ R9-7-304. ~~Member~~ Payment Responsibility
~~R9-7-602.~~ R9-7-305. Identification of Household Income Group
~~R9-7-603.~~ R9-7-306. Calculating Net Income
~~R9-7-305.~~ R9-7-307. Redetermination
~~R9-7-306.~~ R9-7-308. Termination ~~of Enrollment~~

ARTICLE 4. COVERED MEDICAL SERVICES

Section
R9-7-401. General Requirements
~~R9-7-402. Prior Authorization~~
~~R9-7-403.~~ R9-7-402. Audiology Services
~~R9-7-404.~~ R9-7-403. Dental and Orthodontia Services
~~R9-7-405.~~ R9-7-404. Diagnostic Testing and Laboratory Services
~~R9-7-406.~~ R9-7-405. Home Health Services
~~R9-7-407.~~ R9-7-406. Inpatient Services
~~R9-7-408.~~ R9-7-407. Medical Equipment
~~R9-7-409.~~ R9-7-408. Nursing Services
~~R9-7-410.~~ R9-7-409. Nutrition Services
~~R9-7-411.~~ R9-7-410. Outpatient Services
~~R9-7-412.~~ R9-7-411. Pharmaceutical Services
~~R9-7-413.~~ R9-7-412. Physical Therapy and Occupational Therapy

~~R9-7-414.~~ R9-7-413. Physician Services
~~R9-7-415.~~ R9-7-414. Prosthetic and Orthotic Devices
~~R9-7-416.~~ R9-7-415. Psychological Services
~~R9-7-417.~~ R9-7-416. Psychiatric Services
~~R9-7-418.~~ R9-7-417. Social Work Services
~~R9-7-419.~~ R9-7-418. Speech/Language Pathology Services
~~R9-7-420.~~ R9-7-419. Transplants
~~R9-7-421.~~ R9-7-420. Vision Services
R9-7-421. Renumbered

ARTICLE 5. COVERED SUPPORT SERVICES

Section
~~R9-7-501.~~ ~~General Requirements~~
~~R9-7-502.~~ R9-7-501. Advocacy Services
~~R9-7-503.~~ R9-7-502. Child Life Services
~~R9-7-504.~~ R9-7-503. Education Coordination
~~R9-7-505.~~ R9-7-504. Transition Services
~~R9-7-506.~~ R9-7-505. Transportation Services
R9-7-506. Renumbered

ARTICLE 6. ~~MEMBER PAYMENT~~ REPEALED

Section
R9-7-601. ~~General Requirements~~ Repealed
R9-7-602. Renumbered
R9-7-603. Renumbered
R9-7-604. Renumbered

ARTICLE 7. MEMBER APPEALS

Section
R9-7-701. Member Appeals

ARTICLE 1. DEFINITIONS

R9-7-101. Definitions
In this Chapter, unless otherwise specified:

1. No change
2. No change
3. No change
4. No change
5. No change
6. No change
   a. No change
   b. No change
7. "Application packet" means ~~an application form containing~~ the information in ~~R9-7-304(1)~~ R9-7-302(A) and additional documentation required by the Department to determine:
   a. Whether an individual is eligible for CRS; and
   b. If the individual is eligible for CRS, the payment responsibility of the individual or, if the individual is a minor, the individual's parent.

~~8. "Behavioral health service" has the same meaning as in A.A.C. R9-20-101.~~
~~9.~~8. "Biologicals" means medicinal compounds prepared from living organisms and the product of living organisms such as serums, vaccines, antigens, and antitoxins.
~~10. "Business day" means Monday, Tuesday, Wednesday, Thursday, or Friday excluding state and federal holidays.~~
~~11.~~9. No change
~~12.~~10. No change
~~13.~~11. No change
12. "Concurrent review" means an ongoing process conducted by the Department at the same time as the delivery of covered medical services to a member, such as during a member's inpatient treatment by a CRS provider, to determine if the member is receiving medically necessary, effective, and cost-efficient treatment.
~~14. "Co-payment" means the amount the Department requires a member to pay to a CRS provider for a medical service.~~

~~15.~~13. No change
~~16.~~14. "Crisis intervention service" means a behavioral health service as defined in A.A.C. R9-20-101 provided for a limited period of time to a member who is a danger to others as defined in A.A.C. R9-20-101 or a danger to self as defined in A.A.C. R9-20-101.
~~17.~~15. No change
~~18.~~16. "CRS clinic" means outpatient interdisciplinary evaluation and treatment provided by more than one ~~specialist~~ CRS provider at a specific location for a scheduled period of time.
~~19.~~17. "CRS condition" means any of the medical conditions in ~~Article 2 of this Chapter that make an individual medically eligible for CRS.~~ R9-7-202.
~~20.~~18. "CRS provider" means a person who is authorized by employment or written agreement with the Department ~~or a regional contractor~~ to provide covered medical services to a member or covered support services to a member or a member's family.
~~22.~~19. No change
~~21.~~20. "Dental services" means treatment provided by a dentist or a dental hygienist.
~~23.~~21. No change
~~24.~~22. "Department" means the Arizona Department of Health Services or its designee.
~~25.~~23. No change
24. "Designee" means a person acting on behalf of the Department under the authority of the Department.
~~26. "DES" means the Arizona Department of Economic Security.~~
~~27.~~25. No change
~~28.~~26. No change
~~29. "Eligibility interview" means an interaction between a Department representative and an applicant or member or, if the applicant or member is a minor, the applicant's or member's parent to review the documentation in R9-7-304(2) through (11).~~
~~30.~~27. No change
a. No change
b. No change
~~31. "Emergency" means an immediate threat to the health or life of a member.~~
~~32.~~28. No change
~~33.~~29. No change
~~34.~~30. No change
~~35. "Expiration date" means:~~
~~a. The date on which a member's enrollment ends, or~~
~~b. The date on which an individual's Title XIX or Title XXI health care insurance ends.~~
~~36. "Facility" means a building or portion of a building.~~
~~37.~~31. No change
~~38.~~32. "Federal Poverty Level" means the current level of income set by the United States government, based on family size, ~~that is~~ used to determine whether an individual may receive ~~low income~~ income-based federal assistance.
~~39.~~33. No change
34. "Financial screening packet" means the information and documentation required by the Department to determine the payment responsibility of an individual or, if the individual is a minor, the individual's parent.
~~40.~~35. No change
~~41.~~36. "Functionally limiting" means a restriction having a significant effect on an individual's ability to perform an activity of daily living as determined by a ~~specialist.~~ CRS provider.
~~42.~~37. No change
~~43.~~38. No change
~~44.~~39. No change
~~45.~~40. No change
~~46.~~41. No change
~~47.~~42. No change
~~48.~~43. No change
~~49.~~44. No change
~~50.~~45. No change
~~51.~~46. "Household income group" means all of the individuals whose income the Department includes when calculating an individual's or member's payment responsibility for covered services.
~~52.~~47. No change
~~53.~~48. No change
49. "Medical condition" means the state of an individual's physical or mental health, including the individual's illness, injury, or disease.

~~54.~~50. "Medical expenses" means charges incurred by an individual for:
a. ~~medical~~ Medical equipment~~,~~;
b. ~~medication~~ Medication or biologicals prescribed by a physician ~~or specialist~~, physician's assistant, or registered nurse practitioner;
c. ~~dental~~ Dental services~~,~~;
d. ~~treatment~~ Treatment by a ~~physician or specialist~~ health professional, as defined in A.R.S. § 32-3201, except a veterinarian;
e. ~~inpatient~~ Inpatient services~~,~~;
f. ~~outpatient~~ Outpatient services~~,~~; or
g. ~~health~~ Health care insurance premiums for the individual.

~~57.~~51. "Medical service" means evaluation or treatment of a member by a ~~physician or specialist who is~~ CRS provider.

~~55.~~52. No change

~~56.~~53. No change

~~58.~~54. No change

~~59.~~55. No change

~~60.~~56. "Minor" means an individual who is:
a. Under ~~the age of 18 years,~~ 18 years of age and is not:
i. Married; or
ii. Emancipated, as specified in A.R.S. Title 12, Chapter 15;
b. Incompetent, as determined by a court of competent jurisdiction~~,~~; or
c. No change

57. "Net income" means an individual's gross income minus the deductions in R9-7-306(C).

~~61.~~58. No change

~~62.~~59. No change

~~63.~~60. "Occupational therapy" has the same meaning as in A.R.S. § ~~32-2001.~~ 32-3401.

~~64.~~61. No change

~~65.~~62. "Outpatient services" means evaluating, monitoring, or treating an individual at a ~~facility,~~ hospital, physician's office, ~~regional clinic, or outreach clinic~~ or CRS clinic for less than 24 hours.

~~66. "Outreach clinic" means a facility or a specific location in a facility designated by a regional contractor to provide covered medical services or covered support services in a setting other than a regional clinic.~~

~~67.~~63. No change

~~68.~~64. "Payment agreement" means a form containing ~~a~~ an individual's or member's signed, written promise to pay for covered medical services according to the terms on the form.

~~69.~~65. "Payment responsibility" means that portion of the cost for medical services that ~~a~~ an individual or member is required to pay and has agreed to pay according to a signed written agreement.

~~70.~~66. No change

~~71.~~67. "Pharmaceutical services" means medications and biologicals ordered by a physician, dentist, physician's assistant, or registered nurse practitioner.

~~72.~~68. "Physical therapy" has the same meaning as in A.R.S. § ~~32-3401.~~ 32-2001.

~~73.~~69. No change

~~74.~~70. No change
a. No change
b. No change

71. "Physician's assistant" has the same meaning as in A.R.S. § 32-2501.

~~75.~~72. "Prior authorization" means a written approval signed by ~~a regional contractor or the regional contractor's designee~~ the Department or the Department's designee before a covered service is provided to a member.

~~76.~~73. No change

~~77.~~74. No change

~~79.~~75. No change

~~78.~~76. "Psychiatrist" has the same meaning as in A.R.S. § 36-501.

~~81.~~77. No change

~~80.~~78. "Psychologist" means an individual licensed under A.R.S. Title 32, Chapter 19.1.

~~82.~~79. No change

~~83.~~80. "Qualified alien" has the same meaning as in A.R.S. § ~~36-2903.03(G).~~ 36-2903.03(I).

~~86.~~81. "Redetermination" means a decision made by the Department regarding whether a:
a. Member ~~continues to be eligible for CRS, or~~ meets the requirements in R9-7-201, or
b. Member's payment responsibility is changed.

~~84.~~82. No change

~~85.~~83. "Referral source" means a person who refers an individual to CRS.

84. "Registered nurse practitioner" has the same meaning as in A.R.S. § 32-1601.
85. "Retrospective review" means the process conducted by the Department following the completion of the delivery of covered medical services to a member to determine if the member received medically necessary, effective, and cost-efficient treatment.
~~90.~~86. No change
   a. No change
   b. No change
   c. No change
   d. No change
~~87. "Regional clinic" means a facility or specific location in a facility designated by a regional contractor:~~
   ~~a. To provide covered medical services and covered support services, and~~
   ~~b. As the location for the regional contractor's administrative office.~~
~~88. "Regional contractor" means a person who has a written agreement with the Department to provide covered medical services and covered support services.~~
~~89. "Regional medical director" means a physician employed by a regional contractor to make:~~
   ~~a. Medical determinations about members, and~~
   ~~b. Prior authorizations for medical services provided to members.~~
~~91.~~87. No change
~~93.~~88. No change
~~92.~~89. "Social worker" means an individual certified under A.R.S. Title 32, Chapter 33, Article 5.
~~95.~~90. No change
~~96.~~91. No change
~~97.~~92. "Title XIX" means the Federal Medicaid Program, 42 U.S.C. 1396, a health care insurance program administered jointly by the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services and, in Arizona, by AHCCCS, through which an eligible ~~individuals receive~~ individual receives health care, ~~that is administered jointly by the U.S. Department of Health and Human Services and, in Arizona, by AHCCCS~~ excluding provisions for an individual who is not a U.S. citizen or qualified alien.
~~98.~~93. "Title XXI" means the State Children's Health Insurance Program, 42 U.S.C. 1397jj, through which an eligible ~~children receive~~ individual receives health care insurance that is administered by AHCCCS, excluding provisions for an individual who is not a U.S. citizen or qualified alien.
~~94. "Specialist" means:~~
   ~~a. A physician who is a CRS provider with professional education, knowledge, and skills related to a specific service or procedure, age category of patients, body system, or type of disease; or~~
   ~~b. A CRS provider, other than a physician, who requires specific professional education, knowledge, and skills to deliver a medical service or support service.~~
~~99.~~94. No change
~~100.~~95. No change
~~101.~~96. No change
97. "Utilization management" means the processes by which the Department determines medically necessary, effective, and cost-efficient covered medical services and treatment for a member, including:
   a. Prior authorization,
   b. Concurrent review, and
   c. Retrospective review.

ARTICLE 2. ELIGIBILITY

R9-7-201. Eligibility Requirements

A. An individual is eligible to enroll for CRS if the individual:
   1. No change
   2. No change
   3. No change
      a. No change
      b. No change
   4. Is living in Arizona ~~and intends to continue living in Arizona~~.

B. No change
   1. No change
   2. No change

~~**C.** The Department shall continue a member's enrollment in CRS if the member:~~
   ~~1. And, if the member is a minor, the member's parent comply with the requirements in this Chapter;~~

~~2. Meets the requirements in subsections (A)(1), (A)(2), and (A)(4); and~~
~~3. Meets the requirements in subsection (A)(3) or has continuously been a member since August 5, 1999.~~

R9-7-202. Medical Conditions

An individual is medically eligible for CRS, only if the individual has:

1. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
   g. No change
   h. No change
   i. No change
2. One or more of the following endocrine system medical conditions:
   a. Hypothyroidism~~;~~,
   b. Hyperthyroidism~~;~~,
   c. Adrenogenital syndrome~~;~~,
   d. Addison's disease~~;~~,
   e. Hypoparathyroidism~~;~~,
   f. Hyperparathyroidism~~;~~,
   g. Diabetes insipidus~~;~~,
   h. Cystic fibrosis~~;~~, and
   ~~i. For an individual who was a member before November 1, 1995, panhypopituitarism with a deficiency of growth hormone; and~~
   i. Panhypopituitarism;
   ~~j. For an individual who became a member or applies for enrollment after November 1, 1995, panhypopituitarism with a deficiency of growth hormone and two other pituitary hormones;~~
3. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
   g. No change
   h. No change
   i. No change
   j. No change
   k. No change
4. One or more of the following ear, nose, or throat medical conditions:
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
   g. Craniofacial anomaly that requires treatment by more than one ~~specialist~~ CRS provider; and
   h. No change
5. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
   g. No change
   h. No change

i. No change
j. No change
k. No change
l. No change
m. No change
n. No change
o. No change
p. No change
q. No change
r. No change
s. No change
t. No change
u. No change
v. No change
w. No change
x. No change
y. No change
z. No change
aa. No change
bb. No change
cc. No change
dd. No change
ee. No change
ff. No change
gg. No change
    i. No change
    ii. No change
hh. No change
ii. No change
jj. No change
kk. No change
ll. No change
mm. No change
nn. No change
oo. No change
pp. No change
    i. No change
    ii. No change
qq. No change
rr. No change

6. No change
    a. No change
    b. No change
    c. No change
    d. No change
    e. No change
    f. No change
    g. No change
    h. No change
    i. No change
    j. No change
    k. No change
    l. No change
7. No change
    a. No change
    b. No change
    c. No change
    d. No change
    e. No change

f. No change
g. No change
h. No change
i. No change
j. No change
k. No change
l. No change
m. No change
n. No change
o. No change
p. No change
q. No change
r. No change
s. No change
t. No change

8. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
9. No change
   a. No change
   b. No change
10. No change
    a. No change
    b. No change
    c. No change
    d. No change
    e. No change
11. No change
    a. No change
    b. No change
    c. No change
    d. No change
    e. No change
    f. No change
    g. No change
    h. No change
12. No change
13. A medical condition, other than one of the conditions in R9-7-203, that, as determined by ~~a regional medical director:~~ the Department:
    a. Requires specialized treatment similar to the type and quantity of treatment a medical condition in subsections (1) through (12) requires,
    b. Is as likely to result in functional improvement with treatment as a medical condition listed in subsections (1) through (12), and
    c. Requires long-term follow-up of the type and quantity required for a medical condition listed in subsections (1) through (12).

R9-7-203. Medical Ineligibility

~~An individual who has one or more of the following medical conditions, but does not have one or more of the medical conditions in R9-7-202, is not medically eligible for CRS:~~

An individual who does not have one or more of the medical conditions in R9-7-202, and who has one or more of the following medical conditions, is not medically eligible for CRS:

1. No change
   a. No change
   b. No change
   c. No change

d. No change
2. No change
   a. No change
   b. No change
   c. No change
   d. No change
3. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
   g. No change
   h. No change
4. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
   g. No change
   h. No change
   i. No change
   j. No change
   k. No change
   l. No change
5. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
   g. No change
      i. No change
      ii. No change
   h. No change
   i. No change
6. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
   g. No change
   h. No change
7. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
   g. No change
   h. No change
   i. No change

8. No change
   a. No change
   b. No change
   c. No change
   d. No change
9. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
   g. No change
10. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
   g. No change
   h. No change
   i. No change
11. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
   g. No change
      i. No change
      ii. No change
   h. No change
   i. No change
   j. No change
   k. No change
   l. No change
   m. No change
   n. No change
   o. No change

ARTICLE 3. REFERRAL; ENROLLMENT; ~~APPLICATION;~~ FINANCIAL DETERMINATION; REDETERMINATION; TERMINATION

R9-7-301. Referral

~~A.~~ ~~To refer an individual, a referral source shall submit to the Department a referral form containing:~~
   ~~1. The name, sex, home address, and home telephone number of the individual;~~
   ~~2. If the individual is a minor, the name of a parent of the individual;~~
   ~~3. If applicable, the work telephone number of the parent in subsection (A)(2);~~
   ~~4. The name, address, and telephone number of the referral source;~~
   ~~5. If the individual previously received covered medical services or covered support services, the year in which the individual received covered medical services or covered support services, and the regional contractor responsible for providing covered medical services or covered support services to the individual;~~
   ~~6. Relationship of the referral source to the individual; and~~
   ~~7. If known to the referral source, the individual's:~~
      ~~a. Birth date,~~
      ~~b. Diagnosis, and~~
      ~~c. Physician.~~

~~**B.** If an individual has Title XIX, Title XXI, or other health care insurance, a referral source shall submit to the Department the form in subsection (A) and:~~
~~1. Documentation from a physician who evaluated the individual, stating the individual's diagnosis made by the physician; and~~
~~2. Diagnostic test results that support the individual's diagnosis made by the physician.~~
~~**C.** If an individual does not have Title XIX, Title XXI, or other health care insurance, a referral source shall submit to the Department the form in subsection (A) and:~~
~~1. If the individual has not been evaluated by a physician, the reason the referral source believes that the individual may be eligible for CRS; or~~
~~2. If the individual has been evaluated by a physician:~~
~~a. Documentation from the physician who evaluated the individual, stating the individual's diagnosis made by the physician; and~~
~~b. If available, diagnostic test results that support the individual's diagnosis made by the physician.~~
~~**D.** Within 10 business days from the date of receipt of a referral:~~
~~1. If the Department determines that a individual may be eligible for CRS, the Department shall notify the referral source and provide the individual or, if the individual is a minor, the individual's parent:~~
~~a. An application form in R9-7-304(1) and a list of the documentation required in R9-7-304(2) through (11);~~
~~b. A written notice that the individual may be eligible for CRS and that:~~
~~i. After the Department receives the application form in R9-7-304(1) from the individual or, if the individual is a minor, the individual's parent, the individual is authorized to receive an initial evaluation to determine whether the individual is medically eligible for CRS;~~
~~ii. The individual or, if the individual is a minor, the individual's parent is required the participate in a eligibility interview before or during the individual's initial evaluation;~~
~~iii. The Department has scheduled an appointment for the individual's initial evaluation at a CRS clinic, the date of the individual's appointment, the address of the CRS clinic, and the procedure for rescheduling the appointment if the individual is unable to keep the scheduled appointment; and~~
~~iv. The individual is not authorized to receive covered medical services or covered support services other than the initial evaluation until the individual and, if the individual is a minor, the individual's parent comply with the application requirements in R9-7-302(B) and the Department determines that the individual meets the eligibility requirements in R9-7-201; and~~
~~c. Information about CRS, including:~~
~~i. An overview of CRS,~~
~~ii. Medical and non-medical eligibility requirements for CRS,~~
~~iii. The application requirements in R9-7-302(B), and~~
~~iv. Criteria for determining which individuals are part of a household income group;~~
~~2. If the Department determines that the individual is not eligible for CRS, the Department shall:~~
~~a. Notify the referral source; and~~
~~b. Provide the individual or, if the individual is a minor, the individual's parent a written notice that:~~
~~i. Informs the individual or, if the individual is a minor, the individual's parent that the Department has determined the individual is not eligible for CRS; and~~
~~ii. Complies with A.R.S. § 41-1092.03; or~~
~~3. If the Department determines the referral source did not submit the information and documentation required in subsection (A), the Department shall provide a written notice to the referral source that:~~
~~a. Identifies the missing documentation or information;~~
~~b. Requests the referral source to submit the missing information or documentation within 30 calendar days from the date of the notice; and~~
~~c. Informs the referral source that, if the Department does not receive the documentation or information within 30 calendar days from the date of the notice, the Department shall consider the referral withdrawn.~~
~~**E.** If the Department requests information or documents according to subsection (D)(3), and the Department:~~
~~1. Receives the requested documentation and information within 30 calendar days from the date of the notice in subsection (D)(3), the Department shall determine whether the individual may be eligible for CRS and notify the referral source and the individual or, if the individual is a minor, the individual's parent according to subsection (D)(1) or (D)(2) within 10 business days from the date of receipt of the requested documentation and information; or~~
~~2. Does not receive the requested documentation and information within 30 calendar days from the date of notice in subsection (D)(3), the Department shall consider the referral withdrawn.~~
~~**F.** If the Department determines that an individual may be eligible for CRS, the Department shall schedule the date of an initial evaluation no more than 30 calendar days after the date of the determination.~~

A. To refer an individual, a referral source shall submit to the Department the following information:
1. The individual's:

a. Name;
b. Date of birth;
c. Home address; and
d. Contact information, such as a telephone number or e-mail address;
2. If known to the referral source, the individual's Social Security number;
3. If the individual is a minor, the name of a parent of the individual;
4. If known to the referral source, whether the individual is:
a. A U.S. citizen, or
b. A qualified alien;
5. The name, address, and telephone number of the referral source;
6. The relationship of the referral source to the individual;
7. If known to the referral source:
a. The individual's diagnosis, and
b. The name of the individual's physician; and
8. If known to the referral source, whether the individual has:
a. Title XIX health care insurance,
b. Title XXI health care insurance, or
c. Other health care insurance.

B. If an individual has Title XIX, Title XXI, or other health care insurance, a referral source shall submit to the Department the information in subsection (A); and
1. Documentation from a physician who evaluated the individual, stating the individual's diagnosis; and
2. Diagnostic test results that support the individual's diagnosis.

C. If an individual does not have Title XIX, Title XXI, or other health care insurance, a referral source shall submit to the Department the information in subsection (A); and
1. If the individual has not been evaluated by a physician, the reason the referral source believes that the individual may have a CRS condition; or
2. If the individual has been evaluated by a physician:
a. Documentation from the physician who evaluated the individual, stating the individual's diagnosis; and
b. If available, diagnostic test results that support the individual's diagnosis.

D. The Department shall provide written notice of the Department's eligibility determination to a referral source and the referred individual within 14 days from the date of receipt of a referral.

E. If the Department determines that the individual has a CRS condition and may be eligible for CRS, the Department shall provide the individual or, if the individual is a minor, the individual's parent:
1. A written notice that the individual has a CRS condition and that:
a. The individual may be eligible for CRS;
b. The Department will not enroll the individual in CRS until the individual:
i. Completes and submits to the Department the application in R9-7-302(A);
ii. Complies with the financial screening requirements in R9-7-303, if applicable; and
iii. Completes and submits to the Department the payment agreement in R9-7-304(A); and
c. If the Department does not receive the documents in subsection (E)(1)(b) within 90 days from the date of the notice in subsection (E)(1), the Department shall consider the application withdrawn.
2. Information about CRS, including:
a. An overview of CRS,
b. The medical services and support services covered by CRS,
c. The grievance and appeal process,
d. The enrollment requirements in R9-7-301 and R9-7-302 and an explanation of the enrollment process,
e. The financial screening requirements in R9-7-303 and an explanation of the financial screening process, and
f. The percentage of the Federal Poverty Level established according to R9-7-304(C) by which the Department determines a member's payment responsibility and an explanation of the Department's process to determine a member's payment responsibility,
3. The application packet in R9-7-302(A);
4. The financial screening packet in R9-7-303; and
5. The payment agreement in R9-7-304(A).

F. If the Department determines that the individual is not eligible for CRS, the Department shall provide the individual or, if the individual is a minor, the individual's parent a written notice that:
1. Informs the individual or, if the individual is a minor, the individual's parent of the reason why the individual is not eligible for CRS; and
2. Complies with A.R.S. § 41-1092.03.

G. If the Department determines the referral source did not submit the information and documentation required in subsections (A) through (C):
1. The Department shall provide a written notice to the referral source and the referred individual that:
   a. Identifies the missing information or documentation;
   b. Requests the referral source or referred individual to submit the missing information or documentation within 90 days from the date of the notice; and
   c. Informs the referral source and referred individual that, if the Department does not receive the information or documentation within 90 days from the date of the notice, the Department shall consider the referral withdrawn.
2. If the Department receives the information or documentation requested in subsection (G)(1) within 90 days of the notice in that subsection, the Department shall, within 14 days from the date of receipt of the requested information or documentation, make an eligibility determination and provide notice according to this Section.
3. If the Department does not receive the information or documentation requested in subsection (G)(1) within 90 days of the notice in that subsection, the Department shall consider the referral withdrawn.

H. If the Department determines that further diagnostic testing or an initial evaluation is necessary for the Department to determine whether the individual has a CRS condition, the Department shall provide the individual or, if the individual is a minor, the individual's parent:
1. A written notice that:
   a. Further diagnostic testing or an initial evaluation of the individual is necessary in order for the Department to determine whether the individual has a CRS condition, and
   b. If applicable, includes the name and contact information for the person the individual can contact in order to schedule further diagnostic testing or an initial evaluation; and
   c. Informs the individual or, if the individual is a minor, the individual's parent that, if the Department does not receive the results of further diagnostic testing within 90 days from the date of the notice, or the individual does not receive an initial evaluation within 90 days from the date of the notice, the Department shall consider the referral withdrawn;
2. Information about CRS, including:
   a. An overview of CRS,
   b. The medical services and support services covered by CRS,
   c. The grievance and appeal process,
   d. The enrollment requirements in R9-7-301 and R9-7-302 and an explanation of the enrollment process,
   e. The financial screening requirements in R9-7-303 and an explanation of the financial screening process, and
   f. The percentage of the Federal Poverty Level established according to R9-7-304(C) by which the Department determines a member's payment responsibility and an explanation of the Department's process to determine a member's payment responsibility,
3. The application packet in R9-7-302(A);
4. The financial screening packet in R9-7-303; and
5. The payment agreement in R9-7-304(A).

I. If an individual receives the notice in subsection (H)(1) that further diagnostic testing is necessary, the individual shall:
1. If the individual has Title XIX or Title XXI health care insurance, request that AHCCCS complete the diagnostic testing and send the results of the diagnostic testing to the Department;
2. If the individual has other health care insurance that provides the diagnostic testing, complete the diagnostic testing and submit the results of the diagnostic testing to the Department; or
3. If the individual does not have health care insurance or has health care insurance that does not provide the diagnostic testing:
   a. Complete and submit to the Department the payment agreement in R9-7-304(A) before the individual receives the diagnostic testing, and
   b. Contact the person indicated in the notice in subsection (H)(1)(b) to schedule the diagnostic testing, if applicable.

J. If an individual receives the notice in subsection (H)(1) that an initial evaluation is necessary, the individual shall:
1. Complete and submit to the Department the payment agreement in R9-7-304(A) before the individual receives an initial evaluation; and
2. Contact the person indicated in the notice in subsection (H)(1)(b) to schedule an initial evaluation.

K. If the Department receives the results of further diagnostic testing within 90 days from the date of the notice in subsection (H)(1), or the individual receives an initial evaluation within 90 days from the date of the notice in subsection (H)(1), the Department shall, within 14 days from the date of receipt of the results of further diagnostic testing or the completion of the individual's initial evaluation, make an eligibility determination and provide notice according to this Section.

L. If the Department does not receive the results of further diagnostic testing within 90 days from the date of the notice in subsection (H)(1), or the individual does not receive an initial evaluation within 90 days from the date of the notice in subsection (H)(1), as applicable, the Department shall consider the referral withdrawn.

R9-7-302. Enrollment

~~**A.** An individual or, if the individual is a minor, the individual's parent may apply for enrollment after the individual or, if the individual is a minor, the individual's parent receives the notice in R9-7-301(D)(1) from the Department that the individual may be eligible for CRS.~~

~~**B.** To apply for enrollment:~~

~~1. An applicant or, if the applicant is a minor, the applicant's parent shall submit to the Department an application form containing the information in R9-7-304(1);~~

~~2. An applicant or, if the applicant is a minor, the applicant's parent shall submit to the Department the documentation in R9-7-304(2) through (11):~~

~~a. Before an applicant's initial evaluation, or~~

~~b. No later than 10 business days after the date an applicant attends a CRS clinic for an initial evaluation;~~

~~3. After submitting the application form in subsection (B)(1):~~

~~a. An applicant, or if the applicant is a minor, the applicant's parent shall participate in an eligibility interview; and~~

~~b. An applicant shall attend a CRS clinic for an initial evaluation; and~~

~~4. No later than 10 business days after the date an applicant attends a CRS clinic for an initial evaluation, the applicant or, if the applicant is a minor, the applicant's parent shall:~~

~~a. If the applicant is potentially eligible for Title XIX or Title XXI health care insurance, apply for the health care insurance; and~~

~~b. Sign the payment agreement in R9-7-601(B).~~

~~**C.** Except as provided in subsection (H), the Department shall enroll an applicant as soon as:~~

~~1. The applicant and, if applicable, the applicant's parent submit the information and documentation and meet the requirements in this Section; and~~

~~2. The Department determines the applicant is eligible for CRS.~~

~~**D.** If the Department enrolls an applicant, the Department shall provide the applicant or, if the applicant is a minor, the applicant's parent, a written notice that contains:~~

~~1. A statement that the applicant is enrolled in CRS; and~~

~~2. Information about CRS that includes:~~

~~a. Covered medical services and covered support services,~~

~~b. Member payment responsibility, and~~

~~c. The grievance and appeal process.~~

~~**E.** The Department shall not enroll an applicant if:~~

~~1. The applicant and, if the applicant is a minor, the applicant's parent does not submit the information and documentation or comply with the requirements in this Section; or~~

~~2. The Department determines that the applicant is not eligible for CRS.~~

~~**F.** If the Department does not enroll an applicant, the Department shall provide the applicant or, if the applicant is a minor, the applicant's parent, a written notice of denial that complies with A.R.S. § 41-1092.03.~~

~~**G.** The Department shall provide the written notice in subsection (D) or subsection (F) within 10 days from the date of an applicant's initial evaluation or the Department's receipt of the applicant's information and documentation in subsection (B)(2) if the applicant did not submit the information and documentation at the applicant's initial evaluation, whichever is later.~~

~~**H.** If an applicant, who meets the requirements in this Section and is determined to be eligible for CRS, is receiving inpatient services, the Department shall:~~

~~1. Provide the applicant or, if the applicant is a minor, the applicant's parent a written notice:~~

~~a. Stating that the Department will not enroll an applicant while the applicant is receiving inpatient services; and~~

~~b. Requesting that the Department is notified when the applicant is no longer receiving inpatient services; and~~

~~2. When the applicant is no longer receiving inpatient services, enroll the applicant according to subsection (D).~~

~~**I.** If the Department requests information or documentation to determine if a member remains eligible for CRS, the member or, if the member is a minor, the member's parent shall provide the requested information or documentation to the Department within 30 calendar days of the request.~~

A. An applicant for enrollment in CRS shall submit:

1. The following information:
   a. The applicant's name, home address, mailing address, birth date, and marital status;
   b. If the applicant has a Social Security number, the applicant's Social Security number;
   c. Contact information for the applicant, such as a telephone number, cellular phone number, or e-mail address;
   d. Whether the applicant has a legal guardian;
   e. Whether the applicant is an emancipated minor;
   f. If the applicant is a minor, the following information for the applicant's parent:
      i. Name, home address, mailing address, and contact information such as a telephone number, cellular phone number, or e-mail address; and

ii. If the parent is employed, the parent's employer, work address, and work telephone number;
g. A statement that the applicant or, if the applicant is a minor, a parent on behalf of the applicant requests the applicant's enrollment in CRS; and
h. The signature of the individual or, if the individual is a minor, the signature of the individual's parent, and the date signed;
2. If the applicant has a legal guardian, a copy of the court document indicating the applicant's legal guardian;
3. If the applicant is an emancipated minor, a copy of the court document indicating that the applicant is an emancipated minor;
4. If the individual has Title XIX or Title XXI health care insurance:
a. The individual's valid AHCCCS identification number or a copy of the individual's valid AHCCCS identification card; and
b. An assignment of Title XIX or Title XXI health care insurance benefits, as applicable, to the Department;
5. If the applicant does not have Title XIX or Title XXI health care insurance:
a. Except as provided in subsection (A)(5)(b), as proof of the applicant's age and that the applicant is a U.S. citizen, a copy of any of the following documents that includes the applicant's birth date:
i. A certified copy of a birth certificate,
ii. A naturalization certificate reflecting U.S. citizenship,
iii. A current or expired U.S. passport, or
iv. A certificate of U.S. citizenship;
b. If the applicant is a qualified alien, written documentation containing the applicant's birth date that verifies that the applicant:
i. Is a qualified alien, and
ii. Meets the requirements of A.R.S. § 36-2903.03(B);
c. As proof that the applicant resides in Arizona, a copy of any of the following documents, issued in the name of the applicant, the spouse of the applicant, or an adult with whom the applicant lives:
i. A United States Post Office record that contains the applicant's current Arizona address;
ii. An Arizona rent or mortgage receipt for the applicant's current Arizona address;
iii. An Arizona lease for the applicant's current Arizona address;
iv. A written statement that the applicant currently lives at an Arizona nursing care institution licensed under A.R.S. Title 36, Chapter 4, signed by the administrator of the Arizona nursing care institution;
v. A current Arizona motor vehicle operator's license;
vi. A current Arizona motor vehicle registration;
vii. A current pay stub from an Arizona employer;
viii. An Arizona utility bill for the applicant's current Arizona address;
ix. An Arizona phone directory listing for the applicant's current Arizona address;
x. A certified copy of a religious record that contains the applicant's current Arizona address;
xi. A certified copy of a school record that contains the applicant's current Arizona address; or
xii. An affidavit signed by the applicant or, if the applicant is a minor, by the applicant's parent certifying that:
(1) None of the documents in subsections (A)(5)(c)(i) through (xi) are available; and
(2) The applicant currently lives in Arizona; and
d. Unless the application is being submitted for redetermination according to R9-7-307(A)(1), the financial screening packet in:
i. R9-7-303(A), or
ii. R9-7-303(B).

B. The Department shall provide to an applicant within seven days from the date of the receipt of an application in subsection (A) a written notice of:
1. The Department's enrollment determination, and
2. If applicable, the Department's determination of the applicant's payment responsibility.

C. If the Department determines that an applicant is eligible to enroll in CRS and has complied with the requirements in this Section, the Department shall provide the applicant or, if the applicant is a minor, the applicant's parent:
1. A written notice that:
a. The applicant is eligible to enroll in CRS once the Department has received a completed payment agreement from the applicant; and
b. If the applicant does not complete and submit to the Department a payment agreement within 90 days from the date of the notice, the Department shall consider the application withdrawn; and
2. The payment agreement in R9-7-304(A).

D. An applicant who is eligible to enroll in CRS and has complied with the requirements in this Section shall submit to the Department the payment agreement in R9-7-304(A).

E. Except as provided in subsection (I), if the Department receives a completed payment agreement from an applicant who is

eligible to enroll in CRS and has complied with the requirements in this Section, the Department shall:
1. Enroll the applicant in CRS; and
2. Provide the applicant or, if the applicant is a minor, the applicant's parent, a written notice that:
   a. The applicant is enrolled in CRS, and
   b. Includes the name and contact information for the person the member can contact to schedule a medical service with a CRS provider.

F. If the Department determines that an applicant did not submit the information and documentation required in subsection (A):
1. The Department shall provide a written notice to the applicant or, if the applicant is a minor, the applicant's parent that:
   a. Identifies the missing information or documentation;
   b. Requests the applicant or, if the applicant is a minor, the applicant's parent to submit the missing information or documentation within 90 days from the date of the notice; and
   c. Informs the applicant or, if the applicant is a minor, the applicant's parent that, if the Department does not receive the information or documentation within 90 days from the date of the notice, the Department shall consider the application withdrawn.
2. If the Department requests information or documentation according to subsection (F)(1) and receives the information or documentation requested within 90 days of the notice in that subsection, the Department shall, within seven days from the date of receipt of the requested information or documentation, make an enrollment determination and provide notice according to this Section.

G. If the Department determines that an applicant is not eligible for CRS, the Department shall provide the applicant or, if the applicant is a minor, the applicant's parent a written notice that:
1. Informs the applicant or, if the applicant is a minor, the applicant's parent of the reason why the applicant is not eligible to enroll in CRS; and
2. Complies with A.R.S. § 41-1092.03.

H. The Department shall consider an application withdrawn if the Department does not receive:
1. An application in subsection (A) within 90 days from the date of the notice in R9-7-301(E),
2. The information or documentation requested according to subsection (F)(1) within 90 days of the date of the notice in that subsection, or
3. A completed payment agreement in R9-7-304(A) within 90 days from the date of the notice in subsection (C)(1).

I. If the Department receives a completed payment agreement from an applicant who is eligible to enroll in CRS and has complied with the requirements in this Section and the applicant is receiving inpatient services, the Department shall:
1. Provide the applicant or, if the applicant is a minor, the applicant's parent a written notice:
   a. Stating that the Department will not enroll an individual while the individual is receiving inpatient services, and
   b. Requesting that the Department is notified when the individual is no longer receiving inpatient services; and
2. When the Department receives notice that the applicant is no longer receiving inpatient services, enroll the applicant according to subsection (E).

R9-7-303. ~~Initial Evaluation; Further Diagnostic Testing~~ Financial Screening

~~If the Department determines from an applicant's initial evaluation that further diagnostic testing is required to determine whether the applicant is medically eligible for CRS, the Department shall:~~
1. ~~If the applicant has Title XIX or Title XXI health care insurance, request that AHCCCS complete the diagnostic testing and send the results of the diagnostic testing to the Department;~~
2. ~~If the applicant has other health care insurance that agrees to pay the Department for the diagnostic testing, complete the diagnostic testing and submit charges for the diagnostic testing to the health insurance company;~~
3. ~~If the applicant has health care insurance that does not agree to pay the Department for the diagnostic testing but provides the diagnostic testing, request that the applicant have:~~
   a. ~~The diagnostic testing completed through the applicant's health care insurance company, and~~
   b. ~~The results of the diagnostic testing sent to the Department; and~~
4. ~~If the applicant does not have health care insurance or has health care insurance that does not provide or pay for the diagnostic testing, and the applicant:~~
   a. ~~Signs the payment agreement in R9-7-601(B), provide the diagnostic testing to the individual; or~~
   b. ~~Does not sign the payment agreement in R9-7-601(B), provide to the applicant or, if the applicant is a minor, the applicant's parent a written notice of denial that complies with A.R.S. § 41-1092.03.~~

A. A financial screening packet for an individual who is not eligible for Title XIX or Title XXI health care insurance and is not applying for state funding under A.R.S. § 36-263 shall contain the following information:
1. The individual's name and birth date;
2. If the individual has a Social Security number, the individual's Social Security number;
3. A statement that, based on the requirements for eligibility for Title XIX or Title XXI health care insurance provided

to the individual by the Department, the individual is not eligible for Title XIX or Title XXI health care insurance; and

4. The signature of the individual or, if the individual is a minor, the signature of the individual's parent, and the date signed;

B. A financial screening packet for an individual who may be eligible for Title XIX or Title XXI health care insurance and is applying for state funding under A.R.S. § 36-263 shall contain:

1. The following information:
   a. The individual's name and birth date;
   b. If the individual has a Social Security number, the individual's Social Security number;
   c. The individual's marital status;
   d. The names and ages of all individuals in the individual's household income group;
   e. The annual gross income of the individual's household income group;
   f. Whether the individual has health care insurance other than Title XIX or Title XXI health care insurance;
   g. If the individual has health care insurance other than Title XIX or Title XXI health care insurance, for each health care insurance company:
      i. The health care insurance company's name, billing address, and telephone number; and
      ii. For the individual's health care insurance, the individual's policy or plan number, health care insurance identification number, effective or end date, and type of services paid for by the health care insurance; and
   h. The signature of the individual or, if the individual is a minor, the signature of the individual's parent, and the date signed;
2. Copies of the following documentation for each individual in the individual's household income group, if applicable:
   a. If the individual in the household income group is employed, the individual's:
      i. Pay stubs for the 30 days before the date the applicant submitted the application in R9-7-302(A), or
      ii. If the individual cannot provide pay stubs, a written statement from the individual's employer confirming the individual's income from that employer;
   b. If the individual in the household income group is self-employed, the individual's:
      i. Federal tax return, including a schedule C, most recently filed by the individual; or
      ii. Most recent quarterly financial statement signed and dated by the individual;
   c. Documented evidence of all unearned income received by the individual, such as cancelled checks or court orders for child support payments; and
   d. Documented evidence of all medical expenses incurred by the individual during the 12 months before the date the individual submitted the individual's CRS application;
3. If applicable, documented evidence of:
   a. Any court award or settlement related to the individual's CRS condition, and
   b. Expenditures from the court award or settlement made for medical services for the individual; and
4. If applicable, documented evidence of all current dependent care expenses for the individual, including:
   a. The name and age of each dependent for whom the individual incurred dependent care expenses, and
   b. The amount and frequency of dependent care expenses incurred for each dependent.

~~**R9-7-304. Enrollment Application**~~

~~An applicant applying for enrollment or, if the applicant is a minor, a parent applying on behalf of the applicant shall submit to the Department an application packet including:~~

~~1. An application form containing:~~
   ~~a. The applicant's name, home address, mailing address, birth date, place of birth, and marital status;~~
   ~~b. If the applicant has a social security number, the applicant's social security number;~~
   ~~c. If the applicant has a home telephone number, the applicant's home telephone number;~~
   ~~d. If the applicant does not have a home telephone number, a telephone number where a message may be left for the applicant;~~
   ~~e. Whether the applicant has a court-appointed legal guardian or custodian;~~
   ~~f. If the applicant is a minor, the following information for the applicant's parent:~~
      ~~i. Name;~~
      ~~ii. Home address, mailing address, and home or message telephone number;~~
      ~~iii. If the parent has a social security number, the parent's social security number; and~~
      ~~iv. If the parent works, the parent's employer, work address, and work telephone number;~~
   ~~g. The names and ages of all individuals in the applicant's household income group;~~
   ~~h. The annual gross income of the applicant's household income group;~~
   ~~i. Whether the applicant has Title XIX, Title XXI, or other health care insurance;~~
   ~~j. If the applicant has health care insurance other than Title XIX or Title XXI health care insurance, for each health care insurance company:~~

i. The health care insurance company's name, billing address, and telephone number; and
ii. For the applicant's health care insurance, the applicant's policy or plan number, health care insurance identification number, effective or end date, and type of services paid for by the health care insurance;
k. Whether the applicant receives services from the:
i. DES Adoption Subsidy Program,
ii. DES Comprehensive Medical and Dental Program, or
iii. DES Division of Developmental Disabilities;
l. The signature of the applicant or, if the applicant is a minor, the signature of the applicant's parent in subsection (1)(f); and
m. The date the application form is signed;
2. If the applicant has a legal guardian, a copy of the court document indicating the applicant's legal guardian;
3. If the applicant has Title XIX or Title XXI health care insurance, the applicant's AHCCCS identification number or a copy of the applicant's AHCCCS identification card;
4. If the applicant has health care insurance other than Title XIX or Title XXI health care insurance, a copy of the applicant's health care insurance card or written documentation that the applicant has health care insurance from the health care insurance company.
5. As proof of the applicant's age, a copy of one of the following documents that includes the applicant's birth date:
a. An Immigration and Naturalization Service document,
b. A federal or state census record,
c. A hospital record of birth,
d. A certified copy of a birth certificate,
e. A military record,
f. A notification of birth registration,
g. A religious record,
h. A school record, or
i. A U.S. passport;
6. Except as provided in subsection (7), as proof of the applicant's U.S. citizenship, one of the following:
a. A certified copy of a birth certificate,
b. A certified copy of a religious record issued within three months of birth,
c. A naturalization certificate reflecting U.S. citizenship,
d. A current or expired U.S. passport,
e. A certificate of U.S. citizenship, or
f. Documentation evidencing that the individual currently has Title XIX or Title XXI health care insurance;
7. If the applicant is a qualified alien, written documentation verifying that the applicant:
a. Is a qualified alien, and
b. Meets the requirements of A.R.S. § 36-2903.03(B);
8. As proof that the applicant lives in Arizona, a copy of one of the following documents issued in the name of the applicant, the spouse of the applicant, or an adult with whom the applicant lives:
a. The applicant's Title XIX or Title XXI health care insurance identification number or a copy of the applicant's current Title XIX or Title XXI health care insurance card;
b. An Arizona rent or mortgage receipt;
c. An Arizona lease for where the applicant lives;
d. A written statement that the applicant lives at an Arizona nursing care institution licensed under A.R.S. Title 36, Chapter 4 signed by the administrator of the Arizona nursing care institution;
e. An unexpired Arizona motor vehicle operator's license;
f. A current Arizona motor vehicle registration;
g. A pay stub from an Arizona employer;
h. An Arizona utility bill for where the applicant lives;
i. A current Arizona phone directory listing for where the applicant lives;
j. A United States Post Office record reflecting an Arizona address;
k. A certified copy of a religious record reflecting an Arizona address;
l. A certified copy of a school record reflecting an Arizona address; and
m. An affidavit signed by the applicant or, if the applicant is a minor, by the applicant's parent certifying that:
i. None of the documents in subsections (B)(8)(a) through (B)(8)(l) are available; and
ii. The applicant lives in Arizona;
9. As proof of an applicant's intent to continue to live in Arizona, an affidavit that contains an attestation by the applicant or, if the applicant is a minor, the applicant's parent of the applicant's intent to remain in Arizona;
10. If the applicant does not have Title XIX or Title XXI health care insurance, copies of the following documentation for each individual in the applicant's household income group, if applicable:

~~a. If an individual in the household income group is employed, the individual's:~~
~~i. Pay stubs for the 30 calendar days before the date on the applicant's application form,~~
~~ii. Most recent W-2 form, and~~
~~iii. Federal tax return most recently filed by the individual;~~
~~b. If an individual in the household income group is self-employed, the individual's:~~
~~i. Federal tax return, including a schedule C, most recently filed by the individual; or~~
~~ii. Most recent quarterly financial statement signed and dated by the individual;~~
~~c. Documented evidence of all unearned income received by an individual, such as cancelled checks or court orders for child support payments;~~
~~d. Documented evidence of all medical expenses incurred by an individual and paid during the 12 months before the date on the application form; and~~
~~e. Documented evidence of all unpaid medical expenses; and~~
~~11. If applicable, documented evidence of:~~
~~a. Any court award or settlement related to the applicant's CRS condition, and~~
~~b. Expenditures from the court award or settlement made for medical services for the applicant.~~

~~R9-7-604.~~ R9-7-304. ~~Member~~ Payment Responsibility

~~**A.** A member shall pay the cost for covered medical services provided by the Department up to the total amount of any:~~
~~1. Court award or settlement of a claim for the member's CRS condition less money from the court award or settlement expended for medical services for the member;~~
~~2. Health care insurance payment or reimbursement to which the member is entitled for covered medical services; and~~
~~3. Other third-party payment or reimbursement to which the member is entitled for covered medical services;~~
~~**B.** Except as provided in subsection (A), the Department shall not require a member whose household income group's net income is equal to or less than 200% of the Federal Poverty Level to pay for a covered medical service, except the Department may charge the member a $5.00 co-payment for the non-emergency use of a hospital's emergency services to treat a CRS condition.~~

A. A payment agreement shall contain the following information:
1. The individual's or member's name;
2. The individual's or member's date of birth;
3. If the Department has determined the individual's or member's payment responsibility, the individual's or member's payment responsibility;
4. A promise to pay the cost of covered medical services not paid by any third-party payor;
5. An assignment of insurance benefits; and
6. The signature of the individual or, if the individual is a minor, the signature of the individual's parent, and the date signed;

B. The Department shall determine an individual's or member's payment responsibility for covered medical services by:
1. Identifying the individual's or member's household income group;
2. Calculating the net income of the individual's or member's household income group; and
3. Determining whether the net income of the individual's or member's household income group is:
   a. Less than the percentage established according to subsection (C), or
   b. Greater than or equal to the percentage established according to subsection (C).

C. The Department shall establish annually, based on the amount of funding appropriated to CRS under A.R.S. §§ 36-261(A)(5)(h) and 36-261(A)(5)(l) and the Department's projected cost to administer CRS and provide covered medical services and covered support services for the subsequent 12 months, the percentage of the Federal Poverty Level to be used to determine an individual's or member's payment responsibility according to this Section.

D. The Department shall not require an individual, whose household income group's net income is less than the percentage established according to subsection (C), to pay for a covered medical service.

~~C.~~E. ~~A member~~ An individual whose household income group's net income is greater than ~~200% of the Federal Poverty Level~~ or equal to the percentage established according to subsection (C) shall pay for a covered medical service an amount not to exceed the AHCCCS capped fee-for-service rate for the covered medical service.

~~R9-7-602.~~ R9-7-305. Identification of Household Income Group

A. At the time of application or redetermination, the Department shall identify a member's household income group as:
1. If the member is living with a parent of the member, that parent's household income group;
2. If the member is living with an individual other than a parent of the member and a parent of the member claims the member as a dependent for tax purposes for the current tax year, that parent's household income group; or
3. If the member is living with an individual other than a parent of the member and neither parent claims the member as a dependent for tax purposes, the household income group of the individual with whom the member lives.

B. The Department shall consider ~~any of the following, when living together, a household income group~~ as a household income group any of the following who are living together:
1. A married couple and children of either or both,
2. An unmarried couple and children of either or both;
3. A married couple when both are over the age of 21 years;
4. A married couple when either one or both are under the age of 21 years with no children;
5. A single parent and the single parent's children;
6. An applicant or a member between the ages of 18 years and 21 years; or
7. If living with an applicant or a member, one of the groups in subsections (B)(1) through (B)(5), the applicant or member, and:
   a. The applicant's or member's spouse,
   b. A child of the applicant's or member's spouse,
   c. A child of the applicant or member, and
   d. The other parent of the applicant's or member's child.

C. In addition to the individuals in subsection (B), the Department shall include in a household income group an individual who is not living with the household if:
1. The individual is absent from the household; ~~for 30 calendar days or less,~~
   a. For 30 consecutive days or less;
   b. To seek or maintain employment;
   c. To serve in the military; or
   d. To attend an educational institution, and the parent of the individual claims the individual as a dependent on the parent's income tax return; or
2. ~~The individual contributes to the income of the household, or~~
3.2. The parent of the individual claims the individual as a dependent on the parent's income tax.

~~R9-7-603.~~ R9-7-306. Calculating Net Income

A. Except as provided in subsection (B), a household income group's gross income includes all the earned income and unearned income of the individuals in the household income group.
1. For an individual in the household income group who is not self-employed, the Department shall calculate an individual's ~~annual~~ income using the ~~pay stubs required in R9-7-304(10)(a)(i); and~~ documents required in R9-7-303(B)(2)(a); and
2. For an individual in the household income group who is self-employed, the Department shall calculate an individual's ~~annual~~ income using the individual's federal tax return or most recent quarterly financial statement required in ~~R9-7-304(10)(b).~~ R9-7-303(B)(2)(b).

B. Gross income does not include:
1. The items in ~~A.C.C. R9-22-1419(C)~~ A.A.C. R9-22-1420(C), and
2. The first $50.00 per month per child of child support payments ~~paid~~ received by an individual in the household income group.

C. When calculating net income, the Department shall deduct the following from the gross income of the household income group in ~~R9-7-602~~ R9-7-305:
1. For each month the household income group received earned income, a deduction for dependent care that is equal to the AHCCCS allowable deduction in ~~A.A.C. R9-22-1429(E)(2), if the individual who received the earned income and~~ A.A.C. R9-22-1420(F)(2)(b), if the individual who received dependent care ~~are~~ is living in the household;
2. For each individual in the household income group who earned income, an allowance of $90.00 for each month the individual earned income; and
3. ~~The following medical expenses:~~
   a. ~~Unpaid medical expenses that are:~~
      i. ~~Incurred by any individual in the household income group before an application form is submitted or a redetermination is requested; and~~
      ii. ~~Not subject to any applicable third party payment or reimbursement; and~~
   b. ~~Medical expenses for any individual in the household income group that are:~~
      i. ~~Paid by an individual in the household income group during the 12 months before an application form is submitted or a redetermination is requested, and~~
      ii. ~~Not subject to any third party payment or reimbursement.~~
3. Medical expenses that are:
   a. Incurred by the individual during the 12 months before the individual submitted to the Department an application in R9-7-302(A), and
   b. Not subject to any third-party payment or reimbursement.

~~R9-7-305.~~ R9-7-307. Redetermination

~~**A.** At any time, the Department may request a member or, if the member is a minor, the member's parent to submit the information and documents in R9-7-304 to redetermine:~~
~~1. Whether a member remains eligible for CRS, or~~
~~2. A member's payment responsibility.~~

~~**B.** If the member has Title XIX or Title XXI health care insurance, the Department shall, no later than the member's CRS expiration date:~~
~~1. Verify that the member has Title XIX or Title XXI health care insurance, and~~
~~2. Establish a new CRS expiration date for the member that is the same as the member's Title XIX or Title XXI health care insurance expiration date.~~

~~**C.** If the member does not have Title XIX or Title XXI health care insurance and the net income of the member's household income group is more than 200% of the Federal Poverty Level, the member or, if the member is a minor, the member's parent shall submit, before the member's CRS expiration date, a signed payment agreement.~~

~~**D.** If the member does not have Title XIX or Title XXI health care insurance and the net income of the member's household income group is equal to or less than 200% of the Federal Poverty Level, the member or, if the member is a minor, the member's parent shall, at least 30 calendar days before the CRS expiration date:~~
~~1. Participate in an eligibility interview with a Department representative,~~
~~2. Submit to the Department the information and documentation in R9-7-304(10), and~~
~~3. Submit to the Department a signed payment agreement.~~

~~**E.** The Department shall establish a new CRS expiration date for a member who does not have Title XIX or Title XXI health care insurance that is 12 months after the member's CRS expiration date if:~~
~~1. The member and, if the member is a minor, the member's parent comply with the redetermination requirements in this Section before the member's expiration date; and~~
~~2. The Department determines that the member remains eligible for CRS.~~

~~**F.** If the Department determines that a member is no longer eligible for CRS, the Department shall provide the member or, if the member is a minor, the member's parent a written notice that:~~
~~1. Informs the member that the member is no longer eligible for CRS, and~~
~~2. Complies with A.R.S. § 41-1092.03.~~

~~**G.** At any time, a member or, if the member is a minor, the member's parent may request a redetermination of the member's payment responsibility by submitting to the Department:~~
~~1. A written request for redetermination, and~~
~~2. The documentation and information in R9-7-304(10).~~

~~**H.** Within 30 calendar days from the date of the Department's receipt of a member's request for redetermination, the Department shall provide the member or, if the member is a minor, the member's parent:~~
~~1. A written notice of the Department's redetermination;~~
~~2. A new CRS expiration date for the member; and~~
~~3. If applicable, a revised payment agreement.~~

~~**I.** If the Department changes a member's payment responsibility as a result of a redetermination, and the member does not have Title XIX or Title XXI health care insurance, the member or, if the member is a minor, the member's parent shall sign and submit a revised payment agreement.~~

A. At any time, the Department may, to redetermine whether a member remains eligible for CRS or a member's payment responsibility, request a member or, if the member is a minor, the member's parent to submit the following information or documentation:
1. To determine whether a member remains eligible for CRS, the application packet in R9-7-302(A);
2. If the member does not have Title XIX or Title XXI health care insurance, to determine a member's payment responsibility, the financial screening packet in R9-7-303; or
3. If the member has Title XIX or Title XXI health care insurance, to determine whether the member remains eligible for AHCCCS, the member's valid AHCCCS identification number or a copy of the member's valid AHCCCS identification card.

B. The Department shall provide written notice of the Department's request in subsection (A) to the member or, if the member is a minor, the member's parent:
1. Requesting the information or documentation in subsection (A); and
2. Informing the member or, if the member is a minor, the member's parent that if the Department does not receive the information or documentation in subsection (A) within 30 days from the date of the notice, the Department:
   a. Will not provide a covered service to the member, and
   b. If applicable, may terminate the member's enrollment according to R9-7-308.

C. The Department shall, at least once every 12 months:
1. If a member does not have Title XIX or Title XXI health care insurance, redetermine a member's payment responsibility, or

2. If a member has Title XIX or Title XXI health care insurance, redetermine whether a member remains eligible for Title XIX or Title XXI health care insurance.

D. If the Department sends the notice in subsection (B), the member or, if the member is a minor, the member's parent shall submit the requested information or documentation to the Department within 30 days of the request.

E. If the Department receives the information in subsection (A)(1) from the member within 30 days, the Department shall determine the member's eligibility as provided in Article 2.

F. If the Department does not receive the information or documentation in subsection (A)(1) from the member within 30 days, or the Department determines that a member is no longer eligible for CRS, the Department shall provide the member or, if the member is a minor, the member's parent a written notice that:
1. Informs the member that the member is no longer eligible for CRS, and
2. Complies with A.R.S. § 41-1092.03.

G. If the Department receives the information or documentation in subsection (A)(2) from the member and, if applicable, the information or documentation is received within 30 days from the date of the notice in subsection (B), the Department shall redetermine the member's payment responsibility for covered medical services by:
1. Identifying the individual's or member's household income group;
2. Calculating the net income of the individual's or member's household income group;
3. Determining whether the net income of the member's household income group is:
   a. Less than the highest percentage established according to R9-7-304(C) since the member most recently enrolled in CRS, or
   b. Greater than or equal to the highest percentage established according to R9-7-304(C) since the member most recently enrolled in CRS.

H. If the Department does not receive the information or documentation in subsection (A)(2) within 30 days, the Department shall provide the member or, if the member is a minor, the member's parent a written notice that the member is required to comply with the requirements in this Section before the Department provides a covered service to the member.

I. If the Department determines that a member who does not have Title XIX or Title XXI health care insurance may be eligible for Title XIX or Title XXI health care insurance, the Department shall provide the member or, if the member is a minor, the member's parent a written notice that:
1. The member is required to apply for Title XIX or Title XXI health care insurance, and
2. If the member does not apply for Title XIX or Title XXI health care insurance within six months of the written notice, the Department may terminate the member's enrollment.

J. If the Department sends the notice in subsection (I), the member shall apply for Title XIX or Title XXI health care insurance:
1. Within six months of the date of the notice, or
2. Before the Department will provide a covered service to the member.

K. At any time, a member or, if the member is a minor, the member's parent may request a redetermination of the member's payment responsibility by submitting to the Department:
1. A written request for redetermination, and
2. The information or documentation in subsection (A)(2).

L. Within 30 days from the date of the Department's determination under subsection (G), the Department shall provide the member or, if the member is a minor, the member's parent:
1. A written notice of the Department's redetermination; and
2. If applicable, a revised payment agreement.

M. If the Department changes a member's payment responsibility as a result of a redetermination, and the member does not have Title XIX or Title XXI health care insurance, the member or, if the member is a minor, the member's parent shall sign and submit a revised payment agreement before the Department provides a covered service to the member.

N. The Department shall consider a member to have been enrolled in CRS during any period of 90 days or less in which the member was not enrolled in CRS for the purpose of redetermining the member's payment responsibility according to this Section.

~~R9-7-306.~~ R9-7-308. Termination ~~of Enrollment~~

A. The Department shall terminate a member's enrollment if:
1. The Department determines the member ~~no longer meets~~ does not meet the eligibility requirements in R9-7-201; or
~~2. A member does not continue to have Title XIX or Title XXI health care insurance while the member is eligible for the Title XIX or Title XXI health care insurance; or~~
~~3.~~2. The member or, if the member is a minor, the member's parent:
   a. Requests a termination of the member's enrollment; or
   b. Fails to comply with ~~the~~:
      ~~i. Submission requirements in R9-7-302(I) or R9-7-305; or~~
      ~~ii. Signed payment agreement in R9-7-601(B), if applicable.~~

i. The requirements in R9-7-307(J), or
ii. The signed payment agreement in R9-7-304(A).

B. If the Department terminates a member's enrollment, the Department shall:
1. Provide the member or, if the member is a minor, the member's parent a written notice of termination that complies with A.R.S. § 41-1092.03; and
2. If the Department has the name of the member's physician other than a CRS provider, provide the member's physician a written notice of the member's termination.

ARTICLE 4. COVERED MEDICAL SERVICES

R9-7-401. General Requirements

~~**A.** The Department shall not provide covered medical services other than an initial evaluation until the individual and, if the individual is a minor, the individual's parent comply with the application requirements in R9-7-302(B) and the Department determines that the individual meets the eligibility requirements in R9-7-201.~~
~~**B.** The Department shall provide a covered service in this Section:~~
~~1. Through a regional contractor,~~
~~2. At the regional contractor's facility or a facility under contract with the regional contractor; and~~
~~3. Using a CRS provider.~~
~~**C.** The Department shall provide a medical service in R9-7-403 through R9-7-421 to a member if:~~
~~1. A regional medical director or the regional medical director's designee determines that the medical service:~~
~~a. Is medically necessary;~~
~~b. Is related to the member's CRS condition; and~~
~~c. Except as provided in subsection (D), is not to treat one of the conditions in R9-7-203; and~~
~~2. A CRS provider obtains prior authorization, if applicable according to R9-7-402, for the medical service.~~
~~**D.** If the requirements of subsection (C) are met, the Department shall provide a medical service to a member to treat the following medical conditions:~~
~~1. Sinusitis for a member with cystic fibrosis;~~
~~2. An ingrown toenail if secondary to a CRS condition;~~
~~3. Strabismus for a member with cerebral palsy, myelomeningocele, a shunt, a cataract, glaucoma, a disorder of the optic nerve, retinopathy of prematurity, or a disorder of the iris, ciliary bodies, retina, lens or cornea;~~
~~4. Enuresis if secondary to a CRS condition;~~
~~5. Otitis media in a member with cleft lip and cleft palate or a sensorineural hearing loss;~~
~~6. Nasal polyps for a member with cystic fibrosis;~~
~~7. Malabsorption syndrome for a member with cystic fibrosis;~~
~~8. Nephritis associated with lupus erythematosis;~~
~~9. Hydrocele associated with a ventriculo-peritoneal (VP) shunt;~~
~~10. A fracture caused by a CRS condition;~~
~~11. Bunions if secondary to a CRS condition;~~
~~12. Carpal tunnel syndrome if secondary to a CRS condition;~~
~~13. Refraction error for a member with an ophthalmologic CRS condition;~~
~~14. Astigmatism for a member with an ophthalmologic CRS condition; or~~
~~15. With medication for no more than 30 calendar days, depression secondary to a CRS condition.~~
~~**E.** If a member requires a medical service that meets the requirements of subsection (C) and the medical service is not available in Arizona, the Department shall provide the medical service in another state if:~~
~~1. Two physicians, who are CRS providers, practicing a specialty related to the member's CRS condition, each submit in writing to the Department:~~
~~a. A recommendation that the Department provide the medical service in another state; and~~
~~b. A statement that:~~
~~i. The medical service is life-saving for the member, and~~
~~ii. The member is anticipated to experience, as a result of the medical service, functional improvement and that the physician expects the functional improvement to be significant; and~~
~~2. A regional medical director and a regional contractor provide written authorization to the Department before the provision of the medical service outside the state of Arizona.~~
~~**F.** If the Department provides a member a medical service in another state, the Department shall not provide transportation or lodging for the member or the member's family.~~
~~**G.** If a member receives a recommendation for treatment from a CRS provider, the member may obtain a recommendation for treatment from a second CRS provider.~~
~~**H.** The Department shall provide the following medical services to a member beyond the limit specifically stated in the applicable subsection if approved by a regional medical director:~~

~~1. Home health services in R9-7-406(B),~~
~~2. Oxygen and related supplies in R9-7-408(G),~~
~~3. Nutrition services in R9-7-410(A),~~
~~4. Physical therapy and occupational therapy in R9-7-413,~~
~~5. Psychological services in R9-7-416(A),~~
~~6. Psychiatric services in R9-7-417(A), and~~
~~7. Speech/language pathology services in R9-7-419.~~

A. Except as provided in R9-7-307(D), R9-7-307(J), and R9-7-307(M), the Department shall provide a medical service in R9-7-402 through R9-7-420 to a member if the Department determines that the medical service:
1. Is medically necessary,
2. Is related to the member's CRS condition, and
3. Is provided consistent with utilization management practices established by the Department.

B. If a member requires a medical service that meets the requirements of subsection (A) and the medical service is not available in Arizona, the Department shall provide the medical service in another state if:
1. Two physicians, who are CRS providers, practicing a specialty related to the member's CRS condition, each submit in writing to the Department:
   a. A recommendation that the Department provide the medical service in another state; and
   b. A statement that:
      i. The medical service is life-saving for the member, or
      ii. The member is expected to experience, as a result of the medical service, significant functional improvement; and
2. A physician who is the Department's designee provides written authorization before the provision of the medical service outside the state of Arizona.

C. The Department may provide a medical service in a state that borders Arizona if the member's residence is closer to a CRS provider in the state that borders Arizona than to a CRS provider located within Arizona.

D. If the Department provides a member a medical service in another state, the Department shall not provide transportation or lodging for the member or the member's family.

E. If the Department receives from a member, who received a recommendation for treatment from a CRS provider, a request for a second recommendation for treatment, the Department shall:
1. Provide a second recommendation for treatment from a different CRS provider; or
2. If the Department is unable to provide a second recommendation for treatment from a different CRS provider, provide a second recommendation for treatment from another provider other than a CRS provider designated by the Department.

~~R9-7-402. Prior Authorization~~

~~Except in an emergency, a CRS provider shall obtain prior authorization before providing any of the following to a member:~~
~~1. Medical equipment in R9-7-408,~~
~~2. Prosthetic and orthotic devices in R9-7-415,~~
~~3. Physician services in R9-7-414 provided at a physician's office,~~
~~4. Dental services in R9-7-404 provided at a dentist's office,~~
~~5. Outpatient diagnostic testing and laboratory services in R9-7-411(2) not provided by a CRS provider,~~
~~6. Outpatient surgery in R9-7-411(1),~~
~~7. An outpatient positive emission tomography scan,~~
~~8. An implantable bone conduction device in R9-7-403(B)(7),~~
~~9. A tactile hearing aid in R9-7-403(B)(8), and~~
~~10. Admission to a hospital for inpatient services in R9-7-407.~~

~~R9-7-403.~~ R9-7-402. Audiology Services

A. If the requirements ~~of R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide audiology services to a member who has, as determined by a CRS provider, a:
1. No change
2. No change

B. If the requirements in subsection (A) are met, the Department shall provide the following audiology services:
1. No change
2. No change
3. No change
4. No change
5. No change
6. No change

a. No change
b. No change
c. No change
7. An implantable bone conduction device; ~~and~~
8. A cochlear implant; and
~~8.~~9. A tactile hearing aid.

~~**C.** The Department shall not provide a cochlear implant to a member.~~

~~R9-7-404.~~ R9-7-403. Dental and Orthodontia Services

A. If the requirements ~~of R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide dental services to a member who has one of the following medical conditions:
1. No change
2. No change
3. No change
4. No change
5. No change
6. No change
   a. No change
   b. No change
   c. No change

B. If the requirements ~~of R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide orthodontia services and devices to a member who has one of the following medical conditions:
1. No change
2. No change
   a. No change
   b. No change
   c. No change

~~R9-7-405.~~ R9-7-404. Diagnostic Testing and Laboratory Services

A. If the requirements ~~of R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide ~~the following diagnostic testing to a member:~~ diagnostic testing or laboratory services to a member as ordered by a CRS provider.
~~1. Radiology,~~
~~2. Visual evoked response,~~
~~3. Computed tomography scan,~~
~~4. Ultrasound,~~
~~5. Brainstem auditory evoked response,~~
~~6. Magnetic resonance imaging,~~
~~7. Electroencephalogram,~~
~~8. Electrocardiogram, and~~
~~9. Echocardiogram.~~

~~**B.** If the requirements of R9-7-401(C) are met, the Department shall provide the following laboratory services to a member:~~
~~1. A blood bank, accessible to the member,~~
~~2. Pulmonary function testing,~~
~~3. Complete blood counts, and~~
~~4. Urinalysis.~~

~~**C.**~~**B.** The Department shall provide diagnostic testing and laboratory services, ~~as~~ ordered by a ~~physician~~ CRS provider, ~~to a member~~ to determine if ~~the~~ a member has a CRS condition in addition to the CRS condition diagnosed at the ~~member's initial evaluation.~~ time of the member's enrollment.

~~R9-7-406.~~ R9-7-405. Home Health Services

A. If the requirements in ~~R9-7-401(C)~~ R9-7-401 are met, the Department shall provide total parenteral nutrition to a ~~member for no more than 30 calendar days before the member's hospitalization for~~ member, as ordered by a CRS provider, in preparation for a procedure or surgery related to the member's CRS condition.

~~**B.** If the requirements in R9-7-401(C) are met, the Department shall provide home health services to a member after the member's hospitalization:~~
~~1. If a CRS provider requests that the home health services be provided where the member is located;~~
~~2. If the need for home health services is related to the member's CRS condition that was treated during the member's hospitalization; and~~
~~3. Except as provided in R9-7-401(G) for no more than 30 calendar days.~~

~~**C.**~~**B.** If the requirements in ~~subsection (B)~~ R9-7-401 are met, after a member's hospitalization, or instead of hospitalization,

the Department shall provide the following home health services:
1. No change
2. No change
3. No change
4. No change
5. No change
6. No change
7. No change
8. No change
9. No change
10. No change
11. No change

~~R9-7-407.~~ R9-7-406. Inpatient Services

A. If the requirements in ~~R9-7-401(C)~~ R9-7-401 are met, the Department shall provide inpatient services to a member who requires hospitalization related to the member's CRS condition.
1. If, after being hospitalized, a member's hospitalization is no longer related to the member's CRS condition or to complications related to the member's treatment for the member's CRS condition, the Department shall not provide inpatient services to the member.
2. If a member requires inpatient services to determine whether the member has ventricular infection or ventricular shunt failure, the Department shall provide inpatient services until the date the ~~regional medical director or the regional medical director's~~ physician who is the Department's designee determines that the member does not have ventricular infection or ventricular shunt failure.

B. If the requirements in ~~R9-7-401(C)~~ R9-7-401 are met, the Department shall provide transportation for a member who is receiving inpatient services from ~~one~~ a hospital that is a CRS provider to another hospital that is a CRS provider. ~~if:~~
~~1. Ordered by a CRS provider, and~~
~~2. Authorized in writing by a regional medical director.~~

~~R9-7-408.~~ R9-7-407. Medical Equipment

~~**A.** If the requirements of R9-7-401(C) are met and subject to the limitations in subsections (B) through (D), the Department shall provide a non-motorized wheelchair or an ambulation assistive device to a member.~~

~~**B.** The Department shall provide a tilt-in-space wheelchair to a member only if a change in the member's position is necessary to provide medically necessary services such as tracheotomy care or feeding.~~

A. If the requirements in R9-7-401 are met and subject to the limitations in this Section, the Department shall provide the medical equipment indicated in this Section to a member as ordered by a CRS provider.

B. The Department shall provide to a member:
1. A wheelchair,
2. An ambulation assistive device, or
3. A tilt-in-space wheelchair only if a change in the member's position is necessary to provide medically necessary services such as tracheotomy care or feeding.

C. No change
1. No change
2. No change
3. No change

D. No change

E. No change
1. No change
2. No change
3. No change

F. No change

~~**G.** Except as provided in R9-7-401(G), the Department shall provide oxygen and related supplies for no more than 30 calendar days to a member if ordered by a CRS provider.~~

G. Unless approved by a physician who is the Department's designee, the Department shall provide oxygen and related services for no more than 30 consecutive days to a member.

H. No change
1. No change
2. No change

I. Except as provided in subsection (K), in ~~In~~ addition to subsection (H), the Department shall replace medical equipment provided to a member if the medical equipment:

~~1. Is not safe to operate and cannot be repaired to be safe to operate as determined by a CRS provider;~~
1. As determined by a CRS provider, is not safe to operate and cannot be repaired to be safe to operate;
2. No change
   a. No change
   b. No change
3. No change

~~**J.** The Department shall make a repair to a member's medical equipment if:~~
~~1. A written determination by a CRS provider that the repair to the medical equipment is medically necessary for the member is submitted to the Department;~~
~~2. The need for repair is not due to the member's misuse of the medical equipment; and~~
~~3. The repair is to:~~
~~a. Medical equipment provided by the Department; or~~
~~b. A wheelchair that, although not provided to the member by the Department, has been determined by a CRS provider to be safe and appropriate for the member.~~

J. Except as provided in subsection (K), the Department shall repair a member's medical equipment if:
1. The Department determines that the medical equipment, if not repaired, would be provided according to this Section;
2. The Department determines that the repair to the medical equipment is medically necessary; and
3. The repair is to:
   a. Medical equipment provided by the Department; or
   b. Medical equipment that, although not provided to the member by the Department, has been determined by a CRS provider to be safe, appropriate, and medically necessary for the member.

K. The Department shall not repair or replace medical equipment according to subsection (I) or (J) if the need for repair or replacement is due to the member's misuse of the medical equipment.

~~R9-7-409.~~ R9-7-408. Nursing Services
If the requirements ~~of R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide nursing services to a member.

~~R9-7-410.~~ R9-7-409. Nutrition Services
A. If the requirements ~~of R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide the following nutrition services to a member:
1. No change
2. No change
3. If ordered by a CRS provider:
   a. No change
   ~~b. For providing nutrition through a tube;~~
      ~~i. Equipment; and~~
      ~~ii. Except as provided in R9-7-401(G), a commercial product for no more than 30 calendar days; and~~
   b. Medical equipment or a commercial product for providing nutrition through a tube; and
4. If ordered by a CRS provider for a member with cystic fibrosis, and not available through a source other than CRS, a commercial product:
   a. For a member who is not receiving nutrition through a tube, that supplies 50% of the member's daily caloric need; and
   b. No change
   ~~c. Except as provided in R9-7-401(G), for no more than 30 calendar days.~~

B. No change
1. No change
2. No change
3. No change

~~R9-7-411.~~ R9-7-410. Outpatient Services
If the requirements ~~of R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide the following outpatient services to a member:
1. Outpatient surgery by a CRS provider;
2. Diagnostic testing and laboratory services in ~~R9-7-405~~ R9-7-404;
3. Emergency services in a hospital that is a CRS provider;
4. No change
5. Evaluation and treatment by a CRS provider at a location other than a CRS clinic. ~~at:~~
   ~~a. An outreach clinic; or~~
   ~~b. A regional clinic.~~

~~R9-7-412.~~ R9-7-411. Pharmaceutical Services

A. If the requirements ~~of R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide pharmaceutical services to a member.

B. The Department shall provide growth hormone therapy ordered by a physician only for a member who has been diagnosed by a CRS provider with panhypopituitarism.

~~R9-7-413.~~ R9-7-412.Physical Therapy and Occupational Therapy

~~**A.** If the requirements of R9-7-401(C) are met, the Department shall provide physical therapy or occupational therapy to a member only:~~

~~1. Before a scheduled surgery;~~
~~2. After a surgery;~~
~~3. After removal of a cast;~~
~~4. If a medication used to treat the member's CRS condition causes impairment to a neurologic or orthopedic function;~~
~~5. After the member receives an orthotic or prosthetic device;~~
~~6. After a hospitalization; and~~
~~7. If the member:~~
~~a. Is unable to obtain physical therapy or occupational therapy through a source other than CRS, and~~
~~b. Has a strong potential rehabilitation as determined by a CRS provider.~~

~~**B.** Except as provided in R9-7-401(G), the Department shall provide no more than 24 sessions of physical therapy or 24 sessions of occupational therapy for each occurrence in subsection (A).~~

If the requirements in R9-7-401 are met, the Department shall provide physical therapy or occupational therapy to a member only if the member:

1. Is unable to obtain physical therapy or occupational therapy through a source other than CRS or another health care insurance provider, and
2. Is expected to experience a functional improvement as a result of the physical therapy or occupational therapy.

~~R9-7-414.~~ R9-7-413. Physician Services

If the requirements ~~of R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide physician services to a member.

~~R9-7-415.~~ R9-7-414. Prosthetic and Orthotic Devices

A. If the requirements ~~of R9-7-401(C)~~ in R9-7-401 are met, and subject to the limitations in subsection (B), the Department shall provide a prosthetic device or an orthotic device to a member to enhance the member's ability to perform an activity of daily living.

B. No change
1. No change
2. No change

C. The Department shall replace or ~~make a~~ change ~~to~~ a prosthetic device or orthotic device provided to a member if the replacement or change is:
1. No change
2. No change

~~**D.** The Department shall make a repair to a prosthetic device or orthotic device provided by the Department if:~~
~~1. The repair is determined to be medically necessary by a CRS provider, and~~
~~2. The need for repair is not due to the member's misuse of the prosthetic device or orthotic device.~~

D. Except as provided in subsection (F), and in addition to subsection (C), the Department shall replace a prosthetic device or orthotic device provided to the member if the prosthetic device or orthotic device:
1. As determined by a CRS provider, is not safe to operate and cannot be repaired to be safe to operate;
2. Is stolen and the member or, if the member is a minor, the member's parent submits to the Department:
   a. A written request for a replacement prosthetic device or orthotic device, and
   b. A copy of a police report about the stolen prosthetic device or orthotic device; or
3. Is lost and has not been replaced by the Department within the previous 12 months due to loss.

~~**E.** In addition to subsection (C), the Department shall replace a prosthetic device or orthotic device provided to the member if the prosthetic device or orthotic device:~~
~~1. Is stolen and the member or, if the member is a minor, the member's parent submits to the Department:~~
~~a. A written request for a replacement prosthetic device or orthotic device, and~~
~~b. A copy of a police report about the stolen prosthetic or orthotic device; or~~
~~2. Is lost and the prosthetic device or orthotic device has not been replaced by the Department within the previous 12 months due to loss.~~

E. Except as provided in subsection (F), the Department shall repair a prosthetic device or orthotic device provided to a member by the Department if the Department determines that the repair is safe, appropriate, and medically necessary for the member.

F. The Department shall not replace or repair a prosthetic device or orthotic device according to subsection (D) or (E) if the need for replacement or repair is due to the member's misuse of the prosthetic device or orthotic device.

~~R9-7-416.~~ R9-7-415. Psychological Services

A. If the requirements ~~of R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide the following psychological services to a member:
1. No change
2. No change
3. No change

~~**B.** Except as provided in R9-7-401(G), the number of sessions in subsection (A) provided to a member shall not exceed three per calendar year.~~

B. Unless approved by a physician who is the Department's designee, the Department shall not provide more than three sessions in subsection (A) per year.

~~R9-7-417.~~ R9-7-416. Psychiatric Services

A. If the requirements in ~~R9-7-401(C)~~ R9-7-401 are met, the Department shall provide psychiatric services to a member who has received an evaluation and recommendation for psychiatric services from a psychologist who is a CRS provider.

~~**B.** Except as provided in R9-7-401(G), the number of sessions provided to a member according to subsection (A) shall not exceed one per calendar year.~~

B. Unless approved by a physician who is the Department's designee, the Department shall not provide more than one session in subsection (A) per year.

~~R9-7-418.~~ R9-7-417. Social Work Services

The Department shall provide the following social work services to a member or the member's family:
1. An initial psychosocial evaluation performed by a social worker ~~within the member's first three visits to a CRS clinic, regional clinic, or outreach clinic~~ no later than the date of the member's third visit to a CRS provider;
2. Subsequent psychosocial evaluations of a member and the member's family performed by a social worker based on the initial psychological evaluation and as needed throughout the member's enrollment; and
3. No change

~~R9-7-419.~~ R9-7-418. Speech/Language Pathology Services

~~**A.** If the requirements in R9-7-401(C) are met, the Department shall provide speech/language pathology services to a member:~~
~~1. Before a scheduled surgery;~~
~~2. After a surgery;~~
~~3. If a medication used to treat the member's CRS condition causes neurological impairment;~~
~~4. After a hospitalization; and~~
~~5. If the member is not able to obtain speech/language pathology services through a source other than CRS.~~

~~**B.** Except as provided in R9-7-401(G), the Department shall provide no more than 24 sessions of speech/language pathology services for each occurrence in subsection (A).~~

If the requirements in R9-7-401 are met, the Department shall provide speech/language pathology services to a member only if the member:
1. Is unable to obtain speech/language pathology services through a source other than CRS or another health care insurance provider, and
2. Is expected to experience a functional improvement as a result of the speech/language pathology services.

~~R9-7-420.~~ R9-7-419. Transplants

If the requirements ~~of R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide a corneal transplant or a bone-grafting transplant to a member.

~~R9-7-421.~~ R9-7-420. Vision Services

If the requirements ~~of R9-7-401(C)~~ in R9-7-401 are met, the Department shall provide the following vision services to a member:
1. No change
2. No change
3. No change
4. No change
5. No change

R9-7-421. Renumbered

ARTICLE 5. COVERED SUPPORT SERVICES

~~**R9-7-501. General Requirements**~~
~~The Department shall provide a support service in this Section:~~
~~1. Through a regional contractor,~~
~~2. At the regional contractor's facility or a facility under contract with the regional contractor; and~~
~~3. Using a CRS provider.~~

~~**R9-7-502.**~~ **R9-7-501. Advocacy Services**
The Department shall provide the following advocacy services:
1. Explaining the CRS application requirements in ~~R9-7-302(B)~~ R9-7-302 to an applicant or, if the applicant is a minor, the applicant's parent and assisting the applicant or applicant's parent in completing the application;
2. No change
3. No change
4. No change
5. No change
6. No change

~~**R9-7-503.**~~ **R9-7-502. Child Life Services**
No change
1. No change
2. No change
3. No change
4. No change
   a. No change
   b. No change
   c. No change
5. No change

~~**R9-7-504.**~~ **R9-7-503. Education Coordination**
The Department shall provide the following education coordination:
1. No change
2. No change
3. Consulting with the member, the member's family, and school personnel regarding the member's transition under ~~R9-7-505~~ R9-7-504;
4. No change
5. No change

~~**R9-7-505.**~~ **R9-7-504. Transition Services**
A. No change
~~**B.** When a member is 14 years of age, the Department shall develop and implement an on-going plan to transition the member from pediatric care to adult care that:~~
B. The Department shall, at an appropriate time based on the member's age and the member's CRS condition, as determined by a CRS provider, develop and implement an on-going plan to transition the member from pediatric care to adult care that:
1. No change
2. No change

~~**R9-7-506.**~~ **R9-7-505. Transportation Services**
The Department shall provide transportation to a member:
1. From a ~~regional clinic or an outreach clinic~~ location where a CRS provider is evaluating or treating the member to a hospital that is a CRS provider, if medically necessary to respond to an immediate threat to the life or health of the member; or
2. No change

R9-7-506. Renumbered

ARTICLE 6. ~~MEMBER PAYMENT~~ REPEALED

R9-7-601. ~~**General Requirements**~~ **Repealed**
~~**A.** The Department shall determine an applicant's or member's payment responsibility for covered medical services by:~~
~~1. Identifying the applicant's or member's household income group;~~
~~2. Calculating the net income of the applicant's or member's household income group by subtracting allowable deduc-~~

~~tions in R9-7-603 from the gross income of the applicant's or member's household income group; and~~
~~3. Determining whether the net income of the member's household income group is:~~
~~a. At or below 200% of the Federal Poverty Level, or~~
~~b. More than 200% of the Federal Poverty Level.~~

~~**B.** Before the Department enrolls an applicant, the applicant or, if the applicant is a minor, the applicant's parent, shall sign a payment agreement containing:~~
~~1. The applicant's name;~~
~~2. The applicant's date of birth;~~
~~3. The applicant's payment responsibility established according to R9-7-604;~~
~~4. A promise to pay the cost of covered medical services up to the total amount of any:~~
~~a. Court award or settlement of a claim related to the applicant's CRS condition, less money from the court award or settlement expended by the applicant for medical services;~~
~~b. Health care insurance payment or reimbursement to which the applicant is entitled for the covered medical services; and~~
~~c. Other third-party payment or reimbursement to which the applicant is entitled for the covered medical services;~~
~~5. A promise to pay according to the applicant's payment responsibility for covered medical services when subsection (B)(4) does not apply;~~
~~6. An assignment of insurance benefits;~~
~~7. The expiration date of the payment agreement;~~
~~8. The gross income of the applicant's household income group;~~
~~9. Total deductions;~~
~~10. The number of individuals in the applicant's household income group;~~
~~11. The signature of the applicant or, if the applicant is a minor, the applicant's parent and date signed; and~~
~~12. The signature of the Department's representative and date signed.~~

R9-7-602. Renumbered

R9-7-603. Renumbered

R9-7-604. Renumbered

ARTICLE 7. MEMBER APPEALS

R9-7-701. Member Appeals

A. For purposes of this Article, "appeal":
1. Means a written expression of dissatisfaction with a ~~regional contractor's~~ CRS provider's intended decision not to provide a covered service to a member that is submitted to the Department by the member or, if the member is a minor, the member's parent; or
2. No change

B. No change

C. No change

D. If a member or, if the member is a minor, the member's parent, does not submit an appeal within 60 days from the date of a ~~regional contractor's~~ CRS provider's intended decision, the intended decision becomes final.

E. To submit an appeal of a ~~regional contractor's~~ CRS provider's intended decision not to provide covered services, a member shall submit to the Department, no later than 60 ~~calendar~~ days from the date of the intended decision that is the subject of the appeal, a written notice containing:
1. No change
2. No change
3. No change
4. No change

F. The Department shall provide a member or, if the member is a minor, the member's parent with written notification regarding an appeal within 30 days from the date of receiving the appeal as follows.
1. If the Department determines that additional documentation or information is necessary to make a decision, the Department shall provide a written notice to the member requesting that the member provide the additional documentation or information within 14 ~~calendar~~ days after the date of the request.
   a. If the member submits the requested additional documentation or information in subsection (F)(1) within 14 ~~calendar~~ days from the date of the Department's request, the Department shall, within 14 ~~calendar~~ days from the date of receiving the requested additional documentation or information, provide notice to the member according to subsection (F)(2) or (F)(3).
   b. If the member does not submit the requested additional documentation or information within 14 ~~calendar~~ days from the date of the Department's request, the Department shall consider the appeal withdrawn.

2. If the Department determines that the ~~regional contractor's~~ CRS provider's intended decision does not comply with A.R.S. Title 36, Chapter 2, Article 3 or this Chapter, the Department shall reverse the intended decision and provide written notice of the Department's decision to the member and the ~~regional contractor~~ CRS provider.
3. If the Department determines that the ~~regional contractor's~~ CRS provider's intended decision complies with A.R.S. Title 36, Chapter 2, Article 3 or this Chapter, the Department shall provide a written notice of the Department's decision to the:
   a. Member that complies with A.R.S. § 41-1092, and
   b. ~~Regional contractor of the Department's decision.~~ CRS provider.

G. No change

NOTICE OF PROPOSED RULEMAKING

TITLE 14. PUBLIC SERVICE CORPORATIONS; CORPORATIONS AND ASSOCIATIONS; SECURITIES REGULATION

CHAPTER 2. CORPORATION COMMISSION FIXED UTILITIES

[R08-104]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R14-2-2301	New Section
R14-2-2302	New Section
R14-2-2303	New Section
R14-2-2304	New Section
R14-2-2305	New Section
R14-2-2306	New Section
R14-2-2307	New Section
R14-2-2308	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: Article XV of the Arizona Constitution and A.R.S. Title 40

Implementing statute: Not applicable

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

Notice of Rulemaking Docket Opening: 14 A.A.R. 1242, April 18, 2008 *(in this issue)*

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

Name: Jeffrey Pasquinelli, Public Utilities Analyst

Address: Corporation Commission
1200 W. Washington St.
Phoenix, AZ 85007

Telephone: (602) 542-4382

Fax: (602) 364-2270

E-mail: jpasquinelli@azcc.gov

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

The Arizona Corporation Commission ("Commission") issued Decision No. 69877 on August 28, 2007. In that decision the Commission ordered that the Public Utility Regulatory Act ("PURPA") standard on net metering would be adopted for all Commission-jurisdictional electric distribution utilities.

The PURPA standard is as follows:

> Each electric utility shall make available upon request net metering service to any electric consumer that the electric utility serves. For purposes of this paragraph, the term 'net metering service' means service to an electric consumer under which electric energy generated by that electric consumer from an eligible onsite generating facility and delivered to the local distribution facilities

may be used to offset electric energy provided by the electric utility to the electric consumer during the applicable billing period.

The decision also ordered that Commission staff begin a rulemaking process to draft the rules on net metering.

The proposed rules allow any retail customer of a Commission-jurisdictional electric utility to construct a renewable resource or Combined Heat and Power ("CHP") facility and interconnect for the purpose of exchanging electric power and energy with the electric utility that normally serves them. Under the proposed rules, net metering shall be a Commission-approved, tariffed service of Arizona electric distribution utilities.

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:

Not applicable

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 public at large will benefit from net metering; it encourages a larger portion of electricity used in Arizona to be produced from renewable or high-efficiency resources. This will result in fewer adverse impacts on air, land, and water than producing electricity from conventional sources.

Customers of electric utilities who install net metering facilities will incur an initial cost for the equipment, and are then able to meet their own electricity needs rather than purchase from the local utility. Electric energy produced beyond customer needs by the net metering facility may be sold back to the utility. Any class of utility customer may install net metering facilities.

Manufacturers, distributors, and installers of eligible technologies benefit because net-metering customers will purchase and install these eligible technologies. Eligible technologies include solar, wind, and combined heat and power facilities. Employees of the manufacturers, distributors, and installers of eligible technologies will benefit through increased job opportunities.

Load-serving utilities may incur additional costs of complying with reporting requirements, and reviewing net metering customer's plans. These same entities and their customers may benefit from the reduced load on their local distribution systems and a reduced need for procurement of generation and transmission resources.

Probable costs to the Commission of the proposed net metering rules would include costs associated with reviewing filings and contracts, and participating in meetings and hearings.

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:	Jeffrey Pasquinelli, Public Utilities Analyst
Address:	Corporation Commission 1200 W. Washington St. Phoenix, AZ 85007
Telephone:	(602) 542-4382
Fax:	(602) 364-2270
E-mail:	jpasquinelli@azcc.gov

10. The time, place, and nature of the proceedings for the adoption, 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:

Not applicable

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

Not applicable

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

None

13. The full text of the rules follows:

TITLE 14. PUBLIC SERVICE CORPORATIONS; CORPORATIONS AND ASSOCIATIONS; SECURITIES REGULATION

CHAPTER 2. CORPORATION COMMISSION
FIXED UTILITIES

ARTICLE 23. NET METERING

Section

ARTICLE 23. NET METERING

R14-2-2301. Applicability

These rules govern the treatment of Electric Utility Customers in Arizona who wish to interconnect with the Electric Utility which serves them and engage in Net Metering operation as defined below. These rules apply to all Electric Utilities, as defined in these rules.

R14-2-2302. Definitions

For purposes of this Article, the following definitions apply unless the context requires otherwise:

1. "Avoided Costs" means the incremental costs to an Electric Utility for electric energy or capacity or both which, but for the purchase from the Net Metering Facility, such utility would generate itself or purchase from another source.
2. "Biomass" means any raw or processed plant-derived organic matter available on a renewable basis, including:
   a. Dedicated energy crops and trees;
   b. Agricultural food and feed crops;
   c. Agricultural crop wastes and residues;
   d. wood wastes and residues, including:
      i. Landscape waste,
      ii. Right-of-way tree trimmings, or
      iii. Small diameter forest thinnings that are 12 inch in diameter or less;
   e. Dead and downed forest products;
   f. Aquatic plants;
   g. Animal wastes;
   h. Other vegetative waste materials;
   i. Non-hazardous plant matter waste material that is segregated from other waste;
   j. Forest-related resources such as:
      i. Harvesting and mill residue,
      ii. Pre-commercial thinnings,
      iii. Slash, and
      iv. Brush;
   k. Miscellaneous waste such as:
      i. Waste pallets,
      ii. Crates, and
      iii. Dunnage; or
   l. Recycled paper fibers that are no longer suitable for recycled paper production, but not including:
      i. Painted, treated, or pressurized wood,
      ii. Wood contaminated with plastics or metals,
      iii. Tires, or
      iv. Recyclable post-consumer waste paper.
3. "Biogas" means gases that are derived from:
   a. Plant-derived organic matter,
   b. Agricultural food and feed matter,

c. Wood wastes,
d. Aquatic plants,
e. Animal wastes,
f. Vegetative wastes,
g. Wastewater treatment facilities using anaerobic digestion, or
h. Municipal solid waste through:
i. A digester process,
ii. An oxidation process, or
iii. Other gasification process.

4. "Combined Heat and Power" or "CHP" (also known as cogeneration) means a system that generates electricity and useful thermal energy in a single, integrated system.
5. "Commission" means the Arizona Corporation Commission.
6. "Electric Utility" or "Utility" means an electric distribution company that constructs, operates, and maintains the electrical distribution system for the receipt and delivery of power.
7. "Electric Utility Customer" or "Customer" means an end-use retail Customer served under a Utility's rate schedule.
8. "Fuel Cell" means a device that converts the chemical energy of a fuel directly into electricity without intermediate combustion or thermal cycles. For purposes of these Net Metering rules, the source of the chemical reaction must be derived from Renewable Resources.
9. "Geothermal" means heat from within the earth's surface.
10. "Hydroelectric" means the kinetic energy derived from moving water.
11. "Net Metering" means service to an Electric Utility Customer under which electric energy generated by or on behalf of that Electric Utility Customer from a Net Metering Facility and delivered to the Utility's local distribution facilities may be used to offset electric energy provided by the Electric Utility to the Electric Utility Customer during the applicable billing period.
12. "Net Metering Customer" means any Arizona Customer who chooses to take electric service in the manner described in the definition of Net Metering above, and under the Net Metering tariff, as described in Section R14-2-2307.
13. "Net Metering Facility" means a facility for the production of electricity that:
a. Is operated by or on behalf of a Net Metering Customer and is located on the Net Metering Customer's premises;
b. Is intended primarily to provide part or all of the Net Metering Customer's requirements for electricity;
c. Uses Renewable Resources, a Fuel Cell, or CHP to generate electricity;
d. Has a generating capacity less than or equal to 125% of the Net Metering Customer's total connected load, or in the absence of customer load data, capacity less than or equal to the Customer's electric service drop capacity; and
e. Is interconnected with and can operate in parallel and in phase with an Electric Utility's existing distribution system.
14. "Renewable Resources" means natural resources that can be replenished by natural processes, including:
a. Biogas,
b. Biomass,
c. Geothermal,
d. Hydroelectric,
e. Solar, or
f. Wind.
15. "Solar" means radiation or heat from the Earth's sun that produces electricity from a device or system designed for that purpose.
16. "Wind" means energy derived from wind movement across the earth's surface that produces electricity from a device or system designed for that purpose.

R14-2-2303. Requirements and Eligibility

A. An Electric Utility shall interconnect with any retail customer with a Net Metering Facility in the Electric Utility's service territory.

B. Facilities with a generating capability greater than the limit specified in Section R14-2-2302(13)(d) shall require a special contract between the Utility and the Customer.

R14-2-2304. Metering

The meter that is installed on Net Metering Facilities after the effective date of these rules shall be capable of registering and accumulating the kilowatt-hours ("kWh") of electricity flowing in both directions in each billing period.

R14-2-2305. New or Additional Charges

A. Any proposed charge that would increase a Net Metering Customer's costs beyond those of other customers in the same rate class shall be filed by the Electric Utility with the Commission for consideration. The filings shall be supported with

cost of service studies and benefit/cost analyses. The Electric Utility shall have the burden of proof on any new proposed charge.

B. Net Metering costs shall be assessed on a nondiscriminatory basis with respect to other customers with similar load characteristics.

R14-2-2306. Billing for Net Metering

A. On a monthly basis, the Net Metering Customer shall be billed or credited based upon the rates applicable under the Customer's currently effective standard rate schedule and any appropriate rider schedules.

B. The billing period for net metering will be the same as the billing period under the Customer's applicable standard rate schedule.

C. If the kWh supplied by the Electric Utility exceed the kWh that are generated by the Net Metering Facility and delivered back to the Electric Utility during the billing period, the Customer shall be billed for the net kWh supplied by the Electric Utility in accordance with the rates and charges under the Customer's standard rate schedule.

D. If the electricity generated by the Net Metering Customer exceeds the electricity supplied by the Electric Utility in the billing period, the Customer shall be credited during the next billing period for the excess kWh generated. That is, the excess kWh during the billing period will be used to reduce the kWh supplied (not kW or kVA demand or customer charges) and billed by the Electric Utility during the following billing period.

E. Customers taking service under time-of-use rates who are to receive credit in a subsequent billing period for excess kWh generated shall receive such credit during the next billing period during the on- or off-peak periods corresponding to the on- or off-peak periods in which the kWh were generated by the Customer.

F. Once each calendar year the Electric Utility shall issue a check or billing credit to the Net Metering Customer for the balance of any credit due in excess of amounts owed by the Customer to the Electric Utility. The payment for any remaining credits shall be at the Electric Utility's Avoided Cost. That Avoided Cost shall be clearly identified in the Electric Utility's Net Metering tariff.

R14-2-2307. Net Metering Tariff

A. Each Electric Utility shall file, for approval by the Commission, a Net Metering tariff within 120 days from the effective date of these rules, including financial information and supporting data sufficient to allow the Commission to determine the Electric Utility's fair value for the purposes of evaluating any specific proposed charges. The Commission shall issue a decision on these filings within 120 days.

B. The Net Metering tariff shall specify standard rates for annual purchases of remaining credits from Net Metering Facilities and may specify total utility capacity limits. If total utility capacity limits are included in the Tariff, such limits must be fully justified.

C. Electric utilities may include seasonally and time of day differentiated Avoided Cost rates for purchases from Net Metering Customers, to the extent that Avoided Costs vary by season and time of day.

R14-2-2308. Filing and Reporting Requirements

A. Prior to May 1 of each year, each Electric Utility shall file a report listing all existing Net Metering Facilities and the inverter power rating or generator rating as of the end of the previous calendar year.

B. Also included in this report shall be, for each existing Net Metering Facility, the monthly amount of energy delivered to and from the Electric Utility and, if available, the monthly peak demand delivered to and from the Electric Utility.