



TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

The table of contents on the first page contains quick links to the referenced page numbers in this Chapter. Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

Sections, Parts, Exhibits, Tables or Appendices codified in this supplement. The list provided contains quick links to the updated rules.

This Chapter contains rule Sections that were filed to be codified in the *Arizona Administrative Code* between the dates of July 1, 2020 through September 30, 2020 (Supp. 20-3).

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The release of this Chapter in Supp. 20-3 replaces Supp. 19-4, 1-124 pages

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), accepts state agency rule filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into titles. Titles are divided into chapters. A chapter includes state agency rules. Rules in chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each chapter.

First Quarter: January 1 - March 31

Second Quarter: April 1 - June 30

Third Quarter: July 1 - September 30

Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2019 is cited as Supp. 19-1.

Please note: The Office publishes by chapter, not by individual rule section. Therefore there might be only a few sections codified in each chapter released in a supplement. Historical notes at the end of a section provide an effective date and information when a rule was last updated.

AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate chapters of the *Administrative Code* in Supp. 18-1 to comply with A.R.S. § 41-1012(B) and A.R.S. § 5302(1), (2)(d) through (e), and (3)(d) through (e).

A certification verifies the authenticity of each *Code* chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, www.azleg.gov. An agency’s authority

note to make rules is often included at the beginning of a chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

SESSION LAW REFERENCES

Arizona Session Law references in a chapter can be found at the Secretary of State’s website, under Services-> Legislative Filings.

EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor’s notes at the beginning of a chapter provide information about rulemaking sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

EXEMPTIONS AND PAPER COLOR

At one time the office published exempt rules on either blue or green paper. Blue meant the authority of the exemption was given by the Legislature; green meant the authority was determined by a court order. In 2001 the Office discontinued publishing rules using these paper colors.

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Rhonda Paschal, managing rules editor, assisted with the editing of this chapter.



Administrative Rules Division
The Arizona Secretary of State electronically publishes each A.A.C. Chapter with a digital certificate. The certificate-based signature displays the date and time the document was signed and can be validated in Adobe Acrobat Reader.

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

Editor's Note: The Office of the Secretary of State prints all Code Chapters on white paper (Supp 01-3).

Editor's Note: This Chapter contains rules which were adopted or amended under an exemption from the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6), pursuant to Laws 1992, Ch. 301, § 61 and Ch. 302, § 13, and Laws 1993, Ch. 6, § 34. Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Governor's Regulatory Review Council did not review these rules; AHCCCS was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is printed on blue paper.

ARTICLE 1. DEFINITIONS

New Article 1, consisting of Sections R9-22-101 through R9-22-103, R9-22-105, and R9-22-106 through R9-22-112 adopted effective December 8, 1997 (Supp. 97-4).

Former Article 1, consisting of Section R9-22-101, repealed effective December 8, 1997 (Supp. 97-4).

Table listing sections R9-22-101 through R9-22-120 with their respective titles and page numbers.

ARTICLE 2. SCOPE OF SERVICES

Table listing sections R9-22-201 through R9-22-212 with their respective titles and page numbers.

Table listing sections R9-22-213 through R9-22-218 with their respective titles and page numbers.

ARTICLE 3. GENERAL ELIGIBILITY REQUIREMENTS

Article 3, consisting of Sections R9-22-301 through R9-22-303, made by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

Article 3, consisting of Sections R9-22-301 through R9-22-319 and R9-22-321 through R9-22-344, repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section R9-22-320 repealed December 13, 1993 (Supp. 93-4).

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Article 6, consisting of Sections R9-22-601 through R9-22-604, adopted effective July 16, 1985.

Former Article 6, consisting of Sections R9-22-601 through R9-22-603, repealed effective October 1, 1983.

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Article 8, consisting of Sections R9-22-801 through R9-22-804 and Exhibit A, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).

| | |
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| R9-22-805. | Repealed |

ARTICLE 9. REPEALED

Article 22, consisting of Sections R9-22-901 through R9-22-909, repealed by final rulemaking at 12 A.A.R. 4484, January 6, 2007 (Supp. 06-4).

Article 22, consisting of Sections R9-22-901 through R9-22-908, adopted effective August 29, 1985.

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Article 10, consisting of Section R9-22-1001 through R9-22-1002, repealed effective November 7, 1997 (Supp. 97-4).

Article 10 consisting of Sections R9-22-1001 and R9-22-1002 adopted effective October 1, 1985.

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Article 13, consisting of Sections R9-22-1301 through R9-22-1306, made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3).

Article 13, consisting of Sections R9-22-1301 through R9-22-1306, made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Exemption to promulgate rules repealed under Laws 2012, Chapter 299, Section 7 (Supp. 13-3).

Article 13, consisting of Sections R9-22-1301 through R9-22-1309, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 13 is now in 9 A.A.C. 34 (Supp. 04-1).

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Article 15, consisting of Sections R9-22-1501 through R9-22-1508, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

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Article 16, consisting of Sections R9-22-1601 through R9-22-1636, repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

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CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

ARTICLE 1. DEFINITIONS

R9-22-101. Location of Definitions

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

| Definition | Section or Citation | Definition | Section or Citation |
|--|---|--|-----------------------------------|
| “Accommodation” | R9-22-701 | “Court-ordered evaluation” | R9-22-1201 |
| “Active treatment” | R9-22-1301 | “Court-ordered pre-petition screening” | R9-22-1201 |
| “ADHS” | R9-22-101 | “Court-ordered treatment” | R9-22-1201 |
| “Administration” | A.R.S. § 36-2901 | “Covered charges” | R9-22-701 |
| “Adult behavioral health therapeutic home” | 9 A.A.C. 10, Article 1 | “Covered services” | R9-22-101 |
| “Adverse action” | R9-22-101 | “CPT” | R9-22-701 |
| “Affiliated corporate organization” | R9-22-101 | “Creditable coverage” | R9-22-2003 and 42 U.S.C. 300gg(c) |
| “Aged” | 42 U.S.C. 1382c(a)(1)(A) and R9-22-1501 | “Crisis services” | R9-22-1201 |
| “Agency” | R9-22-1201 | “Critical Access Hospital” | R9-22-701 |
| “Aggregate” | R9-22-701 | “CRS application” | R9-22-1301 |
| “AHCCCS” | R9-22-101 | “CRS condition” | R9-22-1301 |
| “AHCCCS inpatient hospital day or days of care” | R9-22-701 | “CRS provider” | R9-22-1301 |
| “AHCCCS registered provider” | R9-22-101 | “Cryotherapy” | R9-22-2001 |
| “Ambulance” | A.R.S. § 36-2201 | “Customized DME” | R9-22-212 |
| “Ancillary service” | R9-22-101 | “Day” | R9-22-101 and R9-22-1101 |
| “Anticipatory guidance” | R9-22-201 | “Date of the Notice of Adverse Action” | R9-22-1441 |
| “Annual enrollment choice” | R9-22-1701 | “DBHS” | R9-22-101 |
| “APC” | R9-22-701 | “DCSS” | R9-22-301 |
| “Applicant” | R9-22-101 or R9-22-301 | “Department” | A.R.S. § 36-2901 |
| “Application” | R9-22-101 | “Dependent child” | A.R.S. § 46-101 or R9-22-1401 |
| “Assessment” | R9-22-1101 or R9-22-1201 | “DES” | R9-22-101 |
| “Assignment” | R9-22-101 | “Diagnostic services” | R9-22-101 |
| “Attending physician” | R9-22-101 or R9-22-202 | “Direct graduate medical education costs” or “direct program costs” | R9-22-701 |
| “Authorized representative” | R9-22-101 | “Direct supervision” | R9-22-1201 |
| “Authorization” | R9-22-202 | “Director” | R9-22-101 |
| “Auto-assignment algorithm” | R9-22-1701 | “Disabled” | R9-22-1501 |
| “AZ-NBCCEDP” | R9-22-2001 | “Discussion” | R9-22-101 |
| “Behavior management services” | R9-22-1201 | “Disenrollment” | R9-22-1701 |
| “Behavioral health therapeutic home care services” | R9-22-1201 | “DME” | R9-22-101 |
| “Behavioral health paraprofessional” | R9-22-101 | “DRI inflation factor” | R9-22-701 |
| “Behavioral health professional” | R9-22-101 | “E.P.S.D.T. services” | 42 CFR 440.40(b) |
| “Behavioral health recipient” | R9-22-201 | “Eligibility posting” | R9-22-701 |
| “Behavioral health services” | R9-22-1201 | “Eligible person” | A.R.S. § 36-2901 |
| “Behavioral health technician” | R9-22-1201 | “Emergency behavioral health condition for a non-FES member” | R9-22-201 |
| “Benefit year” | R9-22-201 | “Emergency behavioral health services for a non-FES member” | R9-22-201 |
| “BHS” | R9-22-301 | “Emergency medical condition for a non-FES member” | R9-22-201 |
| “Billed charges” | R9-22-701 | “Emergency medical services for a non-FES member” | R9-22-201 |
| “Blind” | R9-22-1501 | “Emergency medical services provider” | R9-22-1201 |
| “Burial plot” | R9-22-1401 | “Emergency medical or behavioral health condition for a FES member” | R9-22-217 |
| “Business agent” | R9-22-701 | “Emergency services costs” | A.R.S. § 36-2903.07 |
| “Calculated inpatient costs” | R9-22-712.07 | “Emergency services for a FES member” | R9-22-217 |
| “Capital costs” | R9-22-701 | “Encounter” | R9-22-701 |
| “Capped fee-for-service” | R9-22-101 | “Enrollment” | R9-22-1701 |
| “Caretaker relative” | R9-22-1401 | “Equity” | R9-22-101 |
| “Case management” | R9-22-1201 | “Experimental services” | R9-22-203 |
| “Case record” | R9-22-101 | “Existing outpatient service” | R9-22-701 |
| “Cash assistance” | R9-22-1401 | “Expansion funds” | R9-22-701 |
| “Certified psychiatric nurse practitioner” | R9-22-1201 | “FAA” | R9-22-301 |
| “Charge master” | R9-22-712 | “Facility” | R9-22-101 |
| “Child” | R9-22-1503 | “Factor” | R9-22-701 and 42 CFR 447.10 |
| “Children’s Rehabilitative Services” or “CRS” | R9-22-101 or R9-22-301 | “FBR” | R9-22-101 |
| “Chronic” | R9-22-1301 | “Federal financial participation” or “FFP” | 42 CFR 400.203 |
| “Claim” | R9-22-1101 | “Federal poverty level” or “FPL” | A.R.S. § 36-2981 |
| “Claims paid amount” | R9-22-712.07 | “Fee-For-Service” or “FFS” | R9-22-101 |
| “Clean claim” | A.R.S. § 36-2904 | “FES member” | R9-22-101 |
| “Clinical oversight” | 9 A.A.C. 10 | “FESP” | R9-22-101 |
| “CMDP” | R9-22-1701 | “First-party liability” | R9-22-1001 |
| “CMS” | R9-22-101 | “File” | R9-22-1101 |
| “Continuous stay” | R9-22-101 | “Fiscal agent” | R9-22-210 |
| “Contract” | R9-22-101 | “Fiscal intermediary” | R9-22-701 |
| “Contract year” | R9-22-101 | “Foster care maintenance payment” | 42 U.S.C. 675(4)(A) |
| “Contractor” | A.R.S. § 36-2901 or R9-22-210.01 | “FQHC” | R9-22-101 |
| “Copayment” | R9-22-701 | “Freestanding Children’s Hospital” | R9-22-701 |
| “Cost avoid” | R9-22-1201 | “Functionally limiting” | R9-22-1301 |
| “Cost-To-Charge Ratio” or “CCR” | R9-22-701 or R9-22-712 | “Fund” | R9-22-712.07 |
| | | “Graduate medical education (GME) program” | R9-22-701 |
| | | “GME program approved by the Administration” or “approved GME program” | R9-22-701 |

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| “Grievance” | A.A.C. Chapter 34 | “Physical therapy” | R9-22-201 |
| “GSA” | R9-22-101 | “Physician” | R9-22-101 |
| “HCAC” | R9-22-701 | “Physician assistant” | R9-22-1201 |
| “HCPCS” | R9-22-701 | “Post-stabilization services” | R9-22-201 or 42 CFR 422.113 |
| “Health care institution” | A.R.S. § 36-401 | “PPS bed” | R9-22-701 |
| “Health care practitioner” | R9-22-1201 | “Practitioner” | R9-22-101 |
| “Hearing aid” | R9-22-201 | “Pre-enrollment process” | R9-22-301 |
| “HIPAA” | R9-22-701 | “Prescription” | R9-22-101 |
| “Home health services” | R9-22-201 | “Primary care provider” or “PCP” | R9-22-101 |
| “Hospital” | R9-22-101 | “Primary care provider services” | R9-22-201 |
| “ICU” | R9-22-701 | “Prior authorization” | R9-22-101 |
| “IHS” | R9-22-101 | “Prior period coverage” or “PPC” | R9-22-101 |
| “IHS enrolled” or “enrolled with IHS” | R9-22-708 | “Procedure code” | R9-22-701 |
| “IMD” or “Institution for Mental Diseases” | 42 CFR 435.1010 and R9-22-101 | “Procurement file” | R9-22-601 |
| “Income” | R9-22-301 | “Proposal” | R9-22-101 |
| “Indirect program costs” | R9-22-701 | “Prospective rates” | R9-22-701 |
| “Individual” | R9-22-211 | “Psychiatrist” | R9-22-1201 |
| “In-kind income” | R9-22-1420 | “Psychologist” | R9-22-1201 |
| “Inmate of a public institution” | 42 CFR 435.1010 | “Psychosocial rehabilitation services” | R9-22-201 |
| “Inpatient covered charges” | R9-22-712.07 | “Public hospital” | R9-22-701 |
| “Intermediate Care Facility for the Mentally Retarded” or “ICF-MR” | 42 U.S.C. 1396d(d) | “Qualified alien” | A.R.S. § 36-2903.03 |
| “Intern and Resident Information System” | R9-22-701 | “Qualified behavioral health service provider” | R9-22-1201 |
| “LEEP” | R9-22-2001 | “Quality management” | R9-22-501 |
| “Legal representative” | R9-22-101 | “Radiology” | R9-22-101 |
| “Level I trauma center” | R9-22-2101 | “RBHA” or “Regional Behavioral Health Authority” | R9-22-201 |
| “License” or “licensure” | R9-22-101 | “Reason to know” or “had reason to know” | R9-22-1101 |
| “Licensee” | R9-22-1201 | “Rebase” | R9-22-701 |
| “MAGI-based income” | R9-22-1401 | “Redetermination” | R9-22-1301 |
| “Mailing date” | R9-22-101 | “Referral” | R9-22-101 |
| “Medical education costs” | R9-22-701 | “Rehabilitation services” | R9-22-101 |
| “Medical expense deduction” or “MED” | R9-22-1401 | “Reinsurance” | R9-22-701 |
| “Medical practitioner” | R9-22-1201 | “Remittance advice” | R9-22-701 |
| “Medical record” | R9-22-101 | “Resident” | R9-22-701 |
| “Medical review” | R9-22-701 | “Residual functional deficit” | R9-22-201 |
| “Medical services” | A.R.S. § 36-401 | “Resources” | R9-22-301 |
| “Medical supplies” | R9-22-101 | “Respiratory therapy” | R9-22-201 |
| “Medical support” | R9-22-301 | “Respite” | R9-22-1201 |
| “Medically eligible” | R9-22-1301 | “Responsible offeror” | R9-22-101 |
| “Medically necessary” | R9-22-101 | “Responsive offeror” | R9-22-101 |
| “Medicare claim” | R9-22-101 | “Revenue Code” | R9-22-701 |
| “Medicare Urban or Rural Cost-to-Charge Ratio (CCR)” | R9-22-701 | “Review” | R9-22-101 |
| “Member” | A.R.S. § 36-2901 or R9-22-301 | “Review month” | R9-22-101 |
| “Mental disorder” | A.R.S. § 36-501 | “RFP” | R9-22-101 |
| “Milliman study” | R9-22-712.07 | “Rural Contractor” | R9-22-718 |
| “Monthly equivalent” | R9-22-1401 | “Rural Hospital” | R9-22-718 and R9-22-712.07 |
| “Monthly income” | R9-22-1401 | “Scope of services” | R9-22-201 |
| “National Standard code sets” | R9-22-701 | “Section 1115 Waiver” | A.R.S. § 36-2901 |
| “New hospital” | R9-22-701 | “Service location” | R9-22-101 |
| “NICU” | R9-22-701 | “Service site” | R9-22-101 |
| “Noncontracted Hospital” | R9-22-718 | “SOBRA” | R9-22-101 |
| “Noncontracting provider” | A.R.S. § 36-2901 | “Specialist” | R9-22-101 |
| “Non-FES member” | R9-22-101 | “Specialty facility” | R9-22-701 |
| “Non-IHS Acute Hospital” | R9-22-701 | “Speech therapy” | R9-22-201 |
| “Nursing facility” or “NF” | 42 U.S.C. 1396r(a) | “Spendthrift restriction” | R9-22-1401 |
| “Observation day” | R9-22-701 | “Sponsor” | R9-22-301 |
| “Occupational therapy” | R9-22-201 | “Sponsor deemed income” | R9-22-301 |
| “Offeror” | R9-22-101 | “Sponsoring institution” | R9-22-701 |
| “Operating costs” | R9-22-701 | “Spouse” | R9-22-101 |
| “OPPC” | R9-22-701 | “SSA” | 42 CFR 1000.10 |
| “Organized health care delivery system” | R9-22-701 | “SSI” | 42 CFR 435.4 |
| “Outlier” | R9-22-701 | “SSN” | R9-22-101 |
| “Outpatient hospital service” | R9-22-701 | “Stabilize” | 42 U.S.C. 1395dd |
| “Ownership change” | R9-22-701 | “Standard of care” | R9-22-101 |
| “Ownership interest” | 42 CFR 455.101 | “Sterilization” | R9-22-201 |
| “Partial Care” | R9-22-1201 | “Subcontract” | R9-22-101 |
| “Participating institution” | R9-22-701 | “Submitted” | A.R.S. § 36-2904 |
| “Peer group” | R9-22-701 | “Substance abuse” | R9-22-201 |
| “Peer-reviewed study” | R9-22-2001 | “SVES” | R9-22-201 |
| “Penalty” | R9-22-1101 | “Tax dependent” | 42 CFR 435.4 |
| “Person” | R9-22-1101 | “Taxi” | A.R.S. § 28-101(53) |
| “Pharmaceutical service” | R9-22-201 | “Taxpayer” | R9-22-1401 |
| | | “Third-party” | R9-22-1001 |
| | | “Third-party liability” | R9-22-1001 |

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| “Tier” | R9-22-701 |
| “Tiered per diem” | R9-22-701 |
| “Title IV-D” | R9-22-1401 |
| “Title IV-E” | R9-22-1401 |
| “Total Inpatient payments” | R9-22-712.07 |
| “Trauma and Emergency Services Fund” | A.R.S. § 36-2903.07 |
| “TRBHA” or “Tribal Regional Behavioral Health Authority” | R9-22-1201 |
| “Treatment” | R9-22-2004 |
| “Tribal Facility” | A.R.S. § 36-2981 |
| “Unrecovered trauma center readiness costs” | R9-22-2101 |
| “Urban Contractor” | R9-22-718 |
| “Urban Hospital” | R9-22-718 |
| “USCIS” | R9-22-301 |
| “Utilization management” | R9-22-501 |
| “WWHP” | R9-22-2001 |

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

“ADHS” means the Arizona Department of Health Services.

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

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

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

“AHCCCS registered provider” means a provider or non-contracting provider who:

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

Meets license or certification requirements to provide covered services.

“Ancillary service” means all hospital services for patient care other than room and board and nursing services, including but not limited to, laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, and occupational).

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

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

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

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

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

“Behavioral health paraprofessional” means an individual who is not a behavioral health professional who provides

behavioral health services at or for a health care institution according to the health care institution’s policies and procedures that:

If the behavioral health services were provided in a setting other than a licensed health care institution,

If the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33,

If the behavioral health services were provided in a setting other than a licensed health care institution; and

Are provided under supervision by a behavioral health professional R9-10-101.

“Behavioral Health Professional” has the same meaning as defined A.A.C. R9-10-101 excluding subsection (g).

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

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

“Children’s Rehabilitative Services” or “CRS” means the program that provides covered medical services and covered support services in accordance with A.R.S. § 36-261.

“CMS” means the Centers for Medicare and Medicaid Services.

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

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

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

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

“Day” means a calendar day unless otherwise specified.

“DBHS” means the Division of Behavioral Health Services within the Arizona Department of Health Services.

“DES” means the Department of Economic Security.

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

“Director” means the Director of the Administration or the Director’s designee.

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

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“DME” means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.

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

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

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

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

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

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

“FQHC” means federally qualified health center.

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

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

“IHS” means Indian Health Service.

“IMD” or “Institution for Mental Diseases” means an Institution for Mental Diseases as described in 42 CFR 435.1010 that is licensed by ADHS.

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

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

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

Shown on the postmark;

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

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

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

“Medical supplies” means consumable items that are designed specifically to meet a medical purpose.

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

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

“Non-FES member” means an eligible person who is entitled to full AHCCCS services.

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

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

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

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

“Primary care provider” or “PCP” means an individual who meets the requirements of A.R.S. § 36-2901 (14), and who is responsible for the management of a member’s health care.

“Prior authorization” means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness, compliance with this Article and any applicable contract provisions. Prior authorization is not a guarantee of payment.

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

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

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

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

“Rehabilitation services” means physical, occupational, and speech therapies, and items to assist in improving or restoring a person’s functional level.

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

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

“Review” means a review of all factors affecting a member’s eligibility.

“Review month” means the month in which the individual’s or family’s circumstances and case record are reviewed.

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

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

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

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

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

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

“SSN” means Social Security number.

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

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

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

A marketing organization, or

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

“Taxi” is as defined in A.R.S. § 28-101(53).

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-101 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-101 repealed, former Sections R9-22-102 and R9-22-301

renumbered as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency by adding new paragraphs (24), (46), (84) and (91) and renumbering accordingly effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Amended as an emergency by adding new paragraphs (2) and (15) and renumbering accordingly effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment added paragraphs (2) and (15) and renumbered accordingly effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended paragraphs (10) and (15) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended by deleting paragraphs (39) and (62) and renumbering accordingly effective July 1, 1988 (Supp. 88-3). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted effective December 8, 1997 (Supp. 97-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 3830, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008

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(Supp. 08-2). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 461, effective April 1, 2012 (Supp. 12-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-102. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-102 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1092 (Supp. 82-4). Former Section R9-22-102 renumbered together with former Section R9-22-301 as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). New Section adopted effective December 8, 1997 (Supp. 97-4). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Section repealed by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3).

R9-22-103. Repealed**Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-104. Reserved**R9-22-105. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-106. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4).

R9-22-107. Repealed**Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Section repealed by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

R9-22-108. Repealed**Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 3317, effective

August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-109. Repealed**Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. effective 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-110. Repealed**Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

R9-22-111. Reserved**R9-22-112. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Repealed by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1).

R9-22-113. Reserved**R9-22-114. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4).

R9-22-115. Repealed**Historical Note**

Final Section adopted at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4).

R9-22-116. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-117. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by

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exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-118. Reserved

R9-22-119. Reserved

R9-22-120. Repealed

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

ARTICLE 2. SCOPE OF SERVICES

R9-22-201. Scope of Services-related Definitions

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

“Anticipatory guidance” means a person responsible for a child receives information and guidance of what the person should expect of the child’s development and how to help the child stay healthy.

“Behavioral health recipient” means a Title XIX or Title XXI acute care member who is eligible for, and is receiving, behavioral health services through ADHS/DBHS.

“Benefit year” means a one-year time period of October 1st through September 30th.

“Emergency behavioral health condition for a non-FES member” means a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

Placing the health of the person, including mental health, in serious jeopardy;

Serious impairment to bodily functions;

Serious dysfunction of any bodily organ or part; or

Serious physical harm to another person.

“Emergency behavioral health services for a non-FES member” means those behavioral health services provided for the treatment of an emergency behavioral health condition.

“Emergency medical condition for a non-FES member” means treatment for a medical condition, including labor and delivery, which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

Placing the member’s health in serious jeopardy,

Serious impairment to bodily functions, or

Serious dysfunction of any bodily organ or part.

“Emergency medical services for a non-FES member” means services provided for the treatment of an emergency medical condition.

“Hearing aid” means an instrument or device designed for, or represented by the supplier as aiding or compensating for

impaired or defective human hearing, and includes any parts, attachments, or accessories of the instrument or device.

“Home health services” means services and supplies that are provided by a home health agency that coordinates in-home intermittent services for curative, rehabilitative care, including home-health aide services, licensed nurse services, and medical supplies, equipment, and appliances.

“Occupational therapy” means medically prescribed treatment provided by or under the supervision of a licensed occupational therapist, to restore or improve an individual’s ability to perform tasks required for independent functioning.

“Pharmaceutical service” means medically necessary medications that are prescribed by a physician, practitioner, or dentist under R9-22-209.

“Physical therapy” means treatment services to restore or improve muscle tone, joint mobility, or physical function provided by or under the supervision of a registered physical therapist.

“Post-stabilization services” means covered services related to an emergency medical or behavioral health condition provided after the condition is stabilized.

“Primary care provider services” means healthcare services provided by and within the scope of practice, as defined by law, of a licensed physician, certified nurse practitioner, or licensed physician assistant.

“Psychosocial rehabilitation services” means services that provide education, coaching, and training to address or prevent residual functional deficits and may include services that may assist a member to secure and maintain employment. Psychosocial rehabilitation services may include:

Living skills training,

Cognitive rehabilitation,

Health promotion,

Supported employment, and

Other services that increase social and communication skills to maximize a member’s ability to participate in the community and function independently.

“RBHA” or “Regional Behavioral Health Authority” means the same as in A.R.S. § 36-3401.

“Residual functional deficit” means a member’s inability to return to a previous level of functioning, usually after experiencing a severe psychotic break or state of decompensation.

“Respiratory therapy” means treatment services to restore, maintain, or improve respiratory functions that are provided by, or under the supervision of, a respiratory therapist licensed according to A.R.S. Title 32, Chapter 35.

“Scope of services” means the covered, limited, and excluded services under Articles 2 and 12 of this Chapter.

“Speech therapy” means medically prescribed diagnostic and treatment services provided by or under the supervision of a certified speech therapist.

“Sterilization” means a medically necessary procedure, not for the purpose of family planning, to render an eligible person or member barren in order to:

Prevent the progression of disease, disability, or adverse health conditions; or

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Prolong life and promote physical health.

“Substance abuse” means the chronic, habitual, or compulsive use of any chemical matter that, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse for adults who are 21 years of age or older

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-201 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 3217, effective October 1, 2005 (Supp. 05-3). Section repealed; new Section made by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-202. General Requirements

- A.** For the purposes of this Article, the following definitions apply:
1. “Authorization” means written, verbal, or electronic authorization by:
 - a. The Administration for services rendered to a fee-for-service member, or
 - b. The contractor for services rendered to a prepaid capitated member.
 2. Use of the phrase “attending physician” applies only to the fee-for-service population.
- B.** In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:
1. Only medically necessary, cost effective, and federally-reimbursable and state-reimbursable services are covered services.
 2. Covered services for the federal emergency services program (FESP) are under R9-22-217.
 3. The Administration or a contractor may waive the covered services referral requirements of this Article.
 4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member’s covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.
 5. A contractor shall offer a female member direct access to preventive and routine services from gynecology provid-

- ers within the contractor’s network without a referral from a primary care provider.
 6. A member may receive physical and behavioral health services as specified in Articles 2 and 12.
 7. The Administration or a contractor shall provide services under the Section 1115 Waiver as defined in A.R.S. § 36-2901.
 8. An AHCCCS registered provider shall provide covered services within the provider’s scope of practice.
 9. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
 - a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;
 - b. Services or items furnished gratuitously, and
 - c. Personal care items except as specified under R9-22-212.
 10. Medical or behavioral health services are not covered services if provided to:
 - a. An inmate of a public institution; or
 - b. A person who is in residence at an institution for the treatment of tuberculosis.
- C.** The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained as specified in this Article and Article 7 of this Chapter. The Administration or a contractor shall not provide prior authorization for services unless the provider submits documentation of the medical necessity of the treatment along with the prior authorization request.
- D.** Services under A.R.S. § 36-2908 provided during the prior period coverage do not require prior authorization.
- E.** Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.
- F.** A service is not a covered service if provided outside the GSA unless one of the following applies:
1. A member is referred by a primary care provider for medical specialty care outside the GSA. If a member is referred outside the GSA to receive an authorized medically necessary service, the contractor shall also provide all other medically necessary covered services for the member;
 2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member’s family;
 3. The contractor authorizes placement in a nursing facility located out of the GSA; or
 4. Services are provided during prior period coverage or during the prior quarter coverage.
- G.** If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.
- H.** A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.
- I.** The Administration shall determine the circumstances under which a FFS member may receive services, other than emergency services, from service providers outside the member’s county of residence or outside the state. Criteria considered by the Administration in making this determination shall include availability and accessibility of appropriate care and cost effectiveness.

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- J.** The restrictions, limitations, and exclusions in this Article do not apply to a contractor electing to provide noncovered services.
1. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.
 2. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.
 3. If a member requests a service that is not covered or is not authorized by a contractor, or the Administration, an AHCCCS-registered service provider may provide the service according to R9-22-702.
- K.** Subject to CMS approval, the restrictions, limitations, and exclusions specified in the following subsections do not apply to American Indians receiving services through IHS or a tribal health program operating under P.L. 93-638 when those services are eligible for 100 percent federal financial participation:
1. R9-22-205(A)(8),
 2. R9-22-206,
 3. R9-22-207,
 4. R9-22-212(C),
 5. R9-22-212(D),
 6. R9-22-212(E)(8),
 7. R9-22-215(C)(5), (C)(6), and
 8. R9-22-215(C)(4).

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-202 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2).

Amended effective December 13, 1993 (Supp. 93-4).

Amended effective July 1, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1994, Ch. 322, § 21; filed with the Office of the Secretary of State June 22, 1995 (Supp. 95-3). Amended effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Section repealed effective September 22, 1997 (Supp. 97-3). New Section made by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4). Amended by final rulemaking at 21 A.A.R. 1225, effective July 7, 2015 (Supp. 15-3).

R9-22-203. Experimental Services

- A.** Experimental services are not covered. A service is not experimental if:
1. It is generally and widely accepted as a standard of care in the practice of medicine in the United States and is a safe and effective treatment for the condition for which it is intended or used.

2. The service does not meet the standard in subsection (A)(1), but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of the evidence in peer-reviewed articles in medical journals published in the United States.
 3. The service does not meet the standard in subsection (A)(2) because the condition for which the service is intended or used is rare, but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of opinions from specialists who provide the service or related services.
- B.** The following factors shall be considered when evaluating the weight of peer-reviewed articles or the opinions of specialists:
1. The mortality rate and survival rate of the service as compared to the rates for alternative non-experimental services.
 2. The types, severity, and frequency of complications associated with the services as compared with the complications associated with alternative non-experimental services.
 3. The frequency with which the service has been performed in the past.
 4. Whether there is sufficient historical information regarding the service to provide reliable data regarding risks and benefits.
 5. The reputation and experience of the authors and/or specialists and their record in related areas.
 6. The extent to which medical science in the area develops rapidly and the probability that more definite data will be available in the foreseeable future.
 7. Whether the peer reviewed article describes a random controlled trial or an anecdotal clinical case study.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-203 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2).

Amended effective April 13, 1990 (Supp. 90-2).

Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed effective September 22, 1997 (Supp. 97-3). New Section made by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Section amended by final rulemaking at 20 A.A.R. 1956, effective September 6, 2014 (Supp. 14-3).

R9-22-204. Inpatient General Hospital Services

- A.** The following limitations apply to inpatient general hospital services that are provided by FFS providers.
1. Providers shall obtain prior authorization from the Administration for the following inpatient hospital services:
 - a. Nonemergency and elective admission, including psychiatric hospitalization;
 - b. Elective surgery; and

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- c. Services or items provided to cosmetically reconstruct or improve personal appearance after an illness or injury.
2. The Administration or a contractor may deny a claim if a provider fails to obtain prior authorization.
3. Providers are not required to obtain prior authorization from the Administration for the following inpatient hospital services:
- Voluntary sterilization,
 - Dialysis shunt placement,
 - Arteriovenous graft placement for dialysis,
 - Angioplasties or thrombectomies of dialysis shunts,
 - Angioplasties or thrombectomies of arteriovenous graft for dialysis,
 - Hospitalization for vaginal delivery that does not exceed 48 hours,
 - Hospitalization for cesarean section delivery that does not exceed 96 hours, and
 - Other services identified by the Administration through the Provider Participation Agreement.
4. The Administration may perform concurrent review for hospitalizations of non-FES members to determine whether there is medical necessity for the hospitalization. A provider shall notify the Administration no later than 72 hours after an emergency admission.
- C. Coverage of in-state and out-of-state inpatient hospital services is limited to 25 days per benefit year for members age 21 and older for claims with discharge dates on or before September 30, 2014. The limit applies for all inpatient hospital services with dates of service during the benefit year regardless of whether the member is enrolled in Fee for Service, is enrolled with one or more contractors, or both, during the benefit year.
- For purposes of calculating the limit:
 - Inpatient days are counted towards the limit if paid by the Administration or a contractor;
 - Inpatient days will be counted toward the limit in the order of the adjudication date of a paid claim;
 - Paid inpatient days are allocated to the benefit year in which the date of service occurs;
 - Each 24 hours of paid observation services is counted as one inpatient day if the patient is not admitted to the same hospital directly following the observation services,
 - Observation services, which are directly followed by an inpatient admission to the same hospital are not counted towards the inpatient limit; and
 - After 25 days of inpatient hospital services have been paid as provided for in this rule Section:
 - Outpatient services that are directly followed by an inpatient admission to the same hospital, including observation services, are not covered.
 - Continuous periods of observation services of less than 24 hours that are not directly followed by an inpatient admission to the same hospital are covered.
 - For continuous periods of observation services of 24 hours or more that are not directly followed by an inpatient admission to the same hospital, 23 hours of observations services are covered.
 - The following inpatient days are not included in the inpatient hospital limitation described in this Section:
 - Days reimbursed under specialty contracts between AHCCCS and a transplant facility that are included within the component pricing referred to in the contract;
 - Days related to Behavioral Health:
 - Inpatient days that qualify for the psychiatric tier under R9-22-712.09 and reimbursed by the Administration or its contractors, or
 - Inpatient days with a primary psychiatric diagnosis code reimbursed by the Administration or its contractors, or
 - Inpatient days paid by the Arizona Department of Health Services Division of Behavioral Health Services or a RBHA or TRBHA.
 - Days related to treatment for burns and burn late effects at an American College of Surgeons verified burn center;
 - Same Day Admit Discharge services are excluded from the 25 day limit; and
 - Subject to approval by CMS, days for which the state claims 100% FFP, such as payments for days provided by IHS or 638 facilities.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-204 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective December 22, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1745, effective October 1, 2012 (Supp. 12-2). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 1956, effective September 6, 2014 (Supp. 14-3).

R9-22-205. Attending Physician, Practitioner, and Primary Care Provider Services

- A. A primary care provider, attending physician, or practitioner shall provide primary care provider services within the provider's scope of practice under A.R.S. Title 32. A member may receive primary care provider services in an inpatient or outpatient setting including at a minimum:
- Periodic health examination and assessment;
 - Evaluation and diagnostic workup;
 - Medically necessary treatment;
 - Prescriptions for medication and medically necessary supplies and equipment;
 - Referral to a specialist or other health care professional if medically necessary;
 - Patient education;
 - Home visits if medically necessary; and
 - Preventive health services, such as, well visits, immunizations, colonoscopies, mammograms and PAP smears.

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- B.** The following limitations and exclusions apply to attending physician and practitioner services and primary care provider services:
1. Specialty care and other services provided to a member upon referral from a primary care provider, or to a member upon referral from the attending physician or practitioner are limited to the service or condition for which the referral is made, or for which authorization is given by the Administration or a contractor.
 2. A member's physical examination is not covered if the sole purpose is to obtain documentation for one or more of the following:
 - a. Qualification for insurance,
 - b. Pre-employment physical evaluation,
 - c. Qualification for sports or physical exercise activities,
 - d. Pilot's examination for the Federal Aviation Administration,
 - e. Disability certification to establish any kind of periodic payments,
 - f. Evaluation to establish third-party liabilities, or
 - g. Physical ability to perform functions that have no relationship to primary objectives of the services listed in subsection (A).
 3. Orthognathic surgery is covered only for a member who is less than 21 years of age;
 4. The following services are excluded from AHCCCS coverage:
 - a. Infertility services, reversal of surgically induced infertility (sterilization), and gender reassignment surgeries;
 - b. Pregnancy termination counseling services;
 - c. Pregnancy terminations, unless required by state or federal law.
 - d. Services or items furnished solely for cosmetic purposes; and
 - e. Hysterectomies unless determined medically necessary.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-205 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A), paragraph (15) and added paragraph (20) effective December 22, 1987 (Supp. 87-4). Amended subsection (C)(2) effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

Editor's Note: *The following Section was renumbered and a new Section adopted under an exemption from the provisions of the Administrative Procedure Act which means that this rule was*

not published as a proposed rule in the Arizona Administrative Register; the rule was not reviewed or approved by the Governor's Regulatory Review Council; and the agency was not required to hold public hearings on the rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-206. Organ and Tissue Transplant Services

- A.** Organ and tissue transplant services are covered for a member if prior authorized and coordinated with the member's contractor, or the Administration. Only the following transplants are covered for individuals 21 years of age or older:
1. Heart, including transplants for the treatment of non-ischemic cardiomyopathy;
 2. Liver, including transplants for patients with hepatitis C;
 3. Kidney (cadaveric and live donor);
 4. Simultaneous Pancreas/Kidney (SPK);
 5. Autologous and Allogeneic related and unrelated Hematopoietic Cell transplants;
 6. Cornea;
 7. Bone;
 8. Lung; and
 9. Pancreas after a kidney transplant (PAK).
- B.** The following transplants are not covered for members 21 years of age or older:
1. Pancreas only transplants if it is not performed simultaneously with or following a kidney transplant. Partial pancreas transplants and autologous and allogeneic pancreas islet cell transplants are not covered even if performed simultaneously with or following a kidney transplant,
 2. Intestine transplants, and
 3. Any other type of transplant not specifically listed in subsection (A).
- C.** When there is a transplant of multiple organs, reimbursement will only be made for those covered.
- D.** Organ and tissue transplant services are not covered for non-qualified aliens or noncitizens members of FESP under A.R.S. § 36-2903.03(D).

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-206 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-206 renumbered to R9-22-218, new Section R9-22-206 adopted effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by exempt rulemaking at 16 A.A.R. 1386, effective July 15, 2010 (Supp. 10-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by exempt rulemaking at 17 A.A.R. 1122, April 1, 2011 (Supp. 11-2).

R9-22-207. Dental Services

- A.** The Administration or a contractor shall cover dental services for a member less than 21 years of age under R9-22-213.
- B.** For individuals age 21 years of age or older, the Administration or a contractor shall cover medical and surgical services

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furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician.

1. Except as specified in subsection (C), such services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. Covered dental services include examination of the oral cavity, radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate level of anesthesia and the prescription of pain medication and antibiotics.
 2. Such services do not include services that physicians are not generally competent to perform such as dental cleanings, routine dental examinations, dental restorations including crowns and fillings, extractions, pulpotomies, root canals, and the construction or delivery of complete or partial dentures. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.
- C. For the purposes of this subsection, simple restorations means silver amalgam or composite resin fillings, stainless steel crowns or preformed crowns. In addition, dental services for an individual 21 years of age or older include:
1. The elimination of oral infections and the treatment of oral disease, which includes dental cleanings, treatment of periodontal disease, medically necessary extractions and the provision of simple restorations as a medically necessary pre-requisite to covered transplantation; and
 2. Prophylactic extraction of teeth in preparation for covered radiation treatment of cancer of the jaw, neck or head.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-207 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-207 repealed, new Section R9-22-207 adopted effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3).

R9-22-208. Laboratory, Radiology, and Medical Imaging Services

Laboratory, radiology, and medical imaging services are covered services if:

1. Prescribed by the member's attending physician, practitioner, primary care provider or a dentist, or prescribed by a physician or practitioner upon referral from the primary care provider or dentist.
2. Provided by licensed health care providers in a:
 - a. Hospital,
 - b. Clinic,
 - c. Physician's office, or
 - d. Other health care facility.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-208 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-208 repealed, new Section R9-22-208 adopted effective

October 1, 1985 (Supp. 85-5). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

R9-22-209. Pharmaceutical Services

- A. An inpatient or outpatient provider, including a hospital, clinic, other appropriately licensed health care facility, and pharmacy may provide covered pharmaceutical services.
- B. The Administration or a contractor shall require a provider to make pharmaceutical services:
 1. Available during customary business hours, and
 2. Located within reasonable travel distance of a member's residence.
- C. Pharmaceutical services are covered if:
 1. Prescribed for a member by the member's primary care provider, attending physician, practitioner, or dentist;
 2. Prescribed by a specialist upon referral from the primary care provider or attending physician; or
 3. The contractor or its designee authorizes the service.
- D. The following limitations apply to pharmaceutical services:
 1. A medication personally dispensed by a physician, dentist, or a practitioner within the individual's scope of practice is not covered, except in geographically remote areas where there is no participating pharmacy or if accessible pharmacies are closed.
 2. A new prescription or refill in excess of a 30 day supply is not covered unless:
 - a. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed a 90 day supply; or
 - b. The Contractor authorizes the prescription for an extended time period not to exceed a 90-day supply.
 3. An over-the-counter medication, in place of a covered prescription medication, is covered only if the over-the-counter medication is appropriate, equally effective, safe, and less costly than the covered prescription medication.
- E. A contractor shall monitor and ensure sufficient services to prevent any gap in the pharmaceutical regimen of a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well being.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-209 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective September 24, 1986 (Supp. 86-5). Amended subsections (A) and (C) effective December 22, 1987 (Supp. 87-4). Amended subsection (C)(3), effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by

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final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

R9-22-210. Emergency Medical Services for Non-FES Members**A. General provisions.**

1. **Applicability.** This Section applies to emergency medical services for non-FES members. Provisions regarding emergency behavioral health services for non-FES members are in R9-22-210.01. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
2. **Definitions.**
 - a. For the purposes of this Section, “contractor” has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS or a subcontractor of ADHS/DBHS.
 - b. For the purposes of this Section and R9-22-210.01, “fiscal agent” means a person who bills and accepts payment for a hospital or emergency room provider.
3. **Verification.** A provider of emergency medical services shall verify a person’s eligibility status with AHCCCS, and if eligible, determine whether the person is enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor.
4. **Prior authorization.**
 - a. **Emergency medical services.** A provider is not required to obtain prior authorization for emergency medical services.
 - b. **Non-emergency medical services.** If a non-FES member’s medical condition does not require emergency medical services, the provider shall obtain prior authorization as required by the terms of the provider agreement under R9-22-714(A) or the provider’s subcontract with the contractor, whichever is applicable.
5. **Prohibition against denial of payment.** Neither the Administration nor a contractor shall:
 - a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms,
 - b. Deny or limit payment because the provider failed to obtain prior authorization for emergency services,
 - c. Deny or limit payment because the provider does not have a subcontract.
6. **Grounds for denial.** The Administration and a contractor may deny payment for emergency medical services for reasons including but not limited to:
 - a. The claim was not a clean claim;
 - b. The claim was not submitted timely; and
 - c. The provider failed to provide timely notification under subsection (B)(4) to the contractor or the Administration, as appropriate, and the contractor does not have actual notice from any other source that the member has presented for services.

B. Additional requirements for emergency medical services for non-FES members enrolled with a contractor.

1. **Responsible entity.** A contractor is responsible for the provision of all emergency medical services to non-FES members enrolled with the contractor.
2. **Prohibition against denial of payment.** A contractor shall not limit or deny payment for emergency medical services when an employee of the contractor instructs the member to obtain emergency medical services.
3. **Contractor notification.** A contractor shall not deny payment to a hospital, emergency room provider, or fiscal agent for an emergency medical service rendered to a non-FES member based on the failure of the hospital,

emergency room provider, or fiscal agent to notify the member’s contractor within 10 days from the day that the member presented for the emergency medical service.

4. **Contractor notification.** A hospital, emergency room provider, or fiscal agent shall notify the contractor no later than the 11th day after presentation of the non-FES member for emergency inpatient medical services. A contractor may deny payment for a hospital’s, emergency room provider’s, or fiscal agent’s failure to provide timely notice, under this subsection.

C. Post-stabilization services for non-FES members enrolled with a contractor.

1. After the emergency medical condition of a member enrolled with a contractor is stabilized, a provider shall request prior authorization from the contractor for post-stabilization services.
2. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that have been prior authorized by the contractor.
3. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain the member’s stabilized condition within one hour of a request to the contractor for prior authorization of further post-stabilization services;
4. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain, improve, or resolve the member’s stabilized condition if:
 - a. The contractor does not respond to a request for prior authorization within one hour;
 - b. The contractor authorized to give the prior authorization cannot be contacted; or
 - c. The contractor representative and the treating physician cannot reach an agreement concerning the member’s care and the contractor physician is not available for consultation. In this situation, the contractor shall give the treating physician the opportunity to consult with a contractor physician. The treating physician may continue with care of the member until the contractor physician is reached or:
 - i. A contractor physician with privileges at the treating hospital assumes responsibility for the member’s care,
 - ii. A contractor physician assumes responsibility for the member’s care through transfer,
 - iii. The contractor’s representative and the treating physician reach agreement concerning the member’s care, or
 - iv. The member is discharged.
5. **Transfer or discharge.** The attending physician or practitioner actually treating the member for the emergency medical condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor.

D. Additional requirements for FFS members.

1. **Responsible entity.** The Administration is responsible for the provision of all emergency medical services to non-FES FFS members.
2. **Grounds for denial.** The Administration may deny payment for emergency medical services if a provider fails to provide timely notice to the Administration.
3. **Notification.** A provider shall notify the Administration no later than 72 hours after a FFS member receiving

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emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-210 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-210 repealed, new Section R9-22-210 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (1) effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

R9-22-210.01. Emergency Behavioral Health Services for Non-FES Members**A. General provisions.**

1. Applicability. This Section applies to emergency behavioral health services for non-FES members. Provisions regarding emergency medical services for non-FES members are in R9-22-210. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
 2. Definition. For the purposes of this Section, "contractor" has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS, a subcontractor of ADHS/DBHS, or Children's Rehabilitative Services.
 3. Responsible entity for inpatient emergency behavioral health services.
 - a. Members enrolled with a contractor. ADHS/DBHS. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services to non-FES members with psychiatric or substance abuse diagnoses who are enrolled with the contractor.
 - b. FFS members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services for non-FES FFS members with psychiatric or substance abuse diagnoses unless services are provided in an IHS or tribally operated 638 facility.
 4. Responsible entity for non-inpatient emergency behavioral health services for non-FES members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all non-inpatient emergency behavioral health services for non-FES members.
 5. Verification. A provider of emergency behavioral health services shall verify a person's eligibility status with AHCCCS, and if eligible, determine whether the person is a member enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor, and determine whether the member is a behavioral health recipient as defined in R9-22-201.
6. Prior authorization.
 - a. Emergency behavioral health services. A provider is not required to obtain prior authorization for emergency behavioral health services.
 - b. Non-emergency behavioral health services. When a non-FES member's behavioral health condition is determined by the provider not to require emergency behavioral health services, the provider shall follow the prior authorization requirements of a contractor and ADHS/DBHS or a subcontractor of ADHS/DBHS.
 7. Prohibition against limitation or denial of payment. A contractor, TRBHA, the Administration, ADHS/DBHS, or a subcontractor of ADHS/DBHS shall not limit or deny payment to an emergency behavioral health provider for emergency behavioral health services to a non-FES member for the following reasons:
 - a. On the basis of lists of diagnoses or symptoms;
 - b. Prior authorization was not obtained;
 - c. The provider does not have a contract;
 - d. An employee of the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS instructs the member to obtain emergency behavioral health services; or
 - e. The failure of a hospital, emergency room provider, or fiscal agent to notify the member's contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS within 10 days from the day the member presented for the emergency service.
 8. Grounds for denial. A contractor, the Administration, ADHS/DBHS, or a subcontractor of ADHS/DBHS may deny payment for emergency behavioral health services for reasons including but not limited to the following:
 - a. The claim was not a clean claim;
 - b. The claim was not submitted timely; or
 - c. The provider failed to provide timely notification under subsection (A)(9) to the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS or the Administration.
 9. Notification.
 - a. A hospital, emergency room provider, or fiscal agent shall notify a contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, whichever is appropriate, no later than the 11th day from presentation of the non-FES member for emergency inpatient behavioral health services.
 - b. A hospital, emergency room provider, or fiscal agent shall notify the Administration no later than 72 hours after a FFS member receiving emergency behavioral health services presents to a hospital for inpatient services.
 10. Transfer or discharge. The attending physician or the provider actually treating the non-FES member for the emergency behavioral health condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor and ADHS/DBHS or a subcontractor of ADHS/DBHS.
- B. Post-stabilization requirements for non-FES members.**
 1. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that have been prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS.

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2. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor, ADHS/DBHS, or a subcontractor for prior authorization of further post-stabilization services;
 3. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain, improve, or resolve the member's stabilized condition if:
 - a. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, does not respond to a request for prior authorization within one hour;
 - b. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS authorized to give the prior authorization cannot be contacted; or
 - c. The representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician cannot reach an agreement concerning the member's care and the contractor's, ADHS/DBHS' or the subcontractor's physician, is not available for consultation. The treating physician may continue with care of the member until ADHS/DBHS', the contractor's, or the subcontractor's physician is reached, or:
 - i. A contracted physician with privileges at the treating hospital assumes responsibility for the member's care;
 - ii. ADHS/DBHS', a contractor's, or a subcontractor's physician assumes responsibility for the member's care through transfer;
 - iii. A representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician reach agreement concerning the member's care; or
 - iv. The member is discharged.
 - b. The transport is to the nearest appropriate provider or medical facility capable of meeting the member's medical needs, and
 - c. No prior authorization is required for reimbursement of these transports.
 3. The member's medical condition at the time of transport determines whether the transport is medically necessary.
 4. A ground or air ambulance provider furnishing transport in response to a 911 call or other emergency response system shall notify the member's contractor within 10 working days from the date of transport. Failure of the provider to provide notification is cause for denial.
 5. Notification to the Administration of emergency transportation provided to a FFS member is not required, but the provider shall submit documentation with the claim that justifies the service.
- B.** The Administration or a contractor covers air ambulance services only if at least one criterion in subsection (B)(1) is met and at least one criterion in subsection (B)(2), or the criterion in subsection (B)(3) is met. The criteria are:
1. The air ambulance transport is initiated at the request of:
 - a. An emergency response unit,
 - b. A law enforcement official,
 - c. A clinic or hospital medical staff member, or
 - d. A physician or practitioner, and
 2. The point of pickup:
 - a. Is inaccessible by ground ambulance, or
 - b. Is a great distance from the nearest hospital or other provider with appropriate facilities to treat the member's condition and ground ambulance service will not suffice, or
 3. The medical condition of the member requires immediate intervention from emergency ambulance personnel or providers with the appropriate facilities to treat the member's condition.
- C.** Coverage of medically necessary nonemergency transportation is limited to the cost of transporting the member to an appropriate provider capable of meeting the member's medical needs.
1. As specified in contract, a contractor shall arrange or provide medically necessary nonemergency transportation services for a member who is unable to arrange transportation to a service site or location.
 2. For a fee-for-service member, the Administration shall authorize medically necessary nonemergency transportation for a member who is unable to arrange transportation to a service site or location.
- D.** For the purposes of this subsection, an individual means a person who is not in the business of providing transportation services such as a family or household member, friend, or neighbor. The Administration or a contractor shall cover expenses for transportation in traveling to and returning from an approved and prior authorized health care service site provided by an individual if:
1. The transportation services are authorized by the Administration or the member's contractor or designee,
 2. The individual is an AHCCCS registered provider, and
 3. No other means of appropriate transportation is available.
- E.** The Administration or a contractor shall cover expenses for meals, lodging, and transportation for a member traveling to and returning from an approved health care service site outside of the member's service area or county of residence.
- F.** The Administration or a contractor shall cover the expense of meals, lodging, and transportation for:
1. A family member accompanying a member if:

Historical Note

New Section made by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-211. Transportation Services**A. Emergency ambulance services.**

1. A member shall receive medically necessary emergency transportation in a ground or air ambulance:
 - a. To the nearest appropriate provider or medical facility capable of meeting the member's medical needs, and
 - b. If no other appropriate means of transportation is available.
2. The Administration or a member's contractor shall reimburse a ground or air ambulance transport that originates in response to a 911 call or other emergency response system:
 - a. If the member's medical condition justifies the medical necessity of the type of ambulance transportation received,

1. The transportation services are authorized by the Administration or the member's contractor or designee,
 2. The individual is an AHCCCS registered provider, and
 3. No other means of appropriate transportation is available.
- E.** The Administration or a contractor shall cover expenses for meals, lodging, and transportation for a member traveling to and returning from an approved health care service site outside of the member's service area or county of residence.
- F.** The Administration or a contractor shall cover the expense of meals, lodging, and transportation for:
1. A family member accompanying a member if:

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- a. The member is traveling to or returning from an approved health care service site outside of the member's service area or county of residence; and
 - b. The meals, lodging, and transportation services are authorized by the Administration or the member's contractor or designee.
2. An escort who is not a family member as follows:
- a. If the member is travelling to or returning from an approved and prior authorized health care service site, including an inpatient facility, outside of the member's service area or county of residence;
 - b. If the escort services are authorized by the Administration or the member's contractor or designee; and
 - c. Wage paid to an escort as reimbursement shall not exceed the federal minimum wage.
- G.** A provider shall obtain prior authorization from the Administration for transportation services provided for a member for the following:
- 1. Medically necessary nonemergency transportation services not originated through a 911 call or other emergency response system when the distance traveled exceeds 100 miles (whether one way or round trip); and
 - 2. All meals, lodging, and services of an escort accompanying the member under this Section.
- H.** A charitable organization routinely providing transportation service at no cost to an ambulatory or chairbound person shall not charge or seek reimbursement from the Administration or a contractor for the provision of the service to a member but may enter into a subcontract with a contractor for medically necessary transportation services provided to a member.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-211 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3).

R9-22-212. Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies

- A.** Durable medical equipment, orthotic and prosthetic devices, and medical supplies, including incontinence briefs as specified in subsection (E), are covered services to the extent permitted in this Section if provided in compliance with requirements of this Chapter; and
- 1. Prescribed by the primary care provider, attending physician, or practitioner; or
 - 2. Prescribed by a specialist upon referral from the primary care provider, attending physician, or practitioner; and
 - 3. Authorized as required by the Administration, contractor, or contractor's designee.
- B.** Covered medical supplies are consumable items that are designed specifically to meet a medical purpose, are disposable, and are essential for the member's health.
- C.** Covered DME is any item, appliance, or piece of equipment that is not a prosthetic or orthotic; and
- 1. Is designed for a medical purpose, and is generally not useful to a person in the absence of an illness or injury, and
 - 2. Can withstand repeated use, and
 - 3. Is generally reusable by others.
- D.** Prosthetics are devices prescribed by a physician or other licensed practitioner to artificially replace missing, deformed or malfunctioning portion of the body. Only those prosthetics that are medically necessary for rehabilitation are covered, except as otherwise provided in R9-22-215.
- E.** The following limitations on coverage apply:
- 1. The DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the DME does not exceed the cost of the DME if purchased.
 - 2. Reasonable repair or adjustment of purchased DME is covered if necessary to make the DME serviceable and if the cost of repair or adjustment is less than the cost of renting or purchasing another unit.
 - 3. A change in, or addition to, an original order for DME is covered if approved by the prescriber in subsection (A), or prior authorized by the Administration or contractor, and the change or addition is indicated clearly on the order and initialed by the vendor. No change or addition to the original order for DME may be made after a claim for services is submitted to the member's contractor, or the Administration, without prior written notification of the change or addition to the Administration or the contractor.
 - 4. Reimbursement for rental fees shall terminate:
 - a. No later than the end of the month in which the prescriber in subsection (A) certifies that the member no longer needs the DME;
 - b. If the member is no longer eligible for AHCCCS services; or
 - c. If the member is no longer enrolled with a contractor, with the exception of transitions of care as specified in R9-22-509.
 - 5. Except for incontinence briefs for persons over 3 years old and under 21 years old as provided in subsection (E)(6), personal care items including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition. Personal care items are not covered services if used solely for preventive purposes.
 - 6. Incontinence briefs, including pull-ups are covered to prevent skin breakdown and enable participation in social, community, therapeutic and educational activities under the following circumstances:
 - a. The member is over 3 years old and under 21 years old;
 - b. The member is incontinent due to a documented disability that causes incontinence of bowel or bladder, or both;
 - c. The PCP or attending physician has issued a prescription ordering the incontinence briefs;
 - d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder;
 - e. The member obtains incontinence briefs from providers in the contractor's network;
 - f. Prior authorization has been obtained as required by the Administration, contractor, or contractor's designee. Contractors may require a new prior authorization to be issued no more frequently than every 12 months. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member

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rather than an in-person physician visit. Prior authorization will be permitted to ascertain that:

- i. The member is over age 3 and under age 21;
 - ii. The member has a disability that causes incontinence of bladder or bowel, or both;
 - iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by the contractor; and
 - iv. The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.
7. First aid supplies are not covered unless they are provided in accordance with a prescription.
 8. The following services are not covered for individuals 21 years of age or older:
 - a. Hearing aids;
 - b. Prescriptive lenses unless they are the sole visual prosthetic device used by the member after a cataract extraction;
 - c. Bone Anchor Hearing Aid (BAHA);
 - d. Cochlear implant;
 - e. Percussive vest;
 - f. Insulin pump;
 - g. Microprocessor-controlled lower limbs or microprocessor-controlled joints for lower limbs; and
 - h. Orthotics, which are defined as devices that are prescribed by a physician or other licensed practitioner of the healing arts to support a weak or deformed portion of the body.
- F. Liability and ownership.**
1. Purchased DME that is provided to a member and no longer needed by the member may be disposed of in accordance with each contractor's policy.
 2. The Administration shall retain title to purchased DME provided to a member who becomes ineligible or no longer requires use of the DME.
 3. If customized DME is purchased by the Administration or contractor for a member, the equipment shall remain with the person during times of transition to a different contractor, or upon loss of eligibility. For purposes of this subsection, customized DME refers to equipment that is altered or built to specifications unique to a member's medical needs and that, most likely, cannot be used or reused to meet the needs of another individual.
 4. A member shall return DME obtained fraudulently to the Administration or the contractor.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-212 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-212 repealed, new Section R9-22-212 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (2), and deleted subsection (C) effective October 1, 1986 (Supp. 86-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3272, effective September 11, 2007

(Supp. 07-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3).

R9-22-213. Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)

- A.** The following E.P.S.D.T. services are covered for a member less than 21 years of age:
1. Screening services including:
 - a. Comprehensive health and developmental history;
 - b. Comprehensive unclothed physical examination;
 - c. Appropriate immunizations according to age and health history;
 - d. Laboratory tests; and
 - e. Health education, including anticipatory guidance;
 2. Vision services including:
 - a. Diagnosis and treatment for defects in vision;
 - b. Eye examinations for the provision of prescriptive lenses;
 - c. Prescriptive lenses; and
 - d. Frames.
 3. Hearing services including:
 - a. Diagnosis and treatment for defects in hearing;
 - b. Testing to determine hearing impairment; and
 - c. Hearing aids;
 4. Dental services including:
 - a. Emergency dental services as specified in R9-22-207;
 - b. Preventive services including screening, diagnosis, and treatment of dental disease; and
 - c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
 5. Orthognathic surgery;
 6. Medically necessary, nutritional assessment and nutritional therapy as specified in contract to provide complete daily dietary requirements or supplement a member's daily nutritional and caloric intake;
 7. Behavioral health services under 9 A.A.C. 22, Article 12;
 8. Hospice services do not include home-delivered meals or services provided and covered through Medicare. The following hospice services are covered:
 - a. Hospice services are covered only for a member who is in the final stages of a terminal illness and has a prognosis of death within six months;
 - b. Services available to a member receiving hospice care are limited to those allowable under 42 CFR 418.202, October 1, 2006, incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments;
 9. Incontinence briefs as specified under R9-22-212; and
 10. Other necessary health care, diagnostic services, treatment, and measures required by 42 U.S.C. 1396d(r)(5).
- B.** Providers of E.P.S.D.T. services shall meet the following standards:
1. Ensure that services are provided by or under the direction of the member's primary care provider, attending physician, practitioner, or dentist.
 2. Perform tests and examinations under 42 CFR 441 Subpart B, October 1, 2006, which is incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments.
 3. Refer a member as necessary for dental diagnosis and treatment and necessary specialty care.
 4. Refer a member as necessary for behavioral health evaluation and treatment services.

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- C. Contractors shall meet other E.P.S.D.T. requirements as specified in contract.
- D. A primary care provider, attending physician, or practitioner shall refer a member with special health care needs under R9-7-301 to CRS.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-213 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-213 repealed, new Section R9-22-213 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3272, effective September 11, 2007 (Supp. 07-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

R9-22-214. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-214 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-214 repealed, new Section R9-22-214 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (4) and added subsection (C), paragraph (2) effective October 1, 1986 (Supp. 86-5). Correction to subsection (C), paragraph (2) (Supp. 87-4). Section repealed effective September 22, 1997 (Supp. 97-3).

R9-22-215. Other Medical Professional Services

- A. The following medical professional services are covered services if a member receives these services in an inpatient, outpatient, or office:
1. Dialysis;
 2. The following family planning services if provided to delay or prevent pregnancy:
 - a. Medications,
 - b. Supplies,
 - c. Devices, and
 - d. Surgical procedures;
 3. Family planning services are limited to:
 - a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
 - b. Sterilization; and
 - c. Natural family planning education or referral;
 4. Midwifery services provided by a certified nurse practitioner in midwifery;
 5. Midwifery services for low-risk pregnancies and home deliveries provided by a licensed midwife;
 6. Respiratory therapy;
 7. Ambulatory and outpatient surgery facilities services;
 8. Home health services under A.R.S. § 36-2907(D);
 9. Private or special duty nursing services;

10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology within limitations in subsection (C);
 11. Total parenteral nutrition services, which are the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract; and
 12. Chemotherapy.
- B. Prior authorization from the Administration for a member is required for services listed in subsections (A)(3)(b), and (A)(4) through (11); except for:
1. Voluntary sterilization;
 2. Dialysis shunt placement;
 3. Arteriovenous graft placement for dialysis;
 4. Angioplasties or thrombectomies of dialysis shunts;
 5. Angioplasties or thrombectomies of arteriovenous grafts for dialysis;
 6. Eye surgery for the treatment of diabetic retinopathy;
 7. Eye surgery for the treatment of glaucoma;
 8. Eye surgery for the treatment of macular degeneration;
 9. Home health visits following an acute hospitalization (limited up to five visits);
 10. Hysteroscopies (up to two, one before and one after) when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization;
 11. Physical therapy subject to the limitation in subsection (C);
 12. Facility services related to wound debridement,
 13. Apnea management and training for premature babies up to the age of 1; and
 14. Other services identified by the Administration through the Provider Participation Agreement.
- C. The following are not covered services:
1. Occupational and speech therapies provided on an outpatient basis for a member age 21 or older;
 2. Abortion counseling;
 3. Services or items furnished solely for cosmetic purposes;
 4. Services provided by a podiatrist; or
 5. More than 15 outpatient physical therapy visits per benefit year for persons age 21 years or older for the purpose of restoring a skill or level of function and maintaining that skill or level of function once restored.
 6. More than 15 outpatient physical therapy visits per benefit year for persons age 21 years or older for the purpose of acquiring a new skill or a new level of function and maintaining that skill or level of function once acquired.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-215 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

R9-22-216. NF, Alternative HCBS Setting, or HCBS

- A. Services provided in a NF, including room and board, an alternative HCBS setting as defined in R9-28-101, or a HCBS as

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defined in A.R.S. § 36-2939 are covered for a maximum of 90 days per contract year if the member's medical condition would otherwise require hospitalization.

- B.** Except as otherwise provided in 9 A.A.C. 28, the following services are not itemized for separate billing if provided in a NF, alternative HCBS setting, or HCBS:
1. Nursing services, including:
 - a. Administering medication;
 - b. Tube feedings;
 - c. Personal care services, including but not limited to assistance with bathing and grooming;
 - d. Routine testing of vital signs; and
 - e. Maintenance of a catheter;
 2. Basic patient care equipment and sickroom supplies, including:
 - a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over-the-counter remedies;
 - b. Bathing and grooming supplies;
 - c. Identification device;
 - d. Skin lotion;
 - e. Medication cup;
 - f. Alcohol wipes, cotton balls, and cotton rolls;
 - g. Rubber gloves (non-sterile);
 - h. Laxatives;
 - i. Bed and accessories;
 - j. Thermometer;
 - k. Ice bags;
 - l. Rubber sheeting;
 - m. Passive restraints;
 - n. Glycerin swabs;
 - o. Facial tissue;
 - p. Enemas;
 - q. Heating pad; and
 - r. Incontinence briefs.
 3. Dietary services including preparation and administration of special diets, and adaptive tools for eating;
 4. Any service that is included in a NF's room and board charge or a service that is required of the NF to meet a federal or state licensure standard or county certification requirement;
 5. Physician visits made solely for the purpose of meeting state licensure standards or county certification requirements;
 6. Physical therapy prescribed only as a maintenance regimen; and
 7. Assistive devices and non-customized durable medical equipment.
- C.** A provider shall obtain prior authorization from the Administration for a NF admission for a FFS member.

Historical Note

Adopted effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Subsection (C) amended to correct a typographical error (Supp. 00-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3272, effective September 11, 2007 (Supp. 07-3). Amended by final rulemaking at 13 A.A.R. 4122, effective November 6, 2007 (Supp. 07-4).

R9-22-217. Services Included in the Federal Emergency Services Program

- A.** Definition. Notwithstanding the definition in R9-22-201, for the purposes of this Section, an emergency medical or behav-

ioral health condition for a FES member means a medical condition or a behavioral health condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the member's health in serious jeopardy,
 2. Serious impairment to bodily functions,
 3. Serious dysfunction of any bodily organ or part, or
 4. Serious physical harm to another person.
- B.** Services. "Emergency services for a FES member" mean those medical or behavioral health services provided for the treatment of an emergency condition. Emergency services include outpatient dialysis services for a FES member with End Stage Renal Disease (ESRD) where a treating physician has certified for the month in which services are received that in the physician's opinion the absence of receiving dialysis at least three times per week would reasonably be expected to result in:
1. Placing the member's health in serious jeopardy, or
 2. Serious impairment of bodily function, or
 3. Serious dysfunction of a bodily organ or part.
- C.** Covered services. Services are considered emergency services if all of the criteria specified in subsection (A) are satisfied at the time the services are rendered. The Administration shall determine whether an emergency condition exists on a case-by-case basis.
- D.** Prior authorization. A provider is not required to obtain prior authorization for emergency services for FES members. Prior authorization for outpatient dialysis services is met when the treating physician has completed and signed a monthly certification as described in subsection (B).
- E.** Services rendered through the Federal Emergency Services Program are subject to all exclusions and limitation on services in this Article including but not limited to the limitations on inpatient hospital services in R9-22-204.

Historical Note

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1868, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-218. Repealed**Historical Note**

Section R9-22-218 renumbered from R9-22-206 effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Section repealed effective September 22, 1997 (Supp. 97-3).

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ARTICLE 3. GENERAL ELIGIBILITY REQUIREMENTS**R9-22-301. Reserved****Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-301 renumbered together with former Section R9-22-102 as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). New Section R9-22-301 adopted effective November 20, 1984 (Supp. 84-6).

Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (8), subsection (E), paragraph (3), and subsection (J), paragraph (5) effective October 1, 1986 (Supp. 86-5). Amended subsections (C) and (E) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B) and (C) effective October 1, 1987; amended subsection (D) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section reserved by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

R9-22-302. Reserved**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-302 repealed, new Section R9-22-302 adopted effective November 20, 1984 (Supp. 84-6). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section reserved by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

R9-22-303. Prior Quarter Eligibility

- A.** Subject to CMS approval, prior quarter coverage eligibility shall be limited to applicants who meet the requirements in subsection (B) and who also:
1. Are eligible during any of the three months prior to application; and
 2. Received one or more covered services described in 9 A.A.C. 22, Article 2 and Article 12, and 9 A.A.C. 28, Article 2 during the month; and
 3. Would have qualified for Medicaid at the time services were received if the person had applied regardless of whether the person is alive when the application is made.
- B.** Prior quarter coverage eligibility is limited to applicants who are:
1. Under the age of 19, or
 2. Pregnant, or
 3. In the 60 day post-partum period beginning with the last day of the pregnancy.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-303 repealed, new Section R9-22-303 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999

(Supp. 99-1). New Section made by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 1849, with an immediate effective date of July 1, 2019 (Supp. 19-3).

R9-22-304. Verification of Eligibility Information

- A.** Except as provided in subsection (E), if information provided by or on behalf of an applicant or member on an application, renewal form or otherwise does not conflict with information obtained by the agency through an electronic data match, the Administration or its designee shall determine or renew eligibility based on such information.
- B.** The Administration or its designee shall not require an applicant, member, or representative to provide additional verification unless the verification cannot be obtained electronically or the verification obtained electronically conflicts with information provided by or on behalf of the applicant or member.
- C.** If information provided by or on behalf of an applicant or member does conflict with information obtained through an electronic data match, the applicant or member shall provide the Administration or its designee with information or documentation necessary to verify eligibility, including evidence originating from an agency, organization, or an individual with actual knowledge of the information.
- D.** Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both meet or both exceed the applicable income limit.
- E.** The Administration or its designee shall not accept the applicant's or member's statement by itself as verification of:
1. SSN;
 2. Qualified alien status, except as described under 42 USC 1320b-7(d)(4)(A); or
 3. Citizenship, except as described under 42 USC 1396a(ee)(1).
- F.** The Administration or its designee shall give an applicant or member at least 10 days from the date of a written or electronic request for information to provide required verification. The Administration or its designee may deny the application or discontinue eligibility if an applicant or a member does not provide the required information timely.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-304 repealed, new Section R9-22-304 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-304 made by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-305. Eligibility Requirements

As a condition of eligibility, the Administration or its designee must require applicants, and members to do the following:

1. Take all necessary steps to obtain any annuities, pensions, retirement, disability benefits to which they are entitled, unless they can show good cause for not doing so.
2. Furnish a SSN under 42 CFR 435.910 and 435.920, or in the absence of an SSN, provide proof of a submitted application of SSN. The Administration or its designee will assist in obtaining or verifying the applicant's SSN under 42 CFR 435.910 if an applicant cannot recall the applicant's SSN or has not been issued a SSN. An applicant is not required to furnish an SSN if the applicant is not able to legally obtain a SSN. The Administration or its designee shall determine eligibility notwithstanding the applicant's lack of a SSN, if the applicant is cooperat-

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- ing with the Administration or its designee to obtain a SSN and obtain a SSN prior to the next scheduled review of eligibility.
3. Provide proof of residency of Arizona. An applicant or a member is not eligible unless the applicant or member is a resident of Arizona under 42 CFR 435.403 effective October 1, 2012, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
 4. A written declaration, signed under penalty of perjury, must be provided for each person for whom benefits are being sought stating whether the individual is a citizen or national of the United States, and, if that individual is not a citizen or national of the United States, that the individual is a qualified alien. The declaration must be provided by the individual for whom eligibility is being sought or an adult member of the individual's family or household.
 5. Each applicant who claims qualified alien status must provide either:
 - a. Alien registration documentation or other proof of immigration registration from the Immigration and Naturalization Service that contains the individual's alien admission number or alien file number (or numbers if the individual has more than one number), or
 - b. Other documents that the Administration or its designee accepts as evidence of immigration status, such as:
 - i. a Form I-94 Departure Record issued by the USCIS,
 - ii. a Foreign Passport,
 - iii. a USCIS Parole Notice,
 - iv. a Victim of Trafficking Certification or Eligibility Letter issued by the US DHHS Office of Refugee Resettlement,
 - v. other documentation consistent with 42 CFR 435.406 or 435.407.
 - c. Sufficient information for the Administration or its designee to obtain electronic verification of immigration status from the USCIS.
 6. If a person for whom eligibility is being sought, states that they are an alien, that person is not required to comply with subsections (4) and (5); however, if they do not comply with those sections, and if they meet all other eligibility criteria, benefits will be limited to those necessary to treat an emergency medical condition.
1. The Administration or its designee shall determine eligibility within 90 days for an applicant applying on the basis of disability and 45 days for all other applicants, unless:
 - a. The agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action, or
 - b. When there is an administrative or other emergency beyond the agency's control.
 2. If an applicant dies while an application is pending, the Administration or its designee shall complete an eligibility determination for the deceased applicant.
 3. The Administration or its designee shall complete an eligibility determination on an application filed on behalf of a deceased applicant.
 4. During the application process the Administration or its designee shall provide information to the applicant or member explaining the requirements to:
 - a. Cooperate with DCSS in establishing paternity and enforcing medical support, except in circumstances when good cause under 42 CFR 433.147 exists for not cooperating;
 - b. Establish good cause for not cooperating with DCSS in establishing paternity and enforcing medical support, when applicable;
 - c. Report a change listed under subsection (B)(3)(c) no later than 10 days from the date the applicant or member knows of the change;
 - d. Send to the Administration or its designee any medical support payments resulting from a court order;
 - e. Cooperate with the Administration or its designee's assignment of rights and securing payments received from any liable party for a member's medical care.
 5. Offer to help the applicant or member to complete the application form and to obtain the required verification;
 6. Provide the applicant or member with information explaining:
 - a. The eligibility and verification requirements for AHCCCS medical coverage;
 - b. The requirement that the applicant or member obtain and provide a SSN to the Administration or its designee;
 - c. How the Administration or its designee uses the SSN;
 7. Explain to the applicant or member the practice of exchange of eligibility and income information through the electronic service established by the Secretary;
 8. Explain to the applicant and member the right to appeal an adverse action under R9-22-315;
 9. Use any information provided by the member to complete data matches with potentially liable parties;
 10. Explain the eligibility review process;
 11. Explain the AHCCCS pre-enrollment process;
 12. Use the Systematic Alien Verification for Entitlements (SAVE) process to verify qualified alien status;
 13. Provide information regarding the penalties for perjury and fraud on the application;
 14. Review any verification items provided by the applicant or member and inform the member of any additional verification items and time-frames within which the applicant or member shall provide information to the Administration or its designee;
 15. Explain to the applicant or member the applicant's and member's responsibilities under subsection (B);
 16. Transfer the applicant's information to other insurance affordability programs as described under 42 CFR

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-305 repealed, new Section R9-22-305 adopted effective November 20, 1984 (Supp. 84-6). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-305 made by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-306. Administration, Administration's designee or Member Responsibilities

- A. The Administration or its designee is responsible for the following:

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- 435.1200(e) when the applicant does not qualify for Medicaid;
17. Attain a written record of a collateral contact: such as a verbal statement from a representative of an agency or organization, or an individual with actual knowledge of the information;
 18. Complete a review of eligibility:
 - a. Any time there is a change in a member's circumstance that may affect eligibility,
 - b. For a member approved for the MED program under R9-22-1435 through R9-22-1440 before the end of the six-month eligibility period,
 - c. Of each member's continued eligibility for AHCCCS medical coverage once every 12 months;
 19. The Administration or its designee shall discontinue eligibility and notify the member of the discontinuance under R9-22-307 if the member:
 - a. Fails to comply with the review of eligibility,
 - b. Fails to comply under 42 CFR 433.148 with the requirements and conditions of eligibility under this Article regarding assignment of rights and cooperation of establishing paternity and obtaining medical support, or
 - c. Does not meet the eligibility requirements; and
 20. Redetermine eligibility for a person terminated from the SSI cash program.
 - a. Continuation of AHCCCS medical coverage. The Administration shall continue AHCCCS medical coverage for a person terminated from the SSI cash program until a redetermination of eligibility is completed.
 - b. Coverage group screening. Before terminating a person from the SSI cash program, the Administration shall determine if the person is eligible for coverage as a person described in A.R.S. §§ 36-2901(6)(a)(i) through (vi) or 36-2934.
 - c. Eligibility decision.
 - i. If a person is eligible under this Article or 9 A.A.C. 28, Article 4, the Administration shall send a notice informing the applicant that AHCCCS medical coverage is approved.
 - ii. If a person is ineligible, the Administration shall send a notice to deny AHCCCS medical coverage.
- B. Applicant and Member Responsibilities.**
1. An applicant or a member shall authorize the Administration or its designee to obtain verification for initial eligibility or continuation of eligibility.
 2. As a condition of eligibility, an applicant or a member shall:
 - a. Provide the Administration or its designee with complete and truthful information. The Administration or its designee may deny an application or discontinue eligibility if:
 - i. The applicant or member fails to provide information necessary for initial or continuing eligibility;
 - ii. The applicant or member fails to provide the Administration or its designee with written authorization or electronic authorization to permit the Administration or its designee to obtain necessary initial or continuing eligibility verification;
 - iii. The applicant or member fails to provide verification under R9-22-304 after the Administration or its designee made an effort to obtain the necessary verification but has not obtained the necessary information; or
 - iv. The applicant or member does not assist the Administration or its designee in resolving incomplete, inconsistent, or unclear information that is necessary for initial or continuing eligibility;
 - b. Cooperate with the Division of Child Support Services (DCSS) in establishing paternity and enforcing medical support obligations when requested unless good cause exists for not cooperating under 42 CFR 433.147 as of October 1, 2012, which is incorporated by reference, on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol St., NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments. The Administration or its designee shall not deny AHCCCS eligibility to an applicant who would otherwise be eligible, is a minor child, and whose parent or legal representative does not cooperate with the medical support requirements or first- and third-party liability requirements under Article 10 of this Chapter; and
 - c. Provide the information needed to pursue third party coverage for medical care, such as:
 - i. Name of policyholder,
 - ii. Policyholder's relationship to the applicant or member,
 - iii. Name and address of the insurance company, and
 - iv. Policy number.
3. A member or an applicant shall:
 - a. Send to the Administration or its designee any medical support payments received while the member is eligible that result from a medical support order;
 - b. Cooperate with the Administration or its designee regarding any issues arising as a result of Eligibility Quality Control described under A.R.S. § 36-2903.01; and
 - c. Inform the Administration or its designee of the following changes within 10 days from the date the applicant or member knows of a change:
 - i. In address;
 - ii. In the household's composition;
 - iii. In income;
 - iv. In resources, when required under the Medical Expense Deduction (MED) program;
 - v. In Arizona state residency;
 - vi. In citizenship or immigrant status;
 - vii. In first- or third-party liability that may contribute to the payment of all or a portion of the person's medical costs;
 - viii. That may affect the member's or applicant's eligibility, including a change in a woman's pregnancy status;
 - ix. Death;
 - x. Change in marital status; or
 - xi. Change in school attendance.
 4. As a condition of eligibility, an applicant or a member shall cooperate with the assignment of rights as required by R9-22-311. If the applicant or member receives medical care and services for which a first or third party is or may be liable, the applicant or member shall cooperate

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with the Administration or its designee in assisting, identifying and providing information to assist the Administration or its designee in pursuing any first or third party who is or may be liable to pay for medical care and services.

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

C. Administration or its designee responsibilities at Eligibility Renewal.

1. The Administration or its designee shall renew eligibility without requiring information from the individual if able to do so based on reliable information available to the agency, including through an electronic data match. If able to renew eligibility based on such information, the Administration or its designee shall send the member notice of:
 - a. The eligibility determination; and
 - b. The member's requirement to notify the Administration or its designee if any of the information contained in the renewal notice is inaccurate.
2. If unable to renew eligibility, the Administration or its designee shall:
 - a. Send a pre-populated renewal form listing the information needed to renew eligibility,
 - b. Give the member 30 days from the date of the renewal form to submit the signed renewal form and the information needed,
 - c. Send the member notice of the renewal decision under R9-22-312 or R9-22-1413(B) as applicable.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-306 repealed, new Section R9-22-306 adopted effective November 20, 1984 (Supp. 84-6).

Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraphs (1) and (6) effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (1) and added a new subsection (N) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6).

Amended subsection (B) effective October 1, 1987; amended subsection (N) effective December 22, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-306 made by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-307. Approval or Denial of Eligibility

- A. Approval.** If the applicant meets all the eligibility requirements and conditions of eligibility of this Article, the Administration or its designee shall approve the application and provide the applicant with an approval notice. The approval notice shall contain:
1. The name of each approved applicant,
 2. The effective date of eligibility for each approved applicant,
 3. The reason and the legal citations if a member is approved for only emergency medical services, and
 4. The applicant's right to appeal the decision.

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

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsections (A) and (C), added subsection (G) and (H) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-307 repealed, new Section R9-22-307 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) as an emergency effective December 4, 1985 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 85-6). Permanent amendment to subsection (A) effective February 5, 1986 (Supp. 86-1). Amended subsections (E) and (F) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-307 made by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-308. Reinstating Eligibility

The Administration or its designee shall reopen an application or reinstate eligibility of a member when any of the following conditions are met:

1. The denial or discontinuance of eligibility was due to an administrative error,
2. The discontinuance of eligibility was due to noncompliance with a condition of eligibility and the applicant or member complies prior to the effective date of the discontinuance,
3. The member informs the Administration or its designee of a change of circumstances prior to the effective date of the discontinuance, that would allow for continued eligibility, or
4. Following a discontinuance, the member qualifies for continuation of medical coverage pending an appeal.

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Adopted effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended by adding subsection (C) effective March 2, 1984 (Supp. 84-2). Former Section R9-22-308 repealed, new Section R9-22-308 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-308 made by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-309. Confidentiality and Safeguarding of Information

The Administration or its designee shall maintain the confidentiality of an applicant or member's records and limit the release of safeguarded information under R9-22-512 and 6 A.A.C. 12, Article 1. In the event of a conflict between R9-22-512 and 6 A.A.C. 12, Article 1, R9-22-512 prevails.

Historical Note

Adopted effective August 30, 1984 (Supp. 82-4). Amended (D)(1)(d) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-309 repealed, new Section R9-22-309 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (F) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (A), (B) and (C) effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-309 made by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-310. Ineligible Person

A person is not eligible for AHCCCS medical coverage if the person is:

1. An inmate of a public institution, or
2. Over age 64 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except as allowed in 42 USC 1396d(h) or as allowed under the Administration's Section 1115 waiver.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended (B)(7) and added subsections (C) and (D) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-310 repealed, new Section R9-22-310 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) and deleted subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (7) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective May 30,

1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-310 made by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-311. Assignment of Rights Under Operation of Law

By operation of law and under A.R.S. § 36-2903, a person determined eligible assigns rights to the system medical benefits to which the person is entitled.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-311 repealed, new Section R9-22-311 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-311 made by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-312. Member Notices

- A.** Contents of notice. The Administration or its designee shall issue a notice by mail, personal delivery, or electronic means when an action is taken regarding a person's eligibility or premiums. The notice shall contain the following information:
1. The date of the notice issued;
 2. A statement of the action being taken;
 3. The effective date of the action;
 4. The specific reason for the intended action;
 5. If eligibility is being discontinued due to income in excess of the income standards, the actual figures used in the eligibility determination and the amount by which the person exceeds income standards;
 6. If a premium is imposed or increased, the actual figures used in determining the premium amount;
 7. The specific law or regulation that supports the action, or a change in federal or state law that requires an action;
 8. An explanation of the member's rights to an appeal and continued benefits.
- B.** Advance notice of changes in eligibility or premiums. "Advance notice" means a notice that is issued to a person at least 10 days before the effective date of the change. Except as specified in subsection (C), advance notice shall be issued whenever the following adverse action is taken:
1. To discontinue or suspend or reduce eligibility or covered services; or
 2. To impose a premium or increase a person's premium.
- C.** The Administration or its designee shall issue a Notice of Adverse Action to a member no later than the effective date of action if:
1. The Administration or its designee receives a request to withdraw;
 2. A person provides information that requires termination of eligibility or an increase or imposition of the premium and the person signs a clear written statement waiving advance notice;
 3. A person cannot be located and mail sent to that person has been returned as undeliverable;
 4. A person has been admitted to a public institution where the person is ineligible under R9-22-310;

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5. A person has been approved for Medicaid or CHIP in another state; or
6. The Administration or its designee has information that confirms the death of the person.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsections (A) and (B), added subsection (D) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-312 repealed, new Section R9-22-312 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-312 made by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-313. Withdrawal of Application

- A. An applicant may withdraw an application at any time before the Administration or its designee completes an eligibility determination by making an oral or written request for withdrawal to the Administration or its designee and stating the reason for withdrawal.
- B. If an applicant orally requests withdrawal of the application, the Administration or its designee shall document the:
 1. Date of the request,
 2. Name of the applicant for whom the withdrawal applies, and
 3. Reason for the withdrawal.
- C. An applicant may withdraw an application in writing by:
 1. Completing an Administration-approved voluntary withdrawal form; or
 2. Submitting a written, signed, and dated request to withdraw the application.
- D. The effective date of the withdrawal is the date of the application.
- E. If an applicant requests to withdraw an application, the Administration or its designee shall:
 1. Deny the application, and
 2. Notify the applicant of the denial following the notice requirements under R9-22-307.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended subsections (C) and (D) as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended subsections (D) and (E) as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-313 repealed, new Section R9-22-313 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsections (B), (C), (E) and (G) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B) and (C) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September

29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-313 made by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-314. Withdrawal from AHCCCS Medical Coverage

- A. A member may withdraw from AHCCCS medical coverage at any time by giving oral or written notice of withdrawal to the Administration or its designee. The member or the member's legal or authorized representative shall provide the Administration or its designee with:
 1. The reason for the withdrawal,
 2. The date the notice is effective, and
 3. The name of the member for whom AHCCCS medical coverage is being withdrawn.
- B. If a notice of withdrawal does not identify specific members the Administration or its designee shall discontinue eligibility for any members that the person submitting the withdrawal has legal authority to act on behalf of.
- C. The Administration or its designee shall notify the member of the discontinuance as required by R9-22-312.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsection (A) and added subsection (F) as an emergency effective February 28, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended subsection (A) and added subsection (F) as a permanent rule effective May 16, 1983; text of the amended rule identical to the emergency (Supp. 83-3). Former Section R9-22-314 repealed, new Section R9-22-314 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-314 made by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-315. Notice of Adverse Action

- A. Adverse actions. An applicant or member may appeal, as described under Chapter 34, by requesting a hearing from the Administration or its designee concerning any of the following adverse actions:
 1. Complete or partial denial of eligibility under R9-22-307 and R9-22-313(E);
 2. Suspension, termination, or reduction of AHCCCS medical coverage under R9-22-307, R9-22-312 and R9-22-314;
 3. Delay in the eligibility determination beyond the timeframes under this Article;
 4. The imposition of or increase in a premium or copayment; or
 5. The effective date of eligibility.
- B. Notice of Adverse Action. The Administration or its designee shall personally deliver or send, by mail, or electronic means a Notice of Adverse Action to the person affected by the action.

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For the purpose of this Section, the date of the Notice of Adverse Action shall be the date of personal delivery to the applicant or the postmark date, if mailed.

- C. Automatic change and hearing rights.
1. An applicant or a member is not entitled to a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.
 2. An applicant or a member is entitled to a hearing if a federal or state law requires an automatic change and the applicant or member timely files an appeal that alleges a misapplication of the facts to the law.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-315 repealed, new Section R9-22-315 adopted effective November 20, 1984 (Supp. 84-6). Repealed effective October 1, 1985 (Supp. 85-5). New Section R9-22-315 adopted effective February 5, 1986 (Supp. 86-1). Amended effective February 26, 1988 (Supp. 88-1). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-315 made by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-316. Exemptions from Sponsor Deemed Income

- A. An applicant shall provide proof to the Administration or its designee when claiming an exemption from sponsor deemed income.
- B. The Administration or its designee shall grant an exemption from deeming a sponsor's income for a Lawful Permanent Resident applicant if the applicant:
1. Adjusted immigration status to Lawful Permanent Resident from status as a refugee or asylee;
 2. Is the spouse or dependent child of the sponsor and lives with the sponsor;
 3. Is indigent as specified in subsection (C);
 4. Is a victim of domestic violence or extreme cruelty as specified in subsection (D); or
 5. Has acquired 40 qualified quarters of work credit based on earnings as specified in subsection (E).
- C. Exemption from sponsor deeming based on indigence.
1. The Administration or its designee shall consider the applicant indigent and grant an exemption from sponsor deemed income for an applicant, for a period of 12 months beginning with the first month of eligibility if all the following are met:
 - a. An applicant is indigent if all of the following are met:
 - i. The applicant does not reside with the applicant's sponsor;
 - ii. The applicant does not receive free room and board; and
 - iii. The applicant's total gross income including monies received from the sponsor and the value of any vendor payments received for food, utilities, or shelter does not exceed 100% of the FPL for the size of the income group.
 2. The Administration or its designee shall send a notice under 8 U.S.C. 1631(e)(2) to the Attorney General's Office when approving an applicant who is exempt from sponsor deemed income due to indigence.
- D. The Administration or its designee shall grant an exemption from sponsor deemed income for an applicant who is a victim

of domestic violence or extreme cruelty under 8 CFR 204.2 for a period of 12 months beginning with the first month of eligibility. The Administration or its designee shall redetermine the exemption status at each renewal.

1. The Administration or its designee considers an applicant to be a victim of domestic violence or extreme cruelty when all of the following are met:
 - a. The applicant is the victim, the parent of a child victim, or the child of a parent victim;
 - b. The perpetrator of the domestic violence or extreme cruelty was the spouse or parent of the victim or other family member related by blood, marriage or adoption to the victim;
 - c. The perpetrator was residing in the same household as the victim when the abuse occurred;
 - d. The abuse occurred in the United States;
 - e. The applicant did not participate in the domestic violence or cruelty; and
 - f. The victim does not currently live with the perpetrator.
 2. The applicant shall provide proof that the applicant or the applicant's child is a victim of domestic violence or extreme cruelty by presenting one of the following:
 - a. USCIS form I-360 Petition for Amerasian, Widow, or Special Immigrant;
 - b. USCIS form I-797 USCIS approval of the I-360 petition;
 - c. Reports or affidavits concerning the domestic violence or cruelty documented by police, judges, or other court officials, medical personnel, school officials, clergy, social workers, counseling or mental health personnel, or other social service agency personnel;
 - d. Legal documentation, such as an order of protection against the perpetrator or an order convicting the perpetrator of committing an act of domestic violence or extreme cruelty that chronicles the existence of domestic violence or extreme cruelty;
 - e. Evidence that indicates that the applicant sought safe haven in a battered women's shelter or similar refuge because of the domestic violence or extreme cruelty against the applicant or the applicant's child; or
 - f. Photographs of the applicant or applicant's child showing visible injury.
- E. The Administration or its designee shall grant an exemption from sponsor deemed income for an applicant who has reached 40 qualifying quarters of work credit.
1. The Administration or its designee shall not count quarters credited after January 1, 1997 that were earned while the applicant was receiving any federal means-tested benefits.
 2. The Administration or its designee shall not count the 40 qualifying quarters of work credit unless the credited quarters are:
 - a. Quarters that the applicant worked;
 - b. Quarters worked by the applicant's spouse or deceased spouse during their marriage; or
 - c. Quarters worked by the applicant's parents when the applicant was under age 18.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as an emergency effective February 9, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Former Section R9-22-316 repealed, new Section

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R9-22-316 adopted as a permanent rule effective May 16, 1983; text of permanent rule identical to the emergency (Supp. 83-3). Amended effective October 1, 1983 (Supp. 83-5). Correction subsection (A), paragraph (1) amended effective October 1, 1983, (Supp. 83-6). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-316 repealed, new Section R9-22-316 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective October 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-316 made by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-317. Sponsor Deemed Income

- A. The Administration or its designee shall use income of a USCIS sponsor to determine eligibility for a non-citizen applicant, whether or not the income is available, to the non-citizen applicant unless exempt under R9-22-316.
- B. Counting the income from a sponsor.
 1. This Section applies to non-citizen applicants who:
 - a. Are Lawful Permanent Residents under 8 CFR 101.3;
 - b. Applied for Lawful Permanent Resident Status on or after December 19, 1997;
 - c. Are sponsored by an individual who signed a USCIS I-864 Affidavit of Support; and
 - d. Are eligible for full AHCCCS medical coverage.
 2. Sponsor deemed income shall be considered the income of the non-citizen applicant only.
 3. The Administration or its designee shall not use the provisions of this Section when:
 - a. The applicant becomes a naturalized U.S. citizen;
 - b. The applicant qualifies for an exemption listed in R9-22-316; or
 - c. The sponsor dies.
- C. Determining income from a sponsor.
 1. For an applicant who is exempt from sponsor deeming under R9-22-316, only cash contributions actually received from the sponsor are countable income to the applicant.
 2. For an applicant to whom the sponsor's income is deemed, the Administration or its designee shall exclude any cash contributions received from the sponsor.
- D. Calculation of income from a sponsor.
 1. The Administration or its designee shall include the total gross income of the sponsor and the sponsor's spouse, when living with the sponsor;
 2. The Administration or its designee shall subtract an amount equal to 100% of the FPL for the sponsor's household size from the total gross income under (D)(1); and
 3. The amount calculated under subsection (D)(2) is deemed as income to the applicant for purposes of determining eligibility.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-317 repealed, new Section R9-22-317 adopted effective November 20, 1984 (Supp. 84-6).

Amended effective October 1, 1986 (Supp. 86-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-317 made by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-318. Repealed**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-318 repealed, new Section R9-22-318 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) and added subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective October 1, 1987; amended subsection (A) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective December 13, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-319. Repealed**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-319 repealed, new Section R9-22-319 adopted effective November 20, 1984 (Supp. 84-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-320. Repealed**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-320 repealed, new Section R9-22-320 adopted effective November 20, 1984 (Supp. 84-6). Amended effective April 13, 1990 (Supp. 90-2). Repealed effective December 13, 1993 (Supp. 93-4).

R9-22-321. Repealed**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-321 repealed, new Section R9-22-321 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (B) through (E) effective October

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1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987 (Supp. 87-4). Amended subsections (B) and (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-322. Repealed**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective May 27, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-3). Former Section R9-22-322 repealed, new Section R9-22-322 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-322 repealed, new Section R9-22-322 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective September 29, 1992 (Supp. 92-3). Amended December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-323. Repealed**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-323 repealed, new Section R9-22-323 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-323 repealed, new Section R9-22-323 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (B) through (D) effective October 1, 1986 (Supp. 86-5). Amended subsections (A), (B) and (D) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B), (D) and (E) effective October 1, 1987 (Supp. 87-4). Amended subsections (B) and (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-324. Repealed**Historical Note**

Adopted as an emergency effective July 27, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-4). Former Section R9-22-324 adopted as an emergency renumbered as Section R9-22-327. New Section R9-22-324 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-324 repealed, former Section R9-22-

323 renumbered as Section R9-22-324 and adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Former Section R9-22-324 repealed, new Section R9-22-324 adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-324 repealed, new Section R9-22-324 adopted effective November 20, 1984 (Supp. 84-6). Change in heading only effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-325. Repealed**Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-325 repealed, new Section R9-22-325 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-326. Repealed**Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-326 repealed, new Section R9-22-326 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Change in heading only effective October 1, 1987 (Supp. 87-4). Amended subsection (A) effective May 30, 1989 (Supp. 89-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-327. Repealed**Historical Note**

Former Section R9-22-324 adopted as an emergency effective July 27, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days renumbered as Section R9-22-327 and adopted as a permanent rule effective October 1, 1983 (Supp. 83-5). Former Section R9-22-327 repealed, new Section R9-22-327 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (A), (D), (E), (G), (H), and (I) effective October 1, 1986 (Supp. 86-5). Amended subsection (D) and added a new subsection (J) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (A) and (E) effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-328. Repealed

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Historical Note

Adopted as an emergency effective October 6, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-5). Emergency Expired. New Section R9-22-328 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (A) and (E) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (D) effective October 1, 1987 (Supp. 87-4). Amended subsection (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-329. Repealed**Historical Note**

Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. New Section R9-22-329 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-330. Repealed**Historical Note**

Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. New Section R9-22-330 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended subsection (A) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-331. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-332. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-333. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-334. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-335. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-336. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective September 16, 1987 (Supp. 87-3). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-337. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Correction to subsection (B), paragraph (1) (Supp. 87-3). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-338. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Heading changed effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-339. Repealed

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Adopted effective October 1, 1985 (Supp. 85-5).
 Amended effective October 1, 1986 (Supp. 86-5).
 Amended subsection (B) effective October 1, 1987
 (Supp. 87-4). Amended effective January 14, 1997 (Supp.
 97-1). Section repealed by final rulemaking at 5 A.A.R.
 294, effective January 8, 1999 (Supp. 99-1).

R9-22-340. Reserved**Historical Note**

Adopted effective October 1, 1986 (Supp. 86-5). Section
 repealed by final rulemaking at 5 A.A.R. 294, effective
 January 8, 1999 (Supp. 99-1).

R9-22-341. Repealed**Historical Note**

Adopted effective March 1, 1987, filed December 31,
 1986 (Supp. 86-6). Section repealed by final rulemaking
 at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-342. Repealed**Historical Note**

Adopted effective September 29, 1992 (Supp. 92-3).
 Amended effective September 22, 1997 (Supp. 97-3).
 Section repealed by final rulemaking at 5 A.A.R. 294,
 effective January 8, 1999 (Supp. 99-1).

R9-22-343. Repealed**Historical Note**

Adopted under an exemption from the provisions of the
 Administrative Procedure Act, effective July 1, 1993
 (Supp. 93-3). Amended under an exemption from the pro-
 visions of the Administrative Procedure Act, effective
 October 26, 1993 (Supp. 93-4). Section repealed by final
 rulemaking at 5 A.A.R. 294, effective January 8, 1999
 (Supp. 99-1).

R9-22-344. Repealed**Historical Note**

Adopted under an exemption from the provisions of the
 Administrative Procedure Act, effective October 8, 1996;
 filed with the Office of the Secretary of State November
 6, 1996 (Supp. 96-4). Section repealed by final rulemak-
 ing at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-
 1).

ARTICLE 4. PENALTY FOR OBTAINING ELIGIBILITY BY FRAUD**R9-22-401. Definitions**

Definitions. The following definitions apply specifically to terms
 used within this Article:

“Amounts incurred by the system” include capitation pay-
 ments, costs incurred by any contractor in excess of capitation,
 reinsurance, and other administrative, legal or investigative
 costs associated with a person who obtained eligibility con-
 trary to A.R.S. §§ 36-2905.04 and/or A.R.S. § 36-2991.

“Application for eligibility” means any request for benefits
 administered by AHCCCS under the authority of A.R.S. Title
 36, Chapter 29, including applications for presumptive eligi-
 bility submitted to hospitals as described under Article 16 of
 this Chapter.

“Penalty” means an amount not to exceed the amounts
 incurred by the system during any time period that the person
 would have been ineligible for benefits but for the false or
 fraudulent information provided on the application for eligibil-

ity. A penalty does not include, and does not need to be
 reduced by, the amount of any overpayments that AHCCCS
 may be entitled to recoup from a person who violated A.R.S. §
 36-2905.04 and/or A.R.S. § 36-2991.

Historical Note

Adopted as an emergency effective May 20, 1982 pursu-
 ant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-
 3). Former Section R9-22-401 adopted as an emergency
 now adopted as a permanent rule effective August 30,
 1982 (Supp. 82-4). Amended effective January 31, 1986
 (Supp. 86-1). Amended effective January 31, 1997 (Supp.
 97-1). Amended by final rulemaking at 5 A.A.R. 867,
 effective March 4, 1999 (Supp. 99-1). Section repealed
 by final rulemaking at 8 A.A.R. 424, effective January
 10, 2002 (Supp. 02-1). New Section made by final
 rulemaking at 22 A.A.R. 3191, effective October 19,
 2016 (Supp. 16-4).

R9-22-402. Determining the Amount of the Penalty

- A. AHCCCS shall determine the amount of a penalty according
 to A.R.S. § 36-2905.04(B) or A.R.S. § 36-2991(B), whichever
 is applicable, and this Article.
- B. In addition to any penalty imposed pursuant to ARS §§ 36-
 2905.04 or 36-2991, and this Article, the Administration may
 also recoup from the person the amounts incurred by the sys-
 tem as a part of the notice and appeal process described in this
 Article.

Historical Note

Adopted as an emergency effective May 20, 1982, pursu-
 ant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-
 3). Former Section R9-22-402 adopted as an emergency
 now adopted and amended as a permanent rule effective
 August 30, 1982 (Supp. 82-4). Amended effective Janu-
 ary 31, 1986 (Supp. 86-1). Amended effective January
 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6
 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section
 repealed by final rulemaking at 8 A.A.R. 424, effective
 January 10, 2002 (Supp. 02-1). New Section made by
 final rulemaking at 22 A.A.R. 3191, effective October 19,
 2016 (Supp. 16-4).

R9-22-403. Mitigating and Aggravating Circumstances

- A. AHCCCS shall consider any of the following to be mitigating
 circumstances when determining the amount of a penalty for
 obtaining eligibility by fraud.
 1. Degree of culpability. The degree of culpability of a per-
 son is a mitigating circumstance if the person did not
 intend to provide or cause to be provided false informa-
 tion on the application for eligibility but was negligent as
 to the truthfulness of the information provided.
 2. Prior Offenses. At the time of the submittal of the appli-
 cation the person:
 - a. Did not have any prior criminal convictions; and
 - b. Had not been held civilly liable for defrauding a
 public assistance program.
 3. Financial condition. The financial condition of a person
 who violates A.R.S. §§ 36-2905.04 or 36-2991 is a miti-
 gating circumstance if the imposition of a penalty without
 reduction will render the person incapable of obtaining
 necessities of life such as food, clothing, and shelter.
 AHCCCS may consider the resources available to the
 person when determining the amount of the penalty.
 4. Other matters as justice may require. AHCCCS shall take
 into account other circumstances of a mitigating nature, if
 in the interest of justice; the circumstances require a
 reduction of the penalty.

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B. AHCCCS shall consider any of the following to be aggravating circumstances when determining the amount of a penalty for obtaining eligibility by fraud.

1. Degree of culpability. The degree of culpability of a person who provides or causes to be provided false information on the application for eligibility is an aggravating circumstance if the person knows or had reason to know that the information provided on the application for eligibility was false, or the person failed to correct the false information prior to AHCCCS incurring a financial loss as a result of the application for eligibility.
2. Prior offenses. At any time before the submittal of the application for eligibility, the person was held criminally or civilly liable for committing any fraud, waste, or abuse against any public assistance program.
3. Financial Loss. The person's violation of A.R.S. §§ 36-2905.04 or 36-2991 caused a loss to the system equal to or exceeding \$5,000.00.
4. Other matters as justice may require. AHCCCS shall take into account other circumstances of an aggravating nature, if in the interest of justice; the circumstances require an increase of the penalty.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-403 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended by adding subsection (C) effective October 1, 1987 (Supp. 87-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

R9-22-404. Notice of Intent

- A.** If AHCCCS imposes a penalty pursuant to this Article, AHCCCS shall hand deliver or send by certified mail, return receipt requested, or Federal Express to the person, a written Notice of Intent to impose a penalty.
- B.** The Notice of Intent shall include:
 1. The legal and factual basis for AHCCCS' determination that there has been a violation of A.R.S. §§ 36-2905.04 and/or 36-2991;
 2. The penalty;
 3. The amounts incurred by the system as a result of the violation of A.R.S. §§ 36-2905.04 and/or 36-2991, if AHCCCS intends to recoup those amounts through this process; and
 4. The procedure for requesting a State Fair Hearing.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-404 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

R9-22-405. Failure to Respond to the Notice of Intent

If a person fails to respond to the Notice of Intent within the timeframe described in A.A.C. § R9-22-406(A), AHCCCS shall uphold

the penalty and recoupment amounts described in the Notice of Intent.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-405 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of the amended rule similar to the emergency (Supp. 83-3). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

R9-22-406. Request for State Fair Hearing

- A.** To dispute the agency action described in the Notice of Intent, the person shall file a written Request for State Fair Hearing with AHCCCS within sixty (60) days from the date of receipt of the Notice of Intent.
- B.** If AHCCCS receives a timely request for a State Fair Hearing from the person, AHCCCS shall mail a Notice of Hearing pursuant to the Uniform Administrative Hearing Procedures described in A.R.S. Title 41, Chapter 6, Article 10.
- C.** AHCCCS shall accept a written request for withdrawal of a hearing request if the written request for withdrawal is received from the person before AHCCCS mails a Notice of Hearing under the Uniform Administrative Hearing Procedures described in A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-406 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-406 repealed, new Section R9-22-406 adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as a permanent rule effective May 16, 1983; text of the Section identical to the emergency (Supp. 83-3). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

R9-22-407. Burden of Proof

- A.** In any State Fair Hearing conducted under this Article, AHCCCS shall prove a violation of A.R.S. §§ 36-2905.04 and/or 36-2991, and any aggravating circumstances by a preponderance of the evidence.
- B.** AHCCCS does not have to prove any specific intent to defraud.
- C.** A person shall bear the burden of producing and proving by a preponderance of the evidence any affirmative defense or any circumstance that would justify reducing the amount of the penalty.

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Historical Note

New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

R9-22-408. Rescission of the Notice of Intent

AHCCCS may rescind the Notice of Intent at any time prior to the State Fair Hearing without prejudice.

Historical Note

New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS**R9-22-501. General Provisions and Standards - Related Definitions**

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

“Quality management” means a process used by professional health personnel through a formal program involving multiple organizational components and committees to:

- Assess the degree to which services provided conform to desired medical standards and practices; and
- Quality improvement or maintenance of care and services.

“Quality Improvement” means a process designed to achieve, through ongoing measurements and intervention, significant improvement that is sustained over time, in the areas of clinical care and non-clinical care and is expected to have a favorable effect on health outcomes and member satisfaction. Quality Improvement includes focusing organizational efforts on improving performance and utilizing data to develop intervention strategies to improve performance and outcomes.

“Utilization management/review” means a methodology used by professional health personnel to assess the medical indications, appropriateness, and efficiency of care provided. Utilization management applies to a contractor’s process to evaluate and approve or deny the medical necessity, appropriateness, efficacy and efficiency of health care services, procedures, or settings. Utilization review includes processes for prior authorization, concurrent review, retrospective review, and case management.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-501 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-501 repealed, former Section R9-22-502 renumbered and adopted without change as Section R9-22-501 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-501 repealed, former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-502. Pre-existing Conditions

- A. A contractor shall not impose a pre-existing condition exclusion with respect to covered services.
- B. A contractor or subcontractor shall not adopt or use any procedure to identify a person who has an existing or anticipated medical or psychiatric condition in order to discourage or exclude the person from enrolling in the contractor’s health plan or encourage the person to enroll in another health plan.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-502 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-502 renumbered without change as Section R9-22-501, former Section R9-22-503 renumbered and amended as Section R9-22-502 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-502 repealed, new Section R9-22-502 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4). Amended by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

R9-22-503. Provider Requirements Regarding Records

The provider shall maintain records that meet uniform accounting standards and generally accepted practices for maintenance of medical records, including detailed specification of all patient services delivered, the rationale for delivery, and the service date. A provider shall maintain and upon request, make available to a contractor and to the Administration, financial and medical records relating to payment for not less than five years from the date of final payment, or for records relating to costs and expenses to which the Administration has taken exception, five years after the date of final disposition or resolution of the exception. Providers shall provide one copy of a medical record at no cost if requested by the member.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-503 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-503 renumbered and amended as Section R9-22-502, new Section R9-22-503 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective May 30, 1986 (Supp. 86-3). Amended subsection (D) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (F) and (G) effective December 22, 1987 (Supp. 87-4). Amended subsection (I) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). New Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-504. Marketing; Prohibition Against Inducements; Misrepresentations; Discrimination; Sanctions

- A. A contractor or the contractor’s marketing representative shall not offer or give any form of compensation or reward, or engage in any behavior or activity that may be reasonably construed as coercive, to induce or procure AHCCCS enrollment with the contractor. Any marketing solicitation offering a benefit, good, or service in excess of the covered services in Article 2 is deemed an inducement.
- B. A marketing representative shall not misrepresent itself, the contracting health plan represented, or the AHCCCS program, through false advertising, false statements, or in any other manner to induce a member of another contractor to enroll in

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the represented health plan. Violations of this subsection include, but are not limited to, false or misleading claims, inferences, or representations such as:

1. A member will lose benefits under the AHCCCS program or lose any other health or welfare benefits to which a member is legally entitled, if the member does not enroll in the represented contracting health plan;
 2. Marketing representatives are employees of the state or representatives of the Administration, a county, or any health plan other than the health plan by which they are employed, or by which they are reimbursed; and
 3. The represented health plan is recommended or endorsed as superior to its competition by any state or county agency, or any organization, unless the organization has certified its endorsement in writing to the health plan and the Administration.
- C. A marketing representative shall not engage in any marketing or pre-enrollment practice that discriminates against a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.
- D. The Administration shall hold a contractor responsible for a violation of this Section resulting from the performance of any marketing representative, subcontractor, agent, program, or process under the contractor's employ or direction and shall impose contract sanctions on the contractor as specified in contract.
- E. A contractor shall produce and distribute informational materials that are approved by the Administration to each enrolled member or designated representative after the contractor receives notification of enrollment from the Administration. The contractor shall ensure that the informational materials include, at a minimum:
1. A description of all covered services as specified in contract;
 2. An explanation of service limitations and exclusions;
 3. An explanation of the procedure for obtaining services;
 4. An explanation of the procedure for obtaining emergency services;
 5. An explanation of the procedure for filing a grievance and appeal; and
 6. An explanation of when plan changes may occur as specified in contract.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-504 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-504 repealed, former Section R9-22-505 renumbered and adopted without change as Section R9-22-504 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-504 repealed, former Section R9-22-528 renumbered and amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-505. Standards, Licensure, and Certification for Providers of Hospital and Medical Services

A provider shall not provide hospital or medical services to a member unless the provider is licensed by the Arizona Department of Health Services and meets the requirements in 42 CFR 441 and 482, as of October 1, 2007, and 42 CFR 456 Subpart C, as of Octo-

ber 1, 2007, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation contains no future editions or amendments. An Indian Health Service (IHS) hospital and a Veterans Administration hospital shall not provide services to a member unless accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-505 adopted as an emergency expired, former Section R9-22-506 adopted as an emergency now adopted, amended and renumbered as Section R9-22-505 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-505 renumbered without change as Section R9-22-504, new Section R9-22-505 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-505 renumbered and amended as Section R9-22-509, former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5). Editorial correction, spelling of "paraphernalia" in subsection (A) (Supp. 87-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). New Section made by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-506. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-506 adopted as an emergency adopted, amended and renumbered as Section R9-22-505, former Section R9-22-507 adopted as an emergency now adopted, amended and renumbered as Section R9-22-506 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-506 repealed, new Section R9-22-506 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-506 repealed, new Section R9-22-506 adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (D) effective December 22, 1987 (Supp. 87-4). Repealed effective April 13, 1990 (Supp. 90-2). New Section adopted effective December 13, 1993 (Supp. 93-4). Repealed effective December 8, 1997 (Supp. 97-4).

R9-22-507. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-507 adopted as an emergency adopted, amended and renumbered as Section R9-22-506, former Section R9-22-508 adopted as an emergency now adopted, amended and renumbered as Section R9-22-507 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-507 repealed, new Section R9-22-507 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-508. Repealed

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Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-508 adopted as an emergency adopted, amended and renumbered as Section R9-22-507, former Section R9-22-509 adopted as an emergency now adopted, amended and renumbered as Section R9-22-508 as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-509. Transition and Coordination of Member Care

A. A contractor shall assist in the transition of members to and from other AHCCCS contractors.

1. Both the receiving and relinquishing contractor shall:
 - a. Coordinate with the other contractor to facilitate and schedule appointments for medically necessary services for the transitioned member within the Administration's timelines specified in the contract. If requested by the Administration, a contractor shall submit the policies and procedures regarding transition of members to the Administration for review and approval;
 - b. Assist in the referral of transitioned members to other community health agencies or county medical assistance programs for medically necessary services not covered by the Administration, as appropriate; and
 - c. Develop policies and procedures to be followed when transitioning members who have significant medical conditions; are receiving ongoing services; or have, at the time of the transition, received prior authorization or approval for undelivered, specific services.
2. The relinquishing contractor shall notify the receiving contractor of relevant information about the member's medical condition and current treatment regimens within the timelines defined in contract;
3. The relinquishing contractor shall forward medical records and other relevant materials to the receiving contractor. The relinquishing contractor shall bear the cost of reproducing and forwarding medical records and other relevant materials;
4. Within the timelines specified in contract, the receiving contractor shall ensure that the member selects or is assigned to a primary care provider, and provide the member with:
 - a. Information regarding the contractor's providers,
 - b. Emergency numbers, and
 - c. Instructions about how to obtain services.

B. A contractor shall not use a county or noncontracting provider health resource alternative to diminish the contractor's contractual responsibility or accountability for providing the full scope of covered services. The Administration may impose sanctions as described in contract if a contractor makes referrals to other agencies or programs to reduce expenses incurred by the contractor on behalf of its members.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-509 adopted as an emergency adopted, amended and renumbered as Section R9-22-508, former Section R9-22-510 adopted as an emergency now adopted and renumbered as Section R9-22-509 as a permanent rule effective August 30, 1982 (Supp. 82-4). For-

mer Section R9-22-509 repealed, former Section R9-22-505 renumbered and amended as Section R9-22-509 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-510. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-510 adopted as an emergency adopted and renumbered as Section R9-22-509, former Section R9-22-511 adopted as an emergency now adopted, amended and renumbered as Section R9-22-510 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-510 repealed, new Section R9-22-510 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-511. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-511 adopted as an emergency adopted, amended and renumbered as Section R9-22-510, former Section R9-22-512 adopted as an emergency now adopted, amended and renumbered as Section R9-22-511 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-511 repealed, new Section R9-22-511 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-512. Release of Safeguarded Information

- A. The Administration, contractors, providers, and noncontracting providers shall limit the release of safeguarded information to persons or agencies for the following purposes in accordance with 45 CFR 160 and 45 CFR 164, October 1, 2004, and 42 CFR 431.300 through 431.307, October 1, 2004, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments:
1. Official purposes directly related to the administration of the AHCCCS program including:
 - a. Establishing eligibility and post-eligibility treatment of income, as applicable;
 - b. Determining the amount of medical assistance;
 - c. Providing services for members;
 - d. Performing evaluations and analysis of AHCCCS operations;
 - e. Filing liens on property as applicable;
 - f. Filing claims on estates, as applicable; and
 - g. Filing, negotiating, and settling medical liens and claims.
 2. Law enforcement. The Administration may release safeguarded information without the applicant's or member's written or verbal consent, for the purpose of conducting or assisting an investigation, prosecution, or criminal or civil proceeding related to the administration of the AHCCCS program.

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3. The Administration may release safeguarded member information to a review committee in accordance with the provisions of A.R.S. § 36-2917, without the consent of the applicant or member.
- B.** Except as provided in subsection (A), the Administration, contractors, providers, and noncontracting providers shall disclose safeguarded information only to:
1. An applicant;
 2. A member;
 3. An unemancipated minor, with written permission of a parent, custodial relative, or designated representative, if:
 - a. An Administration employee, authorized representative, or responsible caseworker is present during the examination of the safeguarded information; or
 - b. After written notification to the provider, and at a reasonable time and place.
 4. Persons authorized by the applicant or member; or
 5. A court order or subpoena compliant with 45 CFR 164.512(e), October 1, 2004, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments.
- C.** The Administration, contractors, providers, and noncontracting providers shall safeguard identifiable information, protected health information as specified in 45 CFR 160, and information obtained in the course of application for or re-determination of eligibility concerning an applicant or member, that includes, but is not limited to the following:
1. Name and address;
 2. Social Security number;
 3. Social and economic conditions or circumstances;
 4. Agency evaluation of personal information;
 5. Medical data and information concerning medical services received, including diagnosis and history of disease or disability;
 6. State Data Exchange (SDX) tapes, and other types of information received from outside sources for the purpose of verifying income eligibility and amount of medical assistance payments; and
 7. Any information received in connection with the identification of legally liable third-party resources.
- D.** The restriction upon disclosure of information in this Section does not apply to:
1. De-identified information as described by 45 CFR 164.514, October 1, 2004, incorporated by reference in subsection (A); or
 2. A disclosure, in response to a request for information, that complies with 45 CFR 160 and 45 CFR 164, October 1, 2004, and 42 CFR 431.300 through 431.307, October 1, 2004, incorporated by reference in subsection (A).
- E.** A provider shall furnish records requested by the Administration or a contractor to the Administration or the contractor at no charge.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-512 adopted as an emergency adopted, amended and renumbered as Section R9-22-511, former Section R9-22-513 adopted as an emergency now adopted and renumbered as Section R9-22-512 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-512 repealed, new Section R9-22-512 adopted effective October 1, 1985 (Supp. 85-5).
Amended effective December 13, 1993 (Supp. 93-4).
Amended effective December 8, 1997 (Supp. 97-4).

Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-513. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-513 adopted as an emergency adopted and renumbered as Section R9-22-512, former Section R9-22-514 adopted as an emergency now adopted, amended and renumbered as Section R9-22-513 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-513 repealed, former Section R9-22-526 renumbered and amended as Section R9-22-513 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-514. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-514 adopted as an emergency adopted, amended and renumbered as Section R9-22-513, former Section R9-22-515 adopted as an emergency now adopted, amended and renumbered as Section R9-22-514 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-514 repealed, former Section R9-22-517 renumbered and amended as Section R9-22-514 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-515. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-515 adopted as an emergency adopted, amended and renumbered as Section R9-22-514, former Section R9-22-517 adopted as an emergency now adopted, amended and renumbered as Section R9-22-515 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-515 repealed, former Section R9-22-522 renumbered and amended as Section R9-22-515 effective October 1, 1985 (Supp. 85-5). Repealed effective December 8, 1997 (Supp. 97-4).

R9-22-516. Renumbered**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-516 adopted as an emergency expired, former Section R9-22-518 adopted as an emergency now adopted, amended and renumbered as Section R9-22-516 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-516 renumbered as Section R9-22-513 effective October 1, 1985 (Supp. 85-5).

R9-22-517. Renumbered

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Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-517 adopted as an emergency adopted, amended and renumbered as Section R9-22-515, former Section R9-22-519 adopted as an emergency now adopted and renumbered and amended as Section R9-22-517 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-517 renumbered and amended as Section R9-22-514 effective October 1, 1985 (Supp. 85-5).

R9-22-518. Information to Enrolled Members

- A.** Each contractor shall produce and distribute printed informational materials to each member or family unit no later than 10 days of receipt of notification of enrollment from the Administration. The contractor shall ensure that the informational materials meet the requirements specified in the contractor's current contract.
- B.** A contractor shall provide a member with the name, address, and telephone number of the member's primary care provider no later than 10 days from the date of enrollment. The contractor shall include information on how the member may change primary care providers.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-518 adopted as an emergency adopted, amended and renumbered as Section R9-22-516, former Section R9-22-520 adopted as an emergency now adopted, amended and renumbered as Section R9-22-518 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-518 repealed, new Section R9-22-518 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-519. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-519 adopted as an emergency adopted, amended and renumbered as Section R9-22-517, former Section R9-22-521 adopted as an emergency now adopted, amended and renumbered as Section R9-22-519 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-519 repealed, new Section R9-22-519 adopted effective October 1, 1985 (Supp. 85-5). Repealed effective December 8, 1997 (Supp. 97-4).

R9-22-520. Expired**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-520 adopted as an emergency adopted, amended and renumbered as Section R9-22-518, former Section R9-22-522 adopted as an emergency now adopted, amended and renumbered as Section R9-22-520 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-520 repealed, new Section R9-22-520 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Sec-

tion expired under A.R.S. § 41-1056(E) at 8 A.A.R. 4851, effective October 9, 2002 (Supp. 02-4).

R9-22-521. Program Compliance Audits

- A.** The Administration shall conduct an onsite program compliance audit of a contractor at least once every three years during the term of the Administration's contract with the contractor. The Administration may conduct, without prior notice, inspections of contractor facilities or perform other elements of a program compliance audit.
- B.** An audit team may perform any or all of the following procedures:
1. Conduct private interviews and group conferences with members, physicians, other health professionals, and members of the contractor's administrative staff including, but not limited to, the contractor's principal management persons;
 2. Examine records, books, reports, and papers of the contractor and any management company, and all providers or subcontractors providing health care and other services. The examination may include, but need not be limited to: minutes of medical staff meetings, peer review and quality of care review records, duty rosters of medical personnel, appointment records, written procedures for the internal operation of the health plan, contracts and correspondence with members and with providers of health care services and other services to the plan, and additional documentation deemed necessary by the Administration to review the quality of medical care.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-521 adopted as an emergency adopted, amended and renumbered as Section R9-22-519, former Section R9-22-523 adopted as an emergency now adopted, amended and renumbered as Section R9-22-521 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-521 repealed, new Section R9-22-521 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-522. Quality Management/Utilization Management (QM/UM) Requirements

- A.** A contractor shall comply with Quality Management/Utilization Management (QM/UM) requirements specified in this Section and in contract. The contractor shall ensure compliance with QM/UM requirements that are accomplished through delegation or subcontract with another party.
- B.** In addition to any requirements specified in contract, a contractor shall:
1. Submit to the Administration a written QM/UM plan that includes a description of the systems, methodologies, protocols, and procedures to be used in:

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- a. Monitoring and evaluating the types of services provided;
 - b. Identifying the numbers and costs of services provided;
 - c. Assessing and improving the quality and appropriateness of care and services;
 - d. Evaluating the outcome of care provided to members, and
 - e. Determining the actions necessary to improve service delivery;
2. Submit the QM/UM plan to the Administration on an annual basis within timelines specified in contract. If the QM/UM plan is changed during the year, the contractor shall submit the revised plan to the Administration before implementation;
 3. Receive approval from the Administration before implementing the initial or revised QM/UM plan;
 4. Ensure that a QM/UM committee operates under the control of the contractor's medical director and includes representation from medical and executive management personnel. The committee shall:
 - a. Oversee the development, revision, and implementation of the QM/UM plan; and
 - b. Ensure that there are qualified QM/UM personnel and sufficient resources to implement the contractor's QM/UM activities; and
 5. Ensure that the QM/UM activities include at least:
 - a. Prior authorization for non-emergency or scheduled hospital admissions;
 - b. Concurrent review of inpatient hospitalization;
 - c. Retrospective review of hospital claims;
 - d. Program and provider audits designed to detect over- or under-utilization, service delivery effectiveness, and outcome;
 - e. Medical records audits;
 - f. Surveys to determine satisfaction of members;
 - g. Assessment of the adequacy and qualifications of the contractor's provider network;
 - h. Review and analysis of QM/UM data;
 - i. Measurement of performance using objective quality indicators;
 - j. Ensuring individual and systemic quality of care;
 - k. Integrating quality throughout the organization;
 - l. Process improvement;
 - m. Credentialing a provider network;
 - n. Resolving quality of care grievances; and
 - o. Quality improvement activities focused on improving the quality of care and the efficient, cost-effective delivery and utilization of services.
- C.** A member's primary care provider shall maintain medical records that:
1. Conform to professional medical standards and practices for documentation of medical diagnostic and treatment data;
 2. Facilitate follow-up treatment; and
 3. Permit professional medical review and medical audit processes.
- D.** Within 30 days following termination of the contract between a subcontractor and a contractor, the subcontractor or the subcontractor's designee shall forward to the primary care provider medical records or copies of medical records of all members assigned to the subcontractor or for whom the subcontractor has provided services.
- E.** The Administration shall monitor each contractor and the contractor's providers to ensure compliance with Administration QM/UM requirements and adherence to the contractor's QM/UM plan.
1. A contractor and the contractor's providers shall cooperate with the Administration in the performance of the Administration's QM/UM monitoring activities; and
 2. A contractor and the contractor's providers shall develop and implement mechanisms for correcting deficiencies identified through the Administration's QM/UM monitoring.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-522 adopted as an emergency adopted, amended and renumbered as Section R9-22-520, former Section R9-22-524 adopted as an emergency now adopted and renumbered as Section R9-22-522 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-522 renumbered and amended as Section R9-22-515, new Section R9-22-522 adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-523. Expired**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-523 adopted as an emergency adopted, amended and renumbered as Section R9-22-521, former Section R9-22-525 adopted as an emergency now adopted, amended and renumbered as Section R9-22-523 as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 4851, effective October 9, 2002 (Supp. 02-4).

R9-22-524. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-524 adopted as an emergency adopted and renumbered as Section R9-22-522, former Section R9-22-526 adopted as an emergency now adopted, amended and renumbered as Section R9-22-524 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-524 repealed, new Section R9-22-524 adopted effective October 1, 1985 (Supp. 85-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-525. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-525 adopted as an emergency adopted, amended and renumbered as Section R9-22-523, former Section R9-22-527 adopted as an emergency now

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adopted, amended and renumbered as Section R9-22-525 as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1985 (Supp. 85-5).

R9-22-526. Renumbered**Historical Note**

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of the permanent rule identical to the emergency (Supp. 83-3). Former Section R9-22-526 repealed, new Section R9-22-526 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-1).

R9-22-527. Renumbered**Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5).

R9-22-528. Renumbered**Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-528 renumbered and amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5).

R9-22-529. Renumbered**Historical Note**

Adopted as Section R9-22-529 effective October 1, 1985, then renumbered as Section R9-22-1002 effective October 1, 1985 (Supp. 85-5).

ARTICLE 6. RFP AND CONTRACT PROCESS**R9-22-601. General Provisions**

- A. The Director has full operational authority to adopt rules for the RFP process and the award of contracts under A.R.S. § 36-2906.
- B. This Article applies to the award of contracts under A.R.S. §§ 36-2904 and 36-2906 to provide services under A.R.S. § 36-2907 and the expenditure of public monies by the Administration pertaining to covered services when the procurement so states. The Administration shall establish conflict-of-interest safeguards for officers and employees of this state with responsibilities relating to contracts that comply with 42 U.S.C. 1396u-2(d)(3).
- C. The Administration is exempt from the procurement code under A.R.S. § 41-2501.
- D. The Administration and contractors shall retain all contract records for five years under A.R.S. § 36-2903 and dispose of the records under A.R.S. § 41-2550.
- E. The following terms are defined as related to this Article: "Procurement file" means the official records file of the Director whether located in the Office of the Director or at the public procurement unit. The procurement file shall include in electronic or paper form a list of notified vendors, final solicitation, solicitation amendments, bids/offers, final proposal revisions, clarifications, and final evaluation report.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-601 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983

(Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

R9-22-602. RFP

- A. RFP content. The Administration shall include the following items in any RFP under this Article:
 1. Instructions and information to an offeror concerning the proposal submission including:
 - a. The deadline for submitting a proposal,
 - b. The address of the office at which a proposal is to be received,
 - c. The period during which the RFP remains open, and
 - d. Any special instructions and information;
 2. The scope of covered services under Article 2 of this Chapter and A.R.S. §§ 36-2906 and 36-2907, covered populations, geographic coverage, service and performance requirements, and a delivery or performance schedule;
 3. The contract terms and conditions, including bonding or other security requirements, if applicable;
 4. The factors used to evaluate a proposal;
 5. The location and method of obtaining documents that are incorporated by reference in the RFP;
 6. A requirement that the offeror acknowledge receipt of all RFP amendments issued by the Administration;
 7. The type of contract to be used and a copy of a proposed contract form or provisions;
 8. The length of the contract service;
 9. A requirement for cost or pricing data;
 10. The minimum RFP requirements; and
 11. A provision requiring an offeror to certify that a submitted proposal does not involve collusion or other anti-competitive practices.
- B. Proposal process.
 1. After the deadline for submitting proposals, the Administration may open a proposal publicly and announce and record the name of the offeror. The Administration shall keep all other information contained in a proposal confidential. The Administration shall open a proposal for public inspection after contract award unless the Administration determines that disclosure is not in the best interest of the state.
 2. The Administration shall evaluate a proposal based on the GSA and the evaluation factors listed in the RFP.
 3. The Administration may initiate discussions with a responsive and responsible offeror to clarify and assure full understanding of an offeror's proposal. The Administration shall provide an offeror fair treatment with respect to discussion and revision of a proposal. The Administration shall not disclose information derived from a proposal submitted by a competing offeror.
 4. The Administration shall allow for the adjustment of covered services by expansion, deletion, segregation, or combination in order to secure the most financially advantageous proposals for the state.
 5. The Administration may conduct an investigation of a person or organization who has ownership or management interests in corporate offerors or affiliated corporate organizations of an offeror.
 6. The Administration may issue a written request for best and final offers. The Administration shall state in the

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request the date, time, and place for the submission of best and final offers.

7. The Administration shall not request best and final offers more than once unless the Administration determines that it is advantageous to the state to request additional best and final offers. The Administration shall state in the written request for best and final offers that if the offeror does not submit a notice of withdrawal or a best and final offer, the Administration shall take the most recent offer as the offeror's best and final offer.

C. Proposal rejection.

1. The Administration may reject an offeror's proposal if the offeror fails to supply the information requested by the Administration.
2. The offeror shall not disclose information pertaining to its proposal to any other offeror prior to contract award. The offeror may disclose proposal information to a person other than another offeror if the recipient agrees to keep the information confidential until contract award. Disclosure in violation of this subsection may be grounds for rejecting a proposal.
3. The Administration shall provide written notification to an offeror whose proposal is rejected. The rejection notice shall be part of the contract file and a public record.
4. If the Administration determines that it is in the best interest of the state, the Administration may reject any and all proposals, in whole or in part, under the RFP. The reasons for rejection shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if a proposal is rejected in whole or in part.

- D. Proposal cancellation.** If the Administration determines that it is in the best interest of the state, the Administration may cancel a RFP. The reasons for cancellation shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if a RFP is cancelled.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-602 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

R9-22-603. Contract Award

The Administration shall award a contract to the responsible and responsive offeror whose proposal is determined most advantageous to the state under A.R.S. § 36-2906. If the Administration determines that multiple contracts are in the best interest of the state, the Administration may award multiple contracts. The contract file shall contain the basis on which the award is made.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-603 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final

rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

R9-22-604. Contract or Proposal Protests; Appeals

- A.** Disputes related to contract performance. This Section does not apply to a dispute related to contract performance. A contract performance dispute is governed by 9 A.A.C. 34.
- B.** Resolution of a proposal protest. The procurement officer issuing a RFP shall have the authority to resolve proposal protests. An appeal from the decision of the procurement officer shall be made to the Director.
- C. Filing of a protest.**
1. A person may file a protest with the procurement officer regarding:
 - a. A RFP issued by the Administration,
 - b. A proposed award, or
 - c. An award of a contract.
 2. A protester shall submit a written protest and include the following information:
 - a. The name, address, and telephone number of the protester;
 - b. The signature of the protester or protester's representative;
 - c. Identification of a RFP or contract number;
 - d. A detailed statement of the legal and factual grounds of the protest including copies of any relevant documents; and
 - e. The relief requested.
- D. Time for filing a protest.**
1. A protester filing a protest alleging improprieties in an RFP or an amendment to an RFP shall file the protest at least 14 days before the due date of receipt of proposals.
 2. Any protest alleging improprieties in an amendment issued 14 or fewer days before the due date of the proposal shall be filed before the due date for receipt of proposals.
 3. In cases other than those covered in subsections (D)(1) and (2), a protester shall file a protest no later than 10 days after the procurement officer makes the procurement file available for public inspection.
- E. Stay of procurement during the protest.** If a protester files a protest before the contract award, the procurement officer may issue a written stay of the contract award. In considering whether to issue a written stay of contract, the procurement officer shall consider but is not limited to considering whether:
1. A reasonable probability exists that the protest will be sustained, and
 2. The stay of the contract award is in the best interest of the state.
- F. Stay of contract award during an appeal to the Director.** The Director shall automatically continue the stay of a contract award if:
1. An appeal is filed before a contract award, and
 2. The procurement officer issues a stay of the contract award under subsection (E), unless
 3. The Director issues a written determination that the contract award is necessary to protect the best interest of the state.
- G. Decision by the procurement officer.**
1. The procurement officer shall issue a written decision no later than 14 days after a protest has been filed. The decision shall contain an explanation of the basis of the decision.
 2. The procurement officer shall furnish a copy of the decision to the protester by:

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- a. Certified mail, return receipt requested; or
 - b. Any other method that provides evidence of receipt.
3. The Administration may extend, for good cause, the time-limit for decisions in subsection (G)(1) for a time not to exceed 30 days. The procurement officer shall notify the protester in writing that the time for the issuance of a decision has been extended and the date by which a decision shall be issued.
 4. If the procurement officer fails to issue a decision within the time-limits in subsection (G)(1) or (G)(3), the protester may proceed as if the procurement officer issued an adverse decision.
- H. Remedies.**
1. If the procurement officer sustains the protest in whole or in part and determines that the RFP, proposed contract award, or contract award does not comply with applicable statutes and rules, the procurement officer shall order an appropriate remedy.
 2. In determining an appropriate remedy, the procurement officer shall consider all the circumstances of the procurement or proposed procurement, including:
 - a. Seriousness of the procurement deficiency,
 - b. Degree of prejudice to other interested parties or to the integrity of the RFP process,
 - c. Good faith of the parties,
 - d. Extent of performance,
 - e. Costs to the state, and
 - f. Urgency of the procurement.
 - g. Best interest of the state.
 3. An appropriate remedy may include one or more of the following:
 - a. Terminating the contract;
 - b. Reissuing the RFP;
 - c. Issuing a new RFP;
 - d. Awarding a contract consistent with statutes, rules, and the terms of the RFP; or
 - e. Any relief determined necessary to ensure compliance with applicable statutes and rules.
- I. Appeals to the Director.**
1. A person may file an appeal of a procurement officer's decision with both the Director and the procurement officer no later than five days from the date the decision is received. The date the decision is received shall be determined under subsection (G)(2).
 2. The appeal shall contain:
 - a. The information required in subsection (C)(2),
 - b. A copy of the procurement officer's decision,
 - c. The alleged factual or legal error in the decision of the procurement officer on which the appeal to the Director is based, and
 - d. A request for hearing unless the person requests that the Director's decision be based solely upon the procurement file.
- J. Dismissal.** The Director shall not schedule a hearing and shall dismiss an appeal with a written determination if:
1. The appeal does not state a basis for protest,
 2. The appeal is untimely under subsection (I)(1), or
 3. The appeal is moot.
- K. Hearing.** Hearings under this Section shall be conducted using the Arizona Administrative Procedure Act under A.R.S. Title 41, Ch. 6.

Historical Note

Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 424, effective

January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

R9-22-605. Waiver of Contractor's Subcontract with Hospitals

If a contractor is unable to obtain a subcontract with a hospital as contractually required, the contractor may request in writing a waiver from the Administration as allowed by A.R.S. § 36-2906. The contractor shall state in the request the reasons a waiver is believed to be necessary and all efforts the contractor has made to secure a subcontract.

Historical Note

Adopted effective January 31, 1986 (Supp. 86-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

R9-22-606. Contract Compliance Sanction

- A.** The Director may impose sanctions upon a contractor for violation of any provision of this Chapter or of a contract. Sanctions include but are not limited to:
 1. Suspension of any or all further member enrollment, by choice and/or assignment for a period of time.
 2. Imposition of a monetary sanction.
- B.** The Director shall consider the nature, severity, and length of the violation when determining a sanction.
- C.** The Director shall provide a contractor with written notice specifying grounds and terms for the sanction.
- D.** Nothing contained in this Section shall be construed to prevent the Administration from imposing sanctions as provided in contract under A.R.S. § 36-2903.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

ARTICLE 7. STANDARDS FOR PAYMENTS**R9-22-701. Standard for Payments Related Definitions**

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

"Accommodation" means room and board services provided to a patient during an inpatient hospital stay and includes all staffing, supplies, and equipment. The accommodation is semi-private except when the member must be isolated for medical reasons. Types of accommodation include hospital routine medical/surgical units, intensive care units, and any other specialty care unit in which room and board are provided.

"Aggregate" means the combined amount of hospital payments for covered services provided within and outside the GSA.

"AHCCCS inpatient hospital day or days of care" means each day of an inpatient stay for a member beginning with the day of admission and including the day of death, if applicable, but excluding the day of discharge, provided that all eligibility, medical necessity, and medical review requirements are met.

"Ancillary service" means all hospital services for patient care other than room and board and nursing services, including but

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not limited to, laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, and occupational).

“APC” means the Ambulatory Payment Classification system under 42 CFR 419.31 used by Medicare for grouping clinically and resource-similar procedures and services.

“Billed charges” means charges for services provided to a member that a hospital includes on a claim consistent with the rates and charges filed by the hospital with Arizona Department of Health Services (ADHS).

“Business agent” means a company such as a billing service or accounting firm that renders billing statements and receives payment in the name of a provider.

“Capital costs” means costs as reported by the hospital to CMS as required by 42 CFR 413.20.

“Copayment” means a monetary amount, specified by the Director, that a member pays directly to a contractor or provider at the time covered services are rendered.

“Cost-to-charge ratio” (CCR) means a hospital’s costs for providing covered services divided by the hospital’s charges for the same services. The CCR is the percentage derived from the cost and charge data for each revenue code provided to AHCCCS by each hospital.

“Covered charges” means billed charges that represent medically necessary, reasonable, and customary items of expense for covered services that meet medical review criteria of AHCCCS or a contractor.

“CPT” means Current Procedural Terminology, published and updated by the American Medical Association. CPT is a nationally-accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians that provide a uniform language to accurately designate medical, surgical, and diagnostic services.

“Critical Access Hospital” is a hospital certified by Medicare under 42 CFR 485 Subpart F and 42 CFR 440.170(g). “Direct graduate medical education costs” or “direct program costs” means the costs that are incurred by a hospital for the education activities of an approved graduate medical education program that are the proximate result of training medical residents in the hospital, including resident salaries and fringe benefits, the portion of teaching physician salaries and fringe benefits that are related to the time spent in teaching and supervision of residents, and other related GME overhead costs.

“DRI inflation factor” means Global Insights Prospective Hospital Market Basket.

“Eligibility posting” means the date a member’s eligibility information is entered into the AHCCCS Pre-paid Medical Management Information System (PMMIS).

“Encounter” means a record of a medically-related service rendered by an AHCCCS-registered provider to a member enrolled with a contractor on the date of service.

“Existing outpatient service” means a service provided by a hospital before the hospital files an increase in its charge master as defined in R9-22-712(G), regardless of whether the service was explicitly described in the hospital charge master before filing the increase or how the service was described in the charge master before filing the increase.

“Expansion funds” means funds appropriated to support GME program expansions as described under A.R.S. § 36-2903.01(G)(9)(b) and (c)(i).

“Factor” means a person or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the organization for an added fee or a deduction of a portion of the accounts receivable. Factor does not include a business agent.

“Fiscal intermediary” means an organization authorized by CMS to make determinations and payments for Part A and Part B provider services for a given region.

“Freestanding Children’s Hospital” means a separately standing hospital with at least 120 pediatric beds that is dedicated to provide the majority of the hospital’s services to children.

“GME program approved by the Administration” or “approved GME program” means a graduate medical education program that has been approved by a national organization as described in 42 CFR 415.152.

“Graduate medical education (GME) program” means an approved residency program that prepares a physician for independent practice of medicine by providing didactic and clinical education in a medical environment to a medical student who has completed a recognized undergraduate medical education program.

“HCAC” means a health care acquired condition described under 42 CFR 447.26 but does not include Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

“HCPCS” means the Health Care Procedure Coding System, published and updated by Center for Medicare and Medicaid Services (CMS). HCPCS is a listing of codes and descriptive terminology used for reporting the provision of physician services, other health care services, and substances, equipment, supplies or other items used in health care services.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as specified under 45 CFR 162, that establishes standards and requirements for the electronic transmission of certain health information by defining code sets used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

“ICU” means the intensive care unit of a hospital.

“Indirect program costs” means the marginal increase in operating costs that a hospital experiences as a result of having an approved graduate medical education program and that is not accounted for by the hospital’s direct program costs.

“Intern and Resident Information System” means a software program used by teaching hospitals and the provider community for collecting and reporting information on resident training in hospital and non-hospital settings.

“Medical education costs” means direct hospital costs for intern and resident salaries, fringe benefits, program costs, nursing school education, and paramedical education, as described in the Medicare Provider Reimbursement Manual.

“Medical review” means a clinical evaluation of documentation conducted by AHCCCS or a contractor for purposes of prior authorization, concurrent review, post-payment review, or determining medical necessity. The criteria for medical

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review are established by AHCCCS or a contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

“Medicare Urban or Rural Cost-to-Charge Ratio (CCR)” means statewide average capital cost-to-charge ratio published annually by CMS added to the urban or rural statewide average operating cost-to-charge ratio published annually by CMS.

“National Standard code sets” means codes that are accepted nationally in accordance with federal requirements under 45 CFR 160 and 45 CFR 164.

“New hospital” means a hospital for which Medicare Cost Report claim and encounter data are not available for the fiscal year used for initial rate setting or rebasing.

“NICU” means the neonatal intensive care unit of a hospital that is classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.

“Non-IHS Acute Hospital” means a hospital that is not run by Indian Health Services, is not a free-standing psychiatric hospital, such as an IMD, and is paid under ADHS rates.

“Observation day” means a physician-ordered evaluation period of less than 24 hours to determine whether a person needs treatment or needs to be admitted as an inpatient. Each observation day consists of a period of 24 hours or less.

“Operating costs” means AHCCCS-allowable accommodation costs and ancillary department hospital costs excluding capital and medical education costs.

“OPPC” means an Other Provider Preventable Condition that is: (1) a wrong surgical or other invasive procedure performed on a patient, (2) a surgical or other invasive procedure performed on the wrong body part, or (3) a surgical or other invasive procedure performed on the wrong patient.

“Organized health care delivery system” means a public or private organization that delivers health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization.

“Outlier” means a hospital claim or encounter in which the operating costs per day for an AHCCCS inpatient hospital stay meet the criteria described under this Article and A.R.S. § 36-2903.01(G).

“Outpatient hospital service” means a service provided in an outpatient hospital setting that does not result in an admission.

“Ownership change” means a change in a hospital’s owner, lessor, or operator under 42 CFR 489.18(a).

“Participating institution” means an institution at which portions of a graduate medical education program are regularly conducted and to which residents rotate for an educational experience for at least one month.

“Peer group” means hospitals that share a common, stable, and independently definable characteristic or feature that significantly influences the cost of providing hospital services, including specialty hospitals that limit the provision of services to specific patient populations, such as rehabilitative patients or children.

“PPC” means prior period coverage. PPC is the period of time, prior to the member’s enrollment, during which a member is eligible for covered services. The time-frame is the first day of the month of application or the first eligible month, whichever is later, until the day a member is enrolled with a contractor.

“PPS bed” means Medicare-approved Prospective Payment beds for inpatient services as reported in the Medicare cost reports for the most recent fiscal year for which the Administration has a complete set of Medicare cost reports for every rural hospital as determined as of the first of February of each year.

“Procedure code” means the numeric or alphanumeric code listed in the CPT or HCPCS manual by which a procedure or service is identified.

“Prospective rates” means inpatient or outpatient hospital rates set by AHCCCS in advance of a payment period and representing full payment for covered services excluding any quick-pay discounts, slow-pay penalties, and first-and third-party payments regardless of billed charges or individual hospital costs.

“Public hospital” means a hospital that is owned and operated by county, state, or hospital health care district.

“Qualifying health information exchange organization” means a non-profit health information organization as defined in A.R.S. § 36-3801 that provides the statewide exchange of patient health information among disparate health care organizations and providers not owned, operated, or controlled by the health information exchange. A qualifying health information exchange organization must include representation by the administration on its board of directors, and have a significant number of health care participants, including hospitals, laboratories, payers, community physicians and Federally Qualified Health Centers.

“Rebase” means the process by which the most currently available and complete Medicare Cost Report data for a year and AHCCCS claim and encounter data for the same year are collected and analyzed to reset the Inpatient Hospital Tiered per diem rates, or the Outpatient Hospital Capped Fee-For-Service Schedule.

“Reinsurance” means a risk-sharing program provided by AHCCCS to contractors for the reimbursement of specified contract service costs incurred by a member beyond a certain monetary threshold.

“Remittance advice” means an electronic or paper document submitted to an AHCCCS-registered provider by AHCCCS to explain the disposition of a claim.

“Resident” means a physician engaged in postdoctoral training in an accredited graduate medical education program, including an intern and a physician who has completed the requirements for the physician’s eligibility for board certification.

“Revenue code” means a numeric code, that identifies a specific accommodation, ancillary service, or billing calculation, as defined by the National Uniform Billing committee for UB-04 forms.

“Sub-acute services” means inpatient care for a patient with an acute illness, injury or exacerbation of a disease process when the patient does not require acute inpatient hospitalization. Sub-acute care is rendered immediately after, or instead of, acute inpatient hospitalization.

“Specialty facility” means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.

“Sponsoring institution” means the institution or entity that is recognized by the GME accrediting organization and designated as having ultimate responsibility for the assurance of

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academic quality and compliance with the terms of accreditation.

“Tier” means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure, or revenue codes, peer group, NICU classification level, or any combination of these items.

“Tiered per diem” means an AHCCCS capped fee schedule in which payment is made on a per-day basis depending upon the tier (or tiers) into which an AHCCCS inpatient hospital day of care is assigned.

“Trip” means a one-way transport each time a taxi is called. If the taxi waits for the member then the transport continues to be part of the one-way trip. If the taxi leaves and is called to pick up the member, that is considered a new one-way trip.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-701 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-701 repealed, new Section R9-22-701 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Section repealed; new Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 2188, effective June 6, 2006 (Supp. 06-2). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 1782, effective June 30, 2007 (Supp. 07-2). Amended by exempt rulemaking at 13 A.A.R. 3190, effective October 1, 2007 (Supp. 07-3). Amended by exempt rulemaking at 13 A.A.R. 4032, effective November 1, 2007 (Supp. 07-4). Amended by final rulemaking at 20 A.A.R. 1956, effective September 6, 2014; amended by exempt rulemaking at 20 A.A.R. 2755, effective January 1, 2015 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4).

R9-22-701.01. Reserved

R9-22-701.02. Reserved

R9-22-701.03. Reserved

R9-22-701.04. Reserved

R9-22-701.05. Reserved

R9-22-701.06. Reserved

R9-22-701.07. Reserved

R9-22-701.08. Reserved

R9-22-701.09. Reserved

R9-22-701.10 Scope of the Administration’s and Contractor’s Liability

The Administration shall bear no liability for providing covered services for any member beyond the date of termination of the member’s eligibility or during the member’s enrollment with a contractor. A contractor has no financial responsibility for services provided to a member beyond the last date of enrollment except as provided in Articles 2 and 5 of this Chapter and as specified in contract.

Historical Note

New Section made by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

R9-22-702. Charges to Members

- A.** For purposes of this subsection, the term “member” includes the member’s financially responsible representative as described under A.R.S. § 36-2903.01.
- B.** Registered providers must accept payment from the Administration or a contractor as payment in full.
- C.** Except as provided in subsection (D) a registered provider shall not request or collect payment from, refer to a collection agency, or report to a credit reporting agency an eligible person or a person claiming to be an eligible person.
- D.** An AHCCCS registered provider may charge, submit a claim to, or demand or collect payment from a member:
 1. To collect the copayment described in R9-22-711;
 2. To recover from a member that portion of a payment made by a third party to the member for an AHCCCS covered service if the member has not transferred the payment to the Administration or the contractor as required by the statutory assignment of rights to AHCCCS;
 3. To obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member’s AHCCCS eligibility or enrollment that caused payment to the provider to be reduced or denied;
 4. For a service that is excluded by statute or rule, or provided in an amount that exceeds a limitation in statute or rule, if the member signs a document in advance of receiving the service stating that the member understands the service is excluded or is subject to a limit and that the member will be financially responsible for payment for the excluded service or for the services in excess of the limit;
 5. When the contractor or the Administration has denied authorization for a service if the member signs a document in advance of receiving the service stating that the member understands that authorization has been denied and that the member will be financially responsible for payment for the service;
 6. For services requested for a member enrolled with a contractor, and rendered by a noncontracting provider under circumstances where the member’s contractor is not responsible for payment of “out of network” services under R9-22-705(A), if the member signs a document in advance of receiving the service stating that the member understands the provider is out of network, that the member’s contractor is not responsible for payment, and that the member will be financially responsible for payment for the excluded service;
 7. For services rendered to a person eligible for the FESP if the provider submits a claim to the Administration in the reasonable belief that the service is for treatment of an emergency medical condition and the Administration denies the claim because the service does not meet the criteria of R9-22-217; or
 8. If the provider has received verification from the Administration that the person was not an eligible person on the date of service.
- E.** The signature requirement of subsections (D)(4), (D)(5), and (D)(6) do not apply if:
 1. The member is unable or incompetent to sign such a document, or

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2. When services are rendered for the purpose of treating an emergency medical condition as defined in R9-22-217 and a delay in providing treatment to obtain a signature would have a significant adverse affect on the member's health.
- F. Except as provided for in this Section, registered providers shall not bill a member when the provider could have received reimbursement from the Administration or a contractor but for the provider's failure to file a claim in accordance with the requirements of AHCCCS statutes, rules, the provider agreement, or contract, such as, but not limited to, requirements to request and obtain prior authorization, timely filing, and clean claim requirements.
- Historical Note**
- Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-702 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text identical to the emergency (Supp. 83-3). Former Section R9-22-702 repealed, new Section R9-22-702 adopted effective October 1, 1983 (Supp. 83-5). Amended by adding subsection (B) effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 3217, effective October 1, 2005 (Supp. 05-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3).
- R9-22-703. Payments by the Administration**
- A. General requirements. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of October 1, 2012, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
- B. Timely submission of claims.
1. Under A.R.S. § 36-2904, the Administration shall deem a paper or electronic claim to be submitted on the date that it is received by the Administration. The Administration shall do one or more of the following for each claim it receives:
 - a. Place a date stamp on the face of the claim,
 - b. Assign a system-generated claim reference number, or
 - c. Assign a system-generated date-specific number.
 2. Unless a shorter time period is specified in contract, the Administration shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
 - a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
 - b. Six months from the date of eligibility posting.
 3. Unless a shorter time period is specified in contract, the Administration shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
 - a. Twelve months from the date of service or for an inpatient hospital claim, 12 months from the date of discharge; or
 - b. Twelve months from the date of eligibility posting.
 4. Unless a shorter time period is specified in contract, the Administration shall not pay a claim submitted by an IHS or tribal facility for a covered service unless the claim is initially submitted within 12 months from the date of service, date of discharge, or eligibility posting, whichever is later.
- C. Claims processing.
1. The Administration shall notify the AHCCCS-registered provider with a remittance advice when a claim is processed for payment.
 2. The Administration shall reimburse a hospital for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and in the manner and at the rate described in A.R.S. § 36-2903.01:
 - a. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
 - b. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
 - c. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a fee of one percent per month for each month or portion of a month following the 60th day of receipt of the bill until date of payment.
 3. A claim is paid on the date indicated on the disbursement check.
 4. A claim is denied as of the date of the remittance advice.
 5. The Administration shall process a hospital claim under this Article.
- D. Prior authorization.
1. An AHCCCS-registered provider shall:
 - a. Obtain prior authorization from the Administration for non-emergency hospital admissions, covered services as specified in Articles 2 and 12 of this Chapter, and for administrative days as described in R9-22-712.75,
 - b. Notify the Administration of hospital admissions under Article 2 of this Chapter, and
 - c. Make records available for review by the Administration upon request.
 2. The Administration may deny a claim if the provider fails to comply with subsection (D)(1).
 3. If the Administration issues prior authorization for an inpatient hospital admission, a specific service, or level of care but subsequent medical review indicates that the admission, the service, or level of care was not medically appropriate, the Administration shall adjust the claim payment.
- E. Review of claims and coverage for hospital supplies.
1. The Administration may conduct prepayment and post-payment review of any claims, including but not limited to hospital claims.
 2. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
 - a. Patient care kit,
 - b. Toothbrush,
 - c. Toothpaste,

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- d. Petroleum jelly,
 - e. Deodorant,
 - f. Septi soap,
 - g. Razor or disposable razor,
 - h. Shaving cream,
 - i. Slippers,
 - j. Mouthwash,
 - k. Shampoo,
 - l. Powder,
 - m. Lotion,
 - n. Comb, and
 - o. Patient gown.
3. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
- a. Arm board,
 - b. Diaper,
 - c. Underpad,
 - d. Special mattress and special bed,
 - e. Gloves,
 - f. Wrist restraint,
 - g. Limb holder,
 - h. Disposable item used instead of a durable item,
 - i. Universal precaution,
 - j. Stat charge, and
 - k. Portable charge.
4. The Administration shall determine in a hospital claims review whether services rendered were:
- a. Covered services as defined in Article 2;
 - b. Medically necessary;
 - c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
 - d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2903.01.
5. If the Administration adjudicates a claim, a person may file a claim dispute challenging the adjudication under 9 A.A.C. 34.
- F. Overpayment for AHCCCS services.**
- 1. An AHCCCS-registered provider shall notify the Administration when the provider discovers the Administration made an overpayment.
 - 2. The Administration shall recoup an overpayment from a future claim cycle if an AHCCCS-registered provider fails to return the overpaid amount to the Administration.
 - 3. The Administration shall document any recoupment of an overpayment on a remittance advice.
 - 4. An AHCCCS-registered provider may file a claim dispute under 9 A.A.C. 34 if the AHCCCS-registered provider disagrees with a recoupment action.
- G. For services subject to limitations or exclusions such as the number of hours, days, or visits covered as described in Article 2 of this Chapter, once the limit is reached the Administration will not reimburse the services.**
- H. Prior quarter reimbursement. A provider shall:**
- 1. Bill the Administration for services provided during a prior quarter eligibility period upon verification of eligibility or upon notification from a member of AHCCCS eligibility.
 - 2. Reimburse a member when payment has been received from the Administration for covered services during a prior quarter eligibility period. All funds paid by the member shall be reimbursed.
 - 3. Accept payment received by the Administration as payment in full.
- I. Payment for in-state inpatient hospital services for claims with discharge dates on or before September 30, 2014. The Administration shall reimburse an in-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article.**
- J. Payment for out-of-state inpatient hospital services for claims with discharge dates on or before September 30, 2014. The Administration shall reimburse an out-of-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, for covered inpatient services by multiplying covered charges by the most recent statewide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b).**
- K. Payment for inpatient hospital services for claims with discharge dates on and after October 1, 2014 regardless of admission date. The Administration shall reimburse an in-state or out-of-state provider of inpatient hospital services rendered with a discharge date on or after October 1, 2014, the DRG rate established by the Administration.**
- L. The Administration may enter into contracts for the provisions of transplant services.**

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R-22-703 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-703 repealed, new Section R9-22-703 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (1) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective September 16, 1987 (Supp. 87-3). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 19 A.A.R. 3309, November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-704. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-704 adopted as an emergency now adopted and amended as a permanent rule effective August 30 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended subsection A., Paragraph 2. effective October 1, 1985 (Supp. 85-5). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

R9-22-705. Payments by Contractors

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- A.** General requirements. A contractor shall contract with providers to provide covered services to members enrolled with the contractor. The contractor is responsible for reimbursing providers and coordinating care for services provided to a member. Except as provided in subsection (A)(2), a contractor is not required to reimburse a noncontracting provider for services rendered to a member enrolled with the contractor.
1. Providers. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of March 6, 1992, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
 2. A contractor shall reimburse a noncontracting provider for services rendered to a member enrolled with the contractor as specified in this Article if:
 - a. The contractor referred the member to the provider or authorized the provider to render the services and the claim is otherwise payable under this Chapter, or
 - b. The service is emergent under Article 2 of this Chapter.
- B.** Timely submission of claims.
1. Under A.R.S. § 36-2904, a contractor shall deem a paper or electronic claim as submitted on the date that the claim is received by the contractor. The contractor shall do one or more of the following for each claim the contractor receives:
 - a. Place a date stamp on the face of the claim,
 - b. Assign a system-generated claim reference number, or
 - c. Assign a system-generated date-specific number.
 2. Unless a shorter time period is specified in subcontract, a contractor shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
 - a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
 - b. Six months from the date of eligibility posting.
 3. Unless a shorter time period is specified in subcontract, a contractor shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
 - a. Twelve months from the date of service or for an inpatient hospital claim, 12 months from the date of discharge; or
 - b. Twelve months from the date of eligibility posting.
- C.** Date of claim.
1. A contractor's date of receipt of an inpatient or an outpatient hospital claim is the date the claim is received by the contractor as indicated by the date stamp on the claim, the system-generated claim reference number, or the system-generated date-specific number assigned by the contractor.
 2. A hospital claim is considered paid on the date indicated on the disbursement check.
 3. A denied hospital claim is considered adjudicated on the date of the claim's denial.
 4. For a claim that is pending for additional supporting documentation specified in A.R.S. § 36-2903.01 or 36-2904, the contractor shall assign a new date of receipt upon receipt of the additional documentation.
 5. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. § 36-2903.01 or 36-2904, the contractor shall not assign a new date of receipt.
 6. A contractor and a hospital may, through a contract approved as specified in R9-22-715, adopt a method for identifying, tracking, and adjudicating a claim that is different from the method described in this subsection.
- D.** Payment for in-state inpatient hospital services for claims with discharge dates on or before September 30, 2014. A contractor shall reimburse an in-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, at either a rate specified by subcontract or, in absence of the subcontract, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715. This subsection does not apply to an urban contractor as specified in R9-22-718 and A.R.S. § 36-2905.01.
- E.** Payment for Inpatient out-of-state hospital payments for claims with discharge dates on or before September 30, 2014. In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent statewide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b).
- F.** Payment for inpatient hospital services for claims with discharge dates on and after October 1, 2014 regardless of admission date. Subject to R9-22-718 and A.R.S. § 36-2905.01 regarding urban hospitals, a contractor shall reimburse an in-state or out-of-state provider of inpatient hospital services, at either a rate specified by subcontract or, in absence of a subcontract, the DRG rate established by the Administration and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
- G.** Payment for in-state outpatient hospital services.
A contractor shall reimburse an in-state provider of outpatient hospital services rendered on or after July 1, 2005, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10, A.R.S. § 36-2903.01 and other sections of this Article. The terms of the subcontract are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
- H.** Outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the contractor shall pay the claim by multiplying the covered charges for the outpatient services by the statewide outpatient cost-to-charge ratio.
- I.** Payment for observation days. A contractor shall reimburse a provider and a noncontracting provider for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, as prescribed under R9-22-712, R9-22-712.10, and R9-22-712.45.
- J.** Review of claims and coverage for hospital supplies.
1. A contractor may conduct a review of any claims submitted and recoup any payments made in error.
 2. A hospital shall obtain prior authorization from the appropriate contractor for nonemergency admissions. When issuing prior authorization, a contractor shall consider the medical necessity of the service, and the availability and cost effectiveness of an alternative treatment.

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- Failure to obtain prior authorization when required is cause for nonpayment or denial of a claim. A contractor shall not require prior authorization for medically necessary services provided during any prior period for which the contractor is responsible. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of the subcontract regarding utilization control activities. A hospital shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and shall make the hospital's medical records pertaining to a member enrolled with a contractor available for review.
3. Regardless of prior authorization or concurrent review activities, a contractor may make prepayment or post-payment review of all claims, including but not limited to a hospital claim. A contractor may recoup an erroneously paid claim. If prior authorization was given for an inpatient hospital admission, a specific service, or level of care but subsequent medical review indicates that the admission, the service, or level of care was not medically appropriate, the contractor shall adjust the claim payment.
 4. A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures if the subcontract meets the requirements of R9-22-715.
 5. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
 - a. Patient care kit,
 - b. Toothbrush,
 - c. Toothpaste,
 - d. Petroleum jelly,
 - e. Deodorant,
 - f. Septi soap,
 - g. Razor,
 - h. Shaving cream,
 - i. Slippers,
 - j. Mouthwash,
 - k. Disposable razor,
 - l. Shampoo,
 - m. Powder,
 - n. Lotion,
 - o. Comb, and
 - p. Patient gown.
 6. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
 - a. Arm board,
 - b. Diaper,
 - c. Underpad,
 - d. Special mattress and special bed,
 - e. Gloves,
 - f. Wrist restraint,
 - g. Limb holder,
 - h. Disposable item used instead of a durable item,
 - i. Universal precaution,
 - j. Stat charge, and
 - k. Portable charge.
 7. The contractor shall determine in a hospital claims review whether services rendered were:
 - a. Covered services as defined in R9-22-201;
 - b. Medically necessary;
 - c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
 - d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2904.
 8. If a contractor adjudicates a claim or recoups payment for a claim, a person may file a claim dispute challenging the adjudication or recoupment as described under 9 A.A.C. 34.
 - K. Non-hospital claims. A contractor shall pay claims for non-hospital services in accordance with contract, or in the absence of a contract, at a rate not less than the Administration's capped fee-for-service schedule or at a lower rate if negotiated between the two parties.
 - L. Payments to hospitals. A contractor shall pay for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and as described in A.R.S. § 36-2904:
 1. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
 2. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
 3. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a 1 percent penalty of the rate for each month or portion of the month following the 60th day of receipt of the bill until date of payment.
 - M. Interest payment. In addition to the requirements in subsection (L), a contractor shall pay interest for late claims as defined by contract.
 - N. For services subject to limitations or exclusions such as the number of hours, days, or visits covered as described in Article 2 of this Chapter, once the limit is reached the Administration will not reimburse the services.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-705 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of the amended rule identical to emergency (Supp. 83-3). Former Section R9-22-705 repealed, new Section R9-22-705 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment adopted effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (C) effective October 1, 1987; amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended subsections (A) and (C) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by

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exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-706. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-706 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-706 repealed, new Section R9-22-706 adopted effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Amended as an emergency effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment adopted effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsections (A), (D), (E), (F), and (G) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (F) effective December 22, 1987 (Supp. 87-4). Amended subsections (A) and (F) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 10 A.A.R. 4656, effective January 1, 2005 (Supp. 04-4).

R9-22-707. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-707 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Repealed as a permanent action effective May 16, 1983 (Supp. 83-3). New Section R9-22-707 adopted effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Former Section R9-22-707 repealed, new Section R9-22-707 adopted effective October 1, 1985 (Supp. 85-5). Former Section R9-22-707 repealed, new Section R9-22-707 adopted effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

R9-22-708. Payments for Services Provided to Eligible American Indians

- A. For purposes of this Article “IHS enrolled” or “enrolled with IHS” means an American Indian who has elected to receive covered services through IHS instead of a contractor.
- B. For an American Indian who is enrolled with IHS, AHCCCS shall pay IHS the most recent all-inclusive inpatient, outpatient or ambulatory surgery rates published by Health and Human Services (HHS) in the Federal Register, or a separately contracted rate with IHS, for AHCCCS-covered services provided in an IHS facility. AHCCCS shall reimburse providers for the Medicare coinsurance and deductible amounts required to be paid by the Administration or contractor in Chapter 29, Article 3 of this Title.
- C. When IHS refers an American Indian enrolled with IHS to a provider other than an IHS or tribal facility, the provider to whom the referral is made shall obtain prior authorization from AHCCCS for services as required under Articles 2, 7 or 12 of this Chapter.
- D. For an American Indian enrolled with a contractor, AHCCCS shall pay the contractor a monthly capitation payment.
- E. Once an American Indian enrolls with a contractor, AHCCCS shall not reimburse any provider other than IHS or a Tribal facility.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-708 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-708 repealed, new Section R9-22-708 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-708 renumbered and amended as Section R9-22-709, new Section R9-22-708 adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended by final rulemaking at 10 A.A.R. 4656, effective January 1, 2005 (Supp. 04-4). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-709. Contractor’s Liability to Hospitals for the Provision of Emergency and Post-stabilization Care

A contractor is liable for emergency hospitalization and post-stabilization care as described in R9-22-210 and R9-22-210.01.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-709 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-709 repealed, new Section R9-22-709 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-709 renumbered and amended as Section R9-22-713, former Section R9-22-708 renumbered and amended as Section R9-22-709 effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

Editor’s Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor’s Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publi-

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cation in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-710. Payments for Non-hospital Services

- A.** Capped fee-for-service. The Administration shall provide notice of changes in methods and standards for setting payment rates for services in accordance with 42 CFR 447.205, December 19, 1983, incorporated by reference and on file with the Administration and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
1. Non-contracted services. In the absence of a contract that specifies otherwise, a contractor shall reimburse a provider or noncontracting provider for non-hospital services according to the Administration's capped-fee-for-service schedule.
 2. Procedure codes. The Administration shall maintain a current copy of the National Standard Code Sets mandated under 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004), incorporated by reference and on file with the Administration and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
 - a. A person shall submit an electronic claim consistent with 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004).
 - b. A person shall submit a paper claim using the National Standard Code Sets as described under 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004).
 - c. The Administration may deny a claim for failure to comply with subsection (A) (2) (a) or (b).
 3. Fee schedule. The Administration shall pay providers, including noncontracting providers, at the lesser of billed charges or the capped fee-for-service rates specified in subsections (A)(3)(a) through (A)(3)(d) unless a different fee is specified in a contract between the Administration and the provider, or is otherwise required by law.
 - a. Physician services. Fee schedules for payment for physician services are on file at the central office of the Administration for reference use during customary business hours.
 - b. Dental services. Fee schedules for payment for dental services are on file at the central office of the Administration for reference use during customary business hours.
 - c. Transportation services. Fee schedules for payment for transportation services are on file at the central office of the Administration for reference use during customary business hours. For dates of service beginning:
 - i. October 1, 2012 through September 30, 2013, the Administration and its contractors shall reimburse ambulance services at 68.59 percent of the ADHS rates that are in effect as of August 2, 2012.
 - ii. October 1, 2013 through September 30, 2014, the Administration and its contractors shall reimburse ambulance services at 68.59 percent of the ADHS rates that are in effect as of August 2, 2013.
- iii.** October 1, 2014 through September 30, 2015, the Administration and its contractors shall reimburse ambulance services at 74.74 percent of the ADHS rates that are in effect as of August 2, 2014.
- d.** Medical supplies and durable medical equipment (DME). Fee schedules for payment for medical supplies and DME are on file at the central office of the Administration for reference use during customary business hours. The Administration shall reimburse a provider once for purchase of DME during any two-year period, unless the Administration determines that DME replacement within that period is medically necessary for the member. Unless prior authorized by the Administration, no more than one repair and adjustment of DME shall be reimbursed during any two-year period.
- B.** Pharmacy services. The Administration shall not reimburse pharmacy services unless the services are provided by a pharmacy having a subcontract with a Pharmacy Benefit Manager (PBM) contracted with AHCCCS. Except as specified in subsection (C), the Administration shall reimburse pharmacy services according to the terms of the contract.
- C.** FQHC Pharmacy reimbursement.
1. For purposes of this Section the following terms are defined:
 - a. "340B Drug Pricing Program" means the discount drug purchasing program described in 42 U.S.C 256b.
 - b. "340B Ceiling Price" means the maximum price that drug manufacturers can charge covered entities participating in the 340B Drug Pricing Program as reported by the drug manufacturer to HRSA.
 - c. "340B entity" means a covered entity, eligible to participate in the 340B Drug Pricing Program, as defined by the Health Resources and Human Services Administration.
 - d. "Actual Acquisition Cost (AAC)" means the purchase price of a drug paid by a pharmacy net of discounts, rebates, chargebacks and other adjustments to the price of the drug. The AAC excludes dispensing fees.
 - e. "Contracted Pharmacy" means an arrangement through which a 340B entity may contract with an outside pharmacy to provide comprehensive pharmacy services utilizing medications subject to 340B pricing.
 - f. "Dispensing Fee" means the amount paid for the professional services provided by the pharmacist for dispensing a prescription. The Dispensing Fee does not include any payment for the drugs being dispensed.
 - g. "Federally Qualified Health Center" means a public or private non-profit health care organization that has been identified by HRSA and certified by CMS as meeting the criteria under sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act and receives funds under section 330 of the Public Health Service Act.
 - h. "Federally Qualified Health Center Look-Alike" means a public or private non-profit health care organization that has been identified by HRSA and certified by CMS as meeting the definition of "health center" under section 330 of the Public Health Service Act, but does not receive grant funding under section 330.

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- i. "FQHC or FQHC Look-Alike pharmacy" means a pharmacy that dispenses drugs to FQHC or FQHC-LA patients and that is owned and/or operated by an FQHC/FQHC-LA or by an entity that reports the costs of an FQHC/FQHC-LA on its Medicare Cost Report, whether or not collocated with an FQHC or an FQHC Look-Alike.
2. Effective the later of February 1, 2012, or CMS approval of a State Plan Amendment, an FQHC or FQHC Look-Alike shall:
 - a. Notify the AHCCCS provider registration unit of its status as a 340B covered entity no later than:
 - i. 30 days after the effective date of this Section;
 - ii. 30 days after registration with the Health Resources and Services Administration (HRSA) for participation in the 340B program, or
 - iii. The time of application to become an AHCCCS provider.
 - b. Provide the 340B pricing file to the AHCCCS Administration upon request. The 340B pricing file shall be provided in the file format as defined by AHCCCS.
 - c. Identify 340B drug claims submitted to the AHCCCS FFS PBM or the Managed Care Contractors' PBMs for reimbursement. The 340B drug claim identification and claims processing for a drug claim submission shall be consistent with claim instructions issued and required by AHCCCS to identify such claims.
3. The FQHC and the FQHC Look-Alike pharmacies shall submit claims for AHCCCS members for drugs that are identified in the 340B pricing file, whether or not purchased under the 340B pricing file, with the lesser of:
 - a. The actual acquisition cost, or
 - b. The 340B ceiling price.
4. The AHCCCS Fee-for-Service and Managed Care Contractors' PBMs shall reimburse claims for drugs which are identified in the 340B pricing file dispensed by FQHC and FQHC Look -Alike pharmacies, whether or not purchased under the 340B pricing file, at the amount submitted under subsection (C)(3) plus a dispensing fee listed in the AHCCCS Capped Fee-For-Service Schedule unless a contract between the 340B entity and a Managed Care Contractor's PBM specifies a different dispensing fee.
5. Contracted pharmacies shall not submit claims for drugs dispensed under an agreement with the 340B entity as part of the 340B drug pricing program, and the AHCCCS Administration and Managed Care Contractors shall not reimburse such claims.
6. The AHCCCS Administration and Managed Care Contractors shall reimburse contracted pharmacies for drugs not dispensed under an agreement with the 340B entity as part of the 340B program at the price and dispensing fee set forth in the contract between the contracted pharmacy and the AHCCCS or its Managed Care Contractors' PBMs. Neither the Administration nor its Managed Care Contractors will reimburse a contracted pharmacy that does not have a contract with the Administration or MCO's PBM.
7. The AHCCCS Administration and its Managed Care Contractors shall reimburse FQHC and FQHC Look-Alike pharmacies for drugs that are not eligible under the 340B Drug Pricing Program at the price and dispensing fee set forth in their contract with the AHCCCS or its Managed Care Contractors' PBMs.
8. AHCCCS may periodically conduct audits to ensure compliance with this Section.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-710 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of amended rule identical to emergency (Supp. 83-3). Former Section R9-22-710 repealed, new Section R9-22-710 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985. The capped fee-for-service schedules, deleted from Section R9-22-710, are now on file at the central office of the Administration (Supp. 85-5). Amended subsections (B) through (D) effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective July 1, 1988 (Supp. 88-3). Amended subsection (B) effective April 27, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 11 A.A.R. 3830, effective November 12, 2005 (Supp. 05-3). Amended by exempt rulemaking at 18 A.A.R. 212, effective February 1, 2012 (Supp. 12-1). Amended by exempt rulemaking at 18 A.A.R. 1971, effective August 1, 2012 (Supp. 12-3). Amended by exempt rulemaking at 18 A.A.R. 2630, effective October 1, 2012 (Supp. 12-4). Amended by final rulemaking at 19 A.A.R. 1681, effective August 9, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3525, effective October 18, 2013 (Supp. 13-4)

R9-22-711. Copayments

- A. For purposes of this Article:
 1. A copayment is a monetary amount that a member pays directly to a provider at the time a covered service is rendered.
 2. An eligible individual is assigned to a hierarchy established in subsections (B) through (E), for the purposes of establishing a copayment amount.
 3. No refunds shall be made for a retroactive period if there is a change in an individual's status that alters the amount of a copayment.
- B. The following services are exempt from AHCCCS copayments for all members:
 1. Family planning services and supplies,
 2. Services related to a pregnancy or any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for a pregnant woman,
 3. Emergency services as described in 42 CFR 447.56(2)(i),
 4. All services paid on a fee-for-service basis,
 5. Preventive services, such as well visits, immunizations, pap smears, colonoscopies, and mammograms,
 6. Provider preventable services.
- C. The following individuals are exempt from AHCCCS copayments:
 1. An individual under age 19, including individuals eligible for the KidsCare Program in A.R.S. § 36-2982;
 2. An individual determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services;

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3. An individual eligible for the Arizona Long-Term Care Program in A.R.S. § 36-2931;
 4. An individual eligible for QMB under Chapter 29;
 5. An individual eligible for the Children's Rehabilitative Services program under A.R.S. § 36-2906(E);
 6. An individual receiving nursing facility or HCBS services under R9-22-216;
 7. An individual receiving hospice care as defined in 42 U.S.C. 1396d(o);
 8. An American Indian individual enrolled in a health plan and has received services through an IHS facility, tribal 638 facility or urban Indian health program;
 9. An individual eligible in the Breast and Cervical Cancer program as described under Article 20;
 10. An individual who is pregnant and through the post-partum period following the pregnancy;
 11. An individual with respect to whom child welfare services are made available under Part B of Title IV of the Social Security Act on the basis of being a child in foster care, without regard to age;
 12. An individual with respect to whom adoption or foster care assistance is made available under Part E of Title IV of the Social Security Act, without regard to age; and
 13. An adult eligible under R9-22-1427(E), with income at or below 106% of the FPL.
- D. Non-mandatory copayments.** Unless otherwise listed in subsection (B) or (C), individuals under subsections (D)(1) through (6) are subject to the copayments listed in this subsection. A provider shall not deny a service when a member states to the provider an inability to pay a copayment.
1. A caretaker relative eligible under R9-22-1427(A);
 2. An individual eligible for Young Adult Transitional Insurance (YATI) in A.R.S. § 36-2901(6)(a)(iii);
 3. An individual eligible for State Adoption Assistance in R9-22-1433;
 4. An individual eligible for Supplemental Security Income (SSI);
 5. An individual eligible for SSI Medical Assistance Only (SSI/MAO) in Article 15; and
 6. An individual eligible for the Freedom to Work program in A.R.S. § 36-2901(6)(g).
 7. Copayment amount per service:
 - a. \$2.30 per prescription drug.
 - b. \$3.40 per outpatient visit, excluding an emergency room visit, if any of the services rendered during the visit are coded as evaluation and management services or non-emergent surgical procedures according to the National Standard Code Sets. An outpatient visit includes any setting where these services are performed such as a physician's office, an Ambulatory Surgical Center (ASC), or a clinic.
 - c. \$2.30 per visit, if a copayment is not being imposed under subsection (D)(7)(b) and any of the services rendered during the visit are coded as physical, occupational or speech therapy services according to the National Standard Code Sets.
- E. Mandatory copayments.**
1. Copayments for individuals eligible for Transitional Medical Assistance (TMA) under R9-22-1427(B)(1)(c)(i). Unless otherwise listed in subsection (C), an individual is required to pay the following copayments for prescription drugs and outpatient services unless the service is provided during an emergency room visit or the service is otherwise exempt under subsection (B). An outpatient visit includes any setting where these outpatient services are performed such as, an outpatient hospital, a physician's provider's office, HCBS setting, an Ambulatory Surgical Center (ASC), or a clinic:
 - a. \$2.30 per prescription drug.
 - b. \$4.00 per outpatient visit, if any of the services rendered during the visit are coded as evaluation and management services according to the National Standard Code Sets.
 - c. If a copayment is not being imposed under subsection (E)(1)(b), \$3.00 per visit if any of the services rendered during the visit are coded as physical, occupational or speech therapy services according to the National Standard Code Sets.
 - d. If a copayment is not being imposed under subsection (E)(1)(b) or (c), \$3.00 per visit, if any of the services rendered during the visit are coded as non-emergent surgical procedures according to the National Standard Code Sets.
 2. Copayments for persons eligible under R9-22-1427(E) with income above 106% of the FPL and for persons eligible under A.R.S. §§ 36-2907.10 and 36-2907.11. Subject to CMS approval, unless otherwise listed in subsection (C), these individuals are required to pay the following copayments for prescription drugs and outpatient services unless the service is provided during an emergency room visit or the service is otherwise exempt under subsection (B). An outpatient visit includes any setting where these outpatient services are performed such as, an outpatient hospital, a physician's provider's office, HCBS setting, an Ambulatory Surgical Center (ASC), or a clinic:
 - a. \$4.00 per prescription drug.
 - b. \$5.00 per outpatient visit when the AHCCCS fee schedule for the visit code is a rate from \$50 to less than \$100, if any of the services rendered during the visit are coded as evaluation and management services according to the National Standard Code Sets.
 - c. \$10.00 per outpatient visit when the AHCCCS fee schedule for the visit code is a rate of \$100 or greater, if any of the services rendered during the visit are coded as evaluation and management services according to the National Standard Code Sets.
 - d. If a copayment is not being imposed under subsection (E)(2)(b) or (E)(2)(c), for services coded as physical, occupational or speech therapy services according to the National Standard Code Sets.
 - i. \$2.00 if the rate on the fee schedule is \$20 to \$39.99,
 - ii. \$4.00 if the rate on the fee schedule is \$40 to \$49.99, or
 - iii. \$5.00 if the rate on the fee schedule is \$50 and above per visit.
 - e. If a copayment is not being imposed under subsection (E)(2)(b) – (E)(2)(d), for services coded as non-emergent surgical procedures according to the National Standard Code Sets,
 - i. \$30.00 if the rate on the fee schedule is \$300 to \$499.99, or
 - ii. \$50.00 if the rate on the fee schedule is \$500 and above per visit.
 - f. Unless the individual is otherwise exempt in subsection (C) or the service is exempted under subsection (B) the individual is required to pay \$2.00 per trip for non-emergency transportation in an urban area.
 - g. Unless the individual is otherwise exempt in subsection (C) or the service is exempted under subsection

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(B) the individual is required to pay \$8.00 for non-emergency use of the emergency room.

- h. Unless the individual is otherwise exempt in subsection (C) or the service is exempt under subsection (B) the individual is required to pay \$75 for an Inpatient stay.
- 3. The provider may deny a service if the member does not pay the copayment required by subsection (E), however, a provider may choose to reduce or waive copayments under this subsection on a case-by-case basis.
- F. A provider is responsible for collecting any copayment imposed under this Section.
- G. The total aggregate amount of copayments under subsections (D) or (E) may not exceed 5% of the family's income as applied on a quarterly basis. The member may establish that the aggregate limit has been met on a quarterly basis by providing the Administration with records of copayments incurred during the quarter. In addition, the Administration shall also use claims and encounters information available to the Administration to establish when a member's copayment obligation has reached 5% of the family's income.
- H. Reduction in payments to providers. The Administration and its contractors shall reduce the payment it makes to any provider by the amount of a member's copayment obligation under subsection (E), regardless of whether the provider successfully collects the copayments described in this Section.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Sections R9-22-711 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-711 repealed, new Section R9-22-711 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by exempt rulemaking at 9 A.A.R. 4557, effective October 1, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 2194, effective May 3, 2004 (Supp. 04-2). Amended by exempt rulemaking at 10 A.A.R. 4266, effective October 1, 2004 (Supp. 04-3). Amended by final rulemaking at 16 A.A.R. 1449, effective October 1, 2010 (Supp. 10-3). Section amended by exempt rulemaking at 18 A.A.R. 461, effective April 1, 2012 (Supp. 12-1). Section amended by final rulemaking at 19 A.A.R. 2954, effective November 11, 2013 (Supp. 13-3). Amended by exempt rulemaking at 20 A.A.R. 128, effective December 30, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 2755, effective January 1, 2015 (Supp. 14-3).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the

Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-712. Reimbursement: General

- A. Inpatient and outpatient discounts and penalties. If a claim is pending for additional documentation required under A.R.S. § 36-2903.01(G)(4), the period during which the claim is pending is not used in the calculation of the quick-pay discounts and slow-pay penalties under A.R.S. § 36-2903.01(G)(5).
- B. Inpatient and outpatient in-state or out-of-state hospital payments.
 - 1. Payment for inpatient out-of-state hospital services for claims with discharge dates on or before September 30, 2014. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent statewide urban cost-to-charge ratio as determined in R9-22-712.01(6)(d).
 - 2. Payment for inpatient in-state hospital services for claims with discharge dates on or before September 30, 2014. AHCCCS shall reimburse an in-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, at the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article.
 - 3. Payment for inpatient in-state or out-of-state hospital services for claims with discharge dates on and after October 1, 2014 regardless of admission date. Subject to R9-22-718 and A.R.S. § 36-2905.01 regarding urban hospitals, a contractor shall reimburse an in-state or out-of-state provider of inpatient hospital services, at either a rate specified by subcontract or, in the absence of a subcontract, the DRG rate established by the Administration and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
 - 4. Outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse an out-of-state hospital for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the Administration shall pay the claim by multiplying the covered charges for the outpatient services by the statewide outpatient cost-to-charge ratio.
 - 5. Outpatient in-state hospital payments. A contractor shall reimburse an in-state provider of outpatient hospital services rendered on or after July 1, 2005, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10, A.R.S. § 36-2903.01 and other sections of this Article. The terms of the subcontract are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
- C. Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall allow the Administration access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or the Administration's designated representative in performance of the Administration's utilization control activities. The Administration shall deny a claim for failure to cooperate.
- D. Prior authorization. The Administration or contractor may deny a claim if a provider fails to obtain prior authorization as required under R9-22-210.
- E. Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers, to prepayment medical review

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or post-payment review, or both. The Administration shall conduct post-payment reviews consistent with A.R.S. § 36-2903.01 and may recoup erroneously paid claims.

F. Claim receipt.

1. The Administration's date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the system-generated claim reference number or system-generated date-specific number.
2. Hospital claims are considered paid on the date indicated on disbursement checks.
3. A denied claim is considered adjudicated on the date the claim is denied.
4. Claims that are denied and are resubmitted are assigned new receipt dates.
5. For a claim that is pending for additional supporting documentation specified in A.R.S. § 36-2903.01 or 36-2904, the Administration shall assign a new date of receipt upon receipt of the additional documentation.
6. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. § 36-2903.01 or 36-2904, the Administration shall not assign a new date of receipt.

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

1. Computation of outpatient hospital reimbursement. The Administration shall compute the cost-to-charge ratio on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient operating and capital costs are included in the computation but outpatient medical education costs that are included in the inpatient medical education component are excluded. To calculate the outpatient hospital cost-to-charge ratio annually for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in R9-22-712.01. The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:
 - a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters for outpatient hospital services by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital by taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.
 - b. Cost-to-charge limit. To comply with 42 CFR 447.325, the Administration may limit cost-to-charge ratios to 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are non-covered or not applicable to outpatient hospital services

from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.

2. New hospitals. The Administration shall reimburse new hospitals at the weighted statewide average outpatient hospital cost-to-charge ratio multiplied by covered charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for a new hospital until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing.
3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in a specialty facility.
4. Reimbursement requirements. To receive payment from the Administration, a hospital shall submit claims that are legible, accurate, error free, and have a covered charge greater than zero. The Administration shall not reimburse hospitals for emergency room treatment, observation hours or days, or other outpatient hospital services performed on an outpatient basis, if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation area, or other outpatient department. Services provided in the emergency room, observation area, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment.
5. Rebasing. The Administration shall rebase the outpatient hospital cost-to-charge ratios at least every four years but no more than once a year using updated Medicare Cost Reports and claim and encounter data.
6. If a hospital files an increase in its charge master for an existing outpatient service provided on or after July 1, 2004, and on or before June 30, 2005, which represents an aggregate increase in charges of more than 4.7%, the Administration shall adjust the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (5) by applying the following formula:

$$CCR * [1.047 / (1 + \% \text{ increase})]$$
 Where "CCR" means the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (5) and "% increase" means the aggregate percentage increase in charges for outpatient services shown on the hospital charge master.
 "Charge master" means the schedule of rates and charges as described under A.R.S. § 36-436 and the rules that relate to those rates and charges that are filed with the Director of the Arizona Department of Health Services.

Historical Note

Adopted as an emergency effective February 23, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to emergency (Supp. 83-3). Former Section R9-22-712 repealed, new Section R9-22-712 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-712 renumbered and amended as Section R9-22-1001 effective October 1, 1985 (Supp. 85-5). New Section R9-22-712 adopted under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993

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(Supp. 93-3). Amended effective January 14, 1997 (Supp. 97-1). Amended by exempt rulemaking at 10 A.A.R. 3831, effective August 25, 2004 (Supp. 04-3). Amended by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 11 A.A.R. 3231, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by exempt rulemaking at 17 A.A.R. 1337, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.01. Inpatient Hospital Reimbursement for claims with admission dates and discharge dates from October 1, 1998 through September 30, 2014

Inpatient hospital reimbursement. The Administration shall pay for covered inpatient acute care hospital services provided to eligible persons for claims with admission dates and discharge dates from October 1, 1998 through September 30, 2014, on a prospective reimbursement basis. The prospective rates represent payment in full, excluding quick-pay discounts, slow-pay penalties, and third-party payments for both accommodation and ancillary department services. The rates include reimbursement for operating and capital costs. The Administration shall make reimbursement for direct graduate medical education as described in A.R.S. § 36-2903.01. For payment purposes, the Administration shall classify each AHCCS inpatient hospital day of care into one of several tiers appropriate to the services rendered. The rate for a tier is referred to as the tiered per diem rate of reimbursement. The number of tiers is seven and the maximum number of tiers payable per continuous stay is two. Payment of outlier claims, transplant claims, or payment to out-of-state hospitals, freestanding psychiatric hospitals, and other specialty facilities may differ from the inpatient hospital tiered per diem rates of reimbursement described in this Section.

1. Tier rate data. The Administration shall base tiered per diem rates effective on and after October 1, 1998 on Medicare Cost Reports for Arizona hospitals for the fiscal year ending in 1996 and a database consisting of inpatient hospital claims and encounters for dates of service matching each hospital's 1996 fiscal year end.
 - a. Medicare Cost Report data. Because Medicare Cost Report years are not standard among hospitals and were not audited at the time of the rate calculation, the Administration shall inflate all the costs to a common point in time as described in subsection (2) for each component of the tiered per diem rates. The Administration shall not make any changes to the tiered per diem rates if the Medicare Cost Report data are subsequently updated or adjusted. If a single Medicare Cost Report is filed for more than one hospital, the Administration shall allocate the costs to each of the respective hospitals. A hospital shall submit information to assist the Administration in this allocation.
 - b. Claim and encounter data. For the database, the Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were accepted and processed by the Administration at the time the database was developed for rates effective on and after October 1, 1998. The Administration shall subject the claim and encounter data to a series of data quality, reasonableness, and integrity edits and shall exclude from the database or adjust claims and encounters that fail these edits.

The Administration shall also exclude from the database the following claims and encounters:

- i. Those missing information necessary for the rate calculation,
 - ii. Medicare crossovers,
 - iii. Those submitted by freestanding psychiatric hospitals, and
 - iv. Those for transplant services or any other hospital service that the Administration would pay on a basis other than the tiered per diem rate.
2. Tier rate components. The Administration shall establish inpatient hospital prospective tiered per diem rates based on the sum of the operating and capital components. The rate for the operating component is a statewide rate for each tier except for the NICU and Routine tiers, which are based on peer groups. The rate for the capital component is a blend of statewide and hospital-specific values, as described in A.R.S. § 36-2903.01. The Administration shall use the following methodologies to establish the rates for each of these components.
 - a. Operating component. Using the Medicare Cost Reports and the claim and encounter database, the Administration shall compute the rate for the operating component as follows:
 - i. Data preparation. The Administration shall identify and group into department categories, the Medicare Cost Report data that provide ancillary department cost-to-charge ratios and accommodation costs per day. To comply with 42 CFR 447.271, the Administration shall limit cost-to-charge ratios to 1.00 for each ancillary department.
 - ii. Operating cost calculation. To calculate the rate for the operating component, the Administration shall derive the operating costs from claims and encounters by combining the Medicare Cost Report data and the claim and encounter database for all hospitals. In performing this calculation, the Administration shall match the revenue codes on the claims and encounters to the departments in which the line items on the Medicare Cost Reports are grouped. The ancillary department cost-to-charge ratios for a particular hospital are multiplied by the covered ancillary department charges on each of the hospital's claims and encounters. The AHCCCS inpatient days of care on the particular hospital's claims and encounters are multiplied by the corresponding accommodation costs per day from the hospital's Medicare Cost Report. The ancillary cost-to-charge ratios and accommodation costs per day do not include medical education and capital costs. The Administration shall inflate the resulting operating costs for the claims and encounters of each hospital to a common point in time, December 31, 1996, using the DRI inflation factor and shall reduce the operating costs for the hospital by an audit adjustment factor based on available national data and Arizona historical experience in adjustments to Medicare reimbursable costs. The Administration shall further

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- inflate operating costs to the midpoint of the rate year (March 31, 1999).
- iii. Operating cost tier assignment. After calculating the operating costs, the Administration shall assign the claims and encounters used in the calculation to tiers based on diagnosis, procedure, or revenue codes, or NICU classification level, or a combination of these. For the NICU tier, the Administration shall further assign claims and encounters to NICU Level II or NICU Level III peer groups, based on the hospital's certification by the Arizona Perinatal Trust. For the Routine tier, the Administration shall further assign claims and encounters to the general acute care hospital or rehabilitation hospital peer groups, based on state licensure by the Department of Health Services. For claims and encounters assigned to more than one tier, the Administration shall allocate ancillary department costs to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (6).
 - iv. Operating rate calculation. The Administration shall set the rate for the operating component for each tier by dividing total statewide or peer group hospital costs identified in this subsection within the tier by the total number of AHCCCS inpatient hospital days of care reflected in the claim and encounter database for that tier.
- b. Capital component. For rates effective October 1, 1999 the capital component is calculated as described in A.R.S. § 36-2903.01.
 - c. Statewide inpatient hospital cost-to-charge ratio. For dates of service prior to October 1, 2007, the statewide inpatient hospital cost-to-charge ratio is used for payment of outliers, as described in subsections (4), (5), and (6), and out-of-state hospitals, as described in R9-22-712(B). The Administration shall calculate the AHCCCS statewide inpatient hospital cost-to-charge ratio by using the Medicare Cost Report data and claim and encounter database described in subsection (1) and used to determine the tiered per diem rates. For each hospital, the covered inpatient days of care on the claims and encounters are multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. Similarly, the covered ancillary department charges on the claims and encounters are multiplied by the ancillary department cost-to-charge ratios. The accommodation costs per day and the ancillary department cost-to-charge ratios for each hospital are determined in the same way described in subsection (2)(a) but include costs for operating and capital. The Administration shall then calculate the statewide inpatient hospital cost-to-charge ratio by summing the covered accommodation costs and ancillary department costs from the claims and encounters for all hospitals and dividing by the sum of the total covered charges for these services for all hospitals.
 - d. Unassigned tiered per diem rates. If a hospital has an insufficient number of claims to set a tiered per diem rate, the Administration shall pay that hospital the statewide average rate for that tier.
3. Tier assignment. The Administration shall assign AHC-CCS inpatient hospital days of care to tiers based on information submitted on the inpatient hospital claim or encounter including diagnosis, procedure, or revenue codes, peer group, NICU classification level, or a combination of these.
 - a. Tier hierarchy. In assigning claims for AHCCCS inpatient hospital days of care to a tier, the Administration shall follow the Hierarchy for Tier Assignment through September 30, 2014 in R9-22-712.09. The Administration shall not pay a claim for inpatient hospital services unless the claim meets medical review criteria and the definition of a clean claim. The Administration shall not pay for a hospital stay on the basis of more than two tiers, regardless of the number of interim claims that are submitted by the hospital.
 - b. Tier exclusions. The Administration shall not assign to a tier or pay AHCCCS inpatient hospital days of care that do not occur during a period when the person is eligible. Except in the case of death, the Administration shall pay claims in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, including same day transfers, as an outpatient hospital claim. The Administration shall pay same day admit and discharge claims that qualify for either the maternity or nursery tiers based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.
 - c. Seven tiers. The seven tiers are:
 - i. Maternity. The Administration shall identify the Maternity Tier by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the Administration shall pay the AHCCCS inpatient hospital days of care on the claim at the maternity tiered per diem rate.
 - ii. NICU. The Administration shall identify the NICU Tier by a revenue code. A hospital does not qualify for the NICU tiered per diem rate unless the hospital is classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. The Administration shall pay AHC-CCS inpatient hospital days of care on the claim that meet the medical review criteria for the NICU tier and have a NICU revenue code at the NICU tiered per diem rate. The Administration shall pay any remaining AHCCCS inpatient hospital day on the claim that does not meet NICU Level II or NICU Level III medical review criteria at the nursery tiered per diem rate.
 - iii. ICU. The Administration shall identify the ICU Tier by a revenue code. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that meets the medical review criteria for the ICU tier and has an ICU revenue code at the ICU tiered per diem rate. The Administration may classify any AHCCCS inpatient hospital days on the

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- claim without an ICU revenue code, as surgery, psychiatric, or routine tiers.
- iv. Surgery. The Administration shall identify the Surgery Tier by a revenue code and a valid surgical procedure code that is not on the AHCCCS excluded surgical procedure list. The excluded surgical procedure list identifies minor procedures such as sutures that do not require the same hospital resources as other procedures. The Administration shall only split a surgery tier with an ICU tier. AHCCCS shall pay at the surgery tier rate only when the surgery occurs on a date during which the member is eligible.
 - v. Psychiatric. The Administration shall identify the Psychiatric Tier by either a psychiatric revenue code and a psychiatric diagnosis or any routine revenue code if all diagnosis codes on the claim are psychiatric. The Administration shall not split a claim with AHCCCS inpatient hospital days of care in the psychiatric tier with any tier other than the ICU tier.
 - vi. Nursery. The Administration shall identify the Nursery Tier by a revenue code. The Administration shall not split a claim with AHCCCS inpatient hospital days of care in the nursery tier with any tier other than the NICU tier.
 - vii. Routine. The Administration shall identify the Routine Tier by revenue codes. The routine tier includes AHCCCS inpatient hospital days of care that are not classified in another tier or paid under any other provision of this Section. The Administration shall not split the routine tier with any tier other than the ICU tier.
4. Annual update. The Administration shall annually update the inpatient hospital tiered per diem rates through September 30, 2011.
 5. New hospitals. For rates effective on and after October 1, 1998, the Administration shall pay new hospitals the statewide average rate for each tier, as appropriate. The Administration shall update new hospital tiered per diem rates through September 30, 2011.
 6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers under this Section by multiplying the covered charges on a claim by the Medicare Urban or Rural Cost-to-Charge Ratio. The Urban cost-to-charge ratio will be used for hospitals located in a county of 500,000 residents or more. The Rural cost-to-charge ratio will be used for hospitals located in a county of fewer than 500,000 residents.
 - a. Outlier criteria. For rates effective on and after October 1, 1998, the Administration set the statewide outlier cost threshold for each tier at the greater of three standard deviations from the statewide mean operating cost per day within the tier, or two standard deviations from the statewide mean operating cost per day across all the tiers. If the covered costs per day on a claim exceed the urban or rural cost threshold for a tier, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the applicable Medicare Urban or Rural CCR. The resulting amount will be the outlier payment. If there are two tiers on a claim, the Administration shall determine whether the claim is an outlier by using a weighted threshold for the two tiers. The weighted threshold is calculated by multiplying each tier rate by the number of AHCCCS inpatient hospital days of care for that tier and dividing the product by the total tier days for that hospital. Routine maternity stays shall be excluded from outlier reimbursement. A routine maternity is any one-day stay with a delivery of one or two babies. A routine maternity stay will be paid at tier.
 - b. Update. The CCR is updated annually by the Administration for dates of service beginning October 1, using the most current Medicare cost-to-charge ratios published or placed on display by CMS by August 31 of that year. The Administration shall update the outlier cost thresholds for each hospital through September 30, 2011 as described under A.R.S. § 36-2903.01. For inpatient hospital admissions with begin dates of service on and after October 1, 2011, AHCCCS will increase the outlier cost thresholds by 5% of the thresholds that were effective on September 30, 2011.
 - c. Medicare Cost-to-Charge Ratio Phase-In. AHCCCS shall phase in the use of the Medicare Urban or Rural Cost-to-Charge Ratios for outlier determination, calculation and payment. The three-year phase-in does not apply to out-of-state or new hospitals.
 - i. Medicare Cost-to-Charge Ratio Phase-In outlier determination and threshold calculation. For outlier claims with dates of service on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust each hospital specific inpatient cost-to-charge ratio in effect on September 30, 2007 by subtracting one-third of the difference between the hospital specific inpatient cost-to-charge ratio and the effective Medicare Urban or Rural Cost-to-Charge Ratio. For outlier claims with dates of service on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust each hospital specific inpatient cost-to-charge ratio in effect on September 30, 2007 by subtracting two-thirds of the difference between the hospital specific inpatient cost-to-charge ratio and the effective Medicare Urban or Rural Cost-to-Charge Ratio. The adjusted hospital specific inpatient cost-to-charge ratios shall be used for all calculations using the Medicare Urban or Rural Cost-to-Charge Ratios, including outlier determination, and threshold calculation.
 - ii. Medicare Cost-to-Charge Ratio Phase-In calculation for payment. For payment of outlier claims with dates of service on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust the statewide inpatient hospital cost-to-charge ratio in effect on September 30, 2007 by subtracting one-third of the difference between the statewide inpatient hospital cost-to-charge ratio and the effective Medicare urban or rural cost-to-charge ratio. For payment of outlier claims with dates of service on or after October 1, 2008 through September 30, 2009,

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- AHCCCS shall adjust the statewide inpatient hospital cost-to-charge ratio in effect on September 30, 2007 by subtracting two-thirds of the difference between the statewide inpatient hospital cost-to-charge ratio and the effective Medicare urban or rural cost-to-charge ratio.
- iii. Medicare Cost-to-Charge Ratio for outlier determination, threshold calculation, and payment. For outlier claims with dates of service on or after October 1, 2009, the full Medicare Urban or Rural Cost-to-Charge Ratios shall be utilized for all outlier calculations.
 - d. Cost-to-Charge Ratio used for qualification and payment of outlier claims.
 - i. For qualification and payment of outlier claims with begin dates of service on or after April 1, 2011 through September 30, 2011, the CCR will be equal to 95% of the ratios in effect on October 1, 2010.
 - ii. For qualification and payment of outlier claims with begin dates of service on or after October 1, 2011, the CCR will be equal to 90.25% of the most recent published Urban or Rural Medicare CCR as described in subsection (6)(b).
 - iii. For qualification and payment of outlier claims with begin dates of service on or after October 1, 2011 through September 30, 2012, AHCCCS will reduce the cost-to-charge ratio determined under subsection (6)(d)(ii) for a hospital that filed a charge master with ADHS on or after April 1, 2011 by an additional percentage equal to the total percent increase reported on the charge master.
 - iv. Subject to approval by CMS, for qualification and payment of outlier claims with begin dates of service on or after October 1, 2012, AHCCCS will reduce the cost-to-charge ratio determined under subsection (6)(d)(ii) for a hospital that filed a charge master with ADHS on or after June 1, 2012 by an additional percentage equal to the total percent increase reported on the charge master.
 7. Transplants. The Administration shall reimburse hospitals for an AHCCCS inpatient stay in which a covered transplant as described in R9-22-206 is performed through the terms of the relevant contract. If the Administration and a hospital that performs transplant surgery on an eligible person do not have a contract for the transplant surgery, the Administration shall not reimburse the hospital more than what would have been paid to the contracted hospital for that same surgery.
 8. Ownership change. The Administration shall not change any of the components of a hospital's tiered per diem rates upon an ownership change.
 9. Psychiatric hospitals. The Administration shall pay free-standing psychiatric hospitals an all-inclusive per diem rate based on the contracted rates used by the Department of Health Services.
 10. Specialty facilities. The Administration may negotiate, at any time, reimbursement rates for inpatient specialty facilities or inpatient hospital services not otherwise addressed in this Section as provided by A.R.S. § 36-2903.01. For purposes of this subsection, "specialty facility" means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.
 11. Outliers for new hospitals. Outliers for new hospitals will be calculated using the Medicare Urban or Rural Cost-to-Charge Ratio times covered charges. If the resulting cost is equal to or above the cost threshold, the claim will be paid at the Medicare Urban or Rural Cost-to-Charge ratio.
 12. Reductions to tiered per diem payment for inpatient hospital services. Inpatient hospital admissions with begin dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the tiered per diem rates in effect on September 30, 2011.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 3231, effective October 1, 2005 (Supp. 05-3). Amended by exempt rulemaking at 13 A.A.R. 3190, effective October 1, 2007 (Supp. 07-3). Amended by exempt rulemaking at 17 A.A.R. 1337, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.02. Reserved

R9-22-712.03. Reserved

R9-22-712.04. Reserved

R9-22-712.05. Graduate Medical Education Fund Allocation

A. Graduate medical education (GME) reimbursement as of September 30, 1997. Subject to legislative appropriation, the Administration shall make a distribution based on direct graduate medical education costs as described in A.R.S. § 36-2903.01(G)(9)(a).

B. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for the expansions of GME programs approved by the Administration to hospitals for direct program costs eligible for funding under A.R.S. § 36-2903.01(G)(9)(b). A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (B)(3).

1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (B) if all of the following apply:

- a. It is a hospital in Arizona that is the sponsoring institution of, or a participating institution in, one or more of the GME programs in Arizona;
- b. It incurs direct costs for the training of residents in the GME programs, which costs are or will be reported on the hospital's Medicare Cost Report;
- c. It is not administered by or does not receive its primary funding from an agency of the federal government.

2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (B)(4) the following resident positions are eligible for consideration to the extent that the resident training takes place in Ari-

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- zona and not at a health care facility made ineligible under subsection (B)(1)(c):
- a. Filled resident positions in approved programs established as of October 1, 1999 at hospitals that receive funding as described in A.R.S. § 36-2903.01(G)(9)(a) that are additional to the number of resident positions that were filled as of October 1, 1999; and
 - b. All filled resident positions in approved programs other than GME programs described in A.R.S. § 36-2903.01(G)(9)(a) that were established before July 1, 2006.
3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (B) shall provide the applicable information listed in this subsection to the Administration:
 - a. A GME program shall provide all of the following:
 - i. The program name and number assigned by the accrediting organization;
 - ii. The original date of accreditation;
 - iii. The names of the sponsoring institution and all participating institutions current as of the date of reporting;
 - iv. The number of approved resident positions and the number of filled resident positions current as of the date of reporting;
 - v. For programs established as of October 1, 1999, the number of resident positions that were filled as of October 1, 1999, if the program has not already provided this information to the Administration;
 - b. A hospital seeking a distribution under subsection (B) shall provide all of the following that apply:
 - i. If the hospital uses the Intern and Resident Information System (IRIS) for tracking and reporting its resident activity to the fiscal intermediary, copies of the IRIS master and assignment files for the hospital's two most recently completed Medicare cost reporting years as filed with the fiscal intermediary;
 - ii. If the hospital does not use the IRIS or has less than two cost reporting years available in the form of the IRIS master and assignment files, the information normally contained in the IRIS master and assignment files in an alternative format for the hospital's two most recently completed Medicare cost reporting years;
 - iii. At the request of the Administration, a copy of the hospital's Medicare Cost Report or any part of the report for the most recently completed cost reporting year.
 4. Allocation of expansion funds. Annually the Administration shall allocate available funds to each approved GME program in the following manner:
 - a. Information provided by hospitals under subsection (B)(3)(b) shall be used to determine the program in which each eligible resident is enrolled and the number of days that each eligible resident worked in any area of the hospital complex or in a non-hospital setting under agreement with the reporting hospital during the period of assignment to that hospital. For this purpose, the Administration shall use data relating to the most recent 12-month period that is common to all information provided under subsections (B)(3)(b)(i) and (ii).
 - b. The number of eligible residents allocated to each participating institution within each approved GME program shall be determined as follows:
 - i. Total the number of days determined for each participating institution under subsection (B)(4)(a) and divide each total by 365.
 - ii. Proportionally adjust the result of subsection (B)(4)(b)(i) for each participating institution within each program according to the number of residents determined to be eligible under subsection (B)(2).
 - c. The number of allocated eligible residents determined under subsection (B)(4)(b)(ii) shall be adjusted for Arizona Medicaid utilization using the most recent Medicare Cost Report information on file with the Administration as of the date of reporting under subsection (B)(3) and the Administration's inpatient hospital claims and encounter data for the time period corresponding to the Medicare Cost Report information for each hospital. The Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were adjudicated by the Administration as of the date of reporting under subsection (B)(3). The Medicaid-adjusted eligible residents shall be determined as follows:
 - i. For each hospital, the total AHCCCS inpatient hospital days of care shall be divided by the total Medicare Cost Report inpatient hospital days, multiplied by 100 and rounded up to the nearest multiple of 5 percent.
 - ii. The number of allocated eligible residents determined for each participating hospital under subsection (B)(4)(b)(ii) shall be multiplied by the percentage derived under subsection (B)(4)(c)(i) for that hospital. The number of allocated eligible residents determined under subsection (B)(4)(b)(ii) for a participating institution that is not a hospital and not a health care facility made ineligible under subsection (B)(1)(c) shall be multiplied by the percentage derived under subsection (B)(4)(c)(i) for the program's sponsoring institution or, if the sponsoring institution is not a hospital, the sponsoring institution's affiliated hospital. The number of allocated eligible residents determined under subsection (B)(4)(b)(ii) for a participating institution that is made ineligible under subsection (B)(1)(c) shall be multiplied by zero percent.
 - d. The total allocation for each approved program shall be determined by multiplying the Medicaid-adjusted eligible residents determined under subsection (B)(4)(c)(ii) by the per-resident conversion factor determined below and totaling the resulting dollar amounts for all participating institutions in the program. The per-resident conversion factor shall be determined as follows:
 - i. Calculate the total direct GME costs from the most recent Medicare Cost Reports on file with the Administration for all hospitals that have reported such costs.
 - ii. Calculate the total allocated residents determined under subsection (B)(4)(b)(i) for

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- those hospitals described under subsection (B)(4)(d)(i).
- iii. Divide the total GME costs calculated under subsection (B)(4)(d)(i) by the total allocated residents calculated under subsection (B)(4)(d)(ii).
5. Distribution of expansion funds. On an annual basis subject to available funds, the Administration shall distribute the allocated amounts determined under subsection (B)(4) in the following manner:
- a. The allocated amounts shall be distributed in the following order of priority:
- i. To eligible hospitals that do not receive funding in accordance with A.R.S. § 36-2903.01(G)(9)(a) for the direct costs of programs established before July 1, 2006;
- ii. To eligible hospitals that receive funding in accordance with A.R.S. § 36-2903.01(G)(9)(a) for the direct costs of programs established before July 1, 2006;
- b. The allocated amounts shall be distributed to the eligible hospitals in each approved program in proportion to the number of Medicaid-adjusted eligible residents allocated to each hospital within that program under subsection (B)(4)(c)(ii).
- c. If funds are insufficient to cover all distributions within any priority group described under subsection (B)(5)(a), the Administration shall adjust the distributions proportionally within that priority group.
- C. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for the expansions of GME programs approved by the Administration to hospitals for direct program costs eligible for funding under A.R.S. § 36-2903.01(G)(9)(c)(i). A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (C)(3).
1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (C) if it meets all the conditions of subsections (B)(1)(a) through (c).
2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (C)(4), the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (B)(1)(c):
- a. All filled resident positions in approved programs established on or after July 1, 2006; and
- b. For approved programs established on or after July 1, 2006 that have been established for less than one year as of the date of reporting under subsection (C)(3) and have not yet filled their first-year resident positions, all prospective residents reasonably expected by the program to be enrolled as a result of the most recently completed annual resident match.
3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (C) shall provide to the Administration:
- a. A GME program shall provide all of the following:
- i. The requirements of subsections (B)(3)(a)(i) through (iv);
- ii. The academic year rotation schedule on file with the program current as of the date of reporting; and
- iii. For programs described under subsection (C)(2)(b), the number of residents expected to be enrolled as a result of the most recently completed annual resident match.
- b. A hospital seeking a distribution under subsection (C) shall provide the requirements of subsection (B)(3)(b).
4. Allocation of expansion funds. Annually the Administration shall allocate available funds to approved GME programs in the following manner:
- a. Information provided by hospitals in accordance with subsection (B)(3)(b) shall be used to determine the program in which each eligible resident is enrolled and the number of days that each eligible resident worked in any area of the hospital complex or in a non-hospital setting under agreement with the reporting hospital during the period of assignment to that hospital. For this purpose, the Administration shall use data relating to the most recent 12-month period that is common to all information provided in accordance with subsections (B)(3)(b)(i) and (ii).
- b. For approved programs whose resident activity is not represented in the information provided in accordance with subsection (B)(3)(b), information provided by GME programs under subsection (C)(3)(a) shall be used to determine the number of days that each eligible resident is expected to work at each participating institution.
- c. The number of eligible residents allocated to each participating institution for each approved GME program shall be determined by totaling the number of days determined under subsections (C)(4)(a) and (b) and dividing the totals by 365.
- d. The number of allocated residents determined under subsection (C)(4)(c) shall be adjusted for Arizona Medicaid utilization in accordance with subsection (B)(4)(c).
- e. The total allocation for each approved program shall be determined in accordance with subsection (B)(4)(d).
5. Distribution of expansion funds. On an annual basis subject to available funds, the Administration shall distribute the allocated amounts determined under subsection (C)(4) to the eligible hospitals in each approved program in proportion to the number of Medicaid-adjusted eligible residents allocated to each within that program under subsection (C)(4)(d).
- D. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for GME programs approved by the Administration to hospitals for indirect program costs eligible for funding under A.R.S. § 36-2903.01(G)(9)(c)(ii). A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (D)(3).
1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (D) if all of the following apply:
- a. It is a hospital in Arizona that is the sponsoring institution of, or a participating institution in, one or more of the GME programs in Arizona or is the base hospital for one or more of the GME programs in Arizona whose sponsoring institutions are not hospitals;

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- b. It incurs indirect program costs for the training of residents in the GME programs, which are or will be calculated on the hospital's Medicare Cost Report or are reimbursable under the Children's Hospitals Graduate Medical Education Payment Program administered by HRSA;
 - c. It is not administered by or does not receive its primary funding from an agency of the federal government.
2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (D)(4) the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (D)(1)(c):
 - a. Any filled resident position in an approved program that includes a rotation of at least one month per year in a county other than Maricopa or Pima whose population was less than 500,000 persons at the time the residency rotation was added to the academic year rotation schedule;
 - b. For approved programs that have been established for less than one year as of the date of reporting under subsection (D)(3) and have not yet filled their first-year resident positions, all prospective residents reasonably expected by the program to be enrolled as a result of the most recently completed annual resident match who will perform rotations of at least one month per year in a county other than Maricopa or Pima whose population was less than 500,000 persons at the time the residency rotation was added to the academic year rotation schedule.
 3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (D) shall provide to the Administration:
 - a. A GME program shall provide all of the following:
 - i. The requirements of subsections (B)(3)(a)(i) through (iv);
 - ii. The academic year rotation schedule on file with the program current as of the date of reporting;
 - iii. For programs described under subsection (D)(2)(c), the number of residents expected to be enrolled as a result of the most recently completed annual resident match.
 - b. A hospital seeking a distribution under subsection (D) shall provide the requirements of subsection (B)(3)(b)(iii).
 4. Allocation of funds for indirect program costs. Annually the Administration shall allocate available funds to approved GME programs in the following manner:
 - a. Using the information provided by programs under subsection (D)(3), the Administration shall determine for each program the number of residents in the program who are eligible under subsection (D)(2) and the number of months per year that each eligible resident will perform rotations in counties described by subsection (D)(2), multiply the number of eligible residents by the number of months and multiply the result by the per resident per month conversion factor determined under subsection (D)(4)(b).
 - b. Using the most recent Medicare Cost Reports on file with the Administration for all hospitals that have calculated a Medicare indirect medical education payment, the Administration shall determine a per resident per month conversion factor as follows:
 - i. Calculate each hospital's Medicare share by dividing the Medicare inpatient discharges on the Medicare Cost Report by the total inpatient hospital discharges on the Medicare Cost Report.
 - ii. Calculate the ratio of residents to beds by dividing the total allocated residents described in subsection (B)(4)(d)(ii) by the number of bed days available from the Medicare Cost Report and dividing the result by the number of days in the cost reporting period.
 - iii. Calculate the indirect medical education adjustment factor by adding 1 to the value calculated in (D)(4)(b)(ii), multiplying the result by the exponential value 0.405, subtracting 1 from the result, and multiplying that result by 1.35.
 - iv. Calculate each hospital's total indirect medical education cost by adding the DRG amounts other than outlier payments from the Medicare cost report and the managed care simulated payments from the Medicare Cost Report, multiplying the total by the indirect medical education adjustment factor determined in (D)(4)(b)(iii) and dividing the result by the Medicare share determined in (D)(4)(b)(i).
 - v. Calculate each hospital's Medicaid indirect medical education cost by multiplying the amount determined in (D)(4)(b)(iv) by the value determined in subsection (B)(4)(c)(i).
 - vi. Total the amounts determined in (D)(4)(b)(v) for all hospitals, divide the result by the total allocated residents described in subsection (B)(4)(d)(ii) for all hospitals, and divide that result by 12.
 5. Distribution of funds for indirect program costs. On an annual basis subject to available funds, the Administration shall distribute to each eligible hospital the amount calculated for the hospital at subsection (D)(4)(a).
- E. Reallocation of funds. If funds appropriated for subsection (B) are not allocated by the Administration and funds appropriated for subsections (C) and (D) are insufficient to cover all distributions under subsections (C)(5) and (D)(5), the funds not allocated under subsection (B) shall be allocated under subsections (C) and (D) to the extent of the calculated distributions. If funds are insufficient to cover all distributions under subsections (C)(5) and (D)(5), the Administration shall adjust the distributions proportionally. If funds appropriated for subsections (C) and (D) are not allocated by the Administration and funds appropriated for subsection (B) are insufficient to cover all distributions under subsection (B)(5), the funds not allocated under subsections (C) and (D) shall be allocated under subsection (B) to the extent of the calculated distributions.
 - F. The Administration may enter into intergovernmental agreements with local, county, and tribal governments wherein local, county and tribal governments may transfer funds or certify public expenditures to the Administration. Such funds or certification, subject to approval by CMS, will be used to qualify for additional federal funds. Those funds will be used for the purposes of reimbursing hospitals that are eligible under subsection (D)(1) and specified by the local, county, or tribal government for indirect program costs other than those

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reimbursed under subsection (D). The Administration shall allocate available funds in accordance with subsection (D) except that reimbursement with such funds is not limited to resident positions or rotations in counties with populations of less than 500,000 persons. On an annual basis subject to available funds, the Administration shall distribute to each eligible hospital the greatest among the following amounts, less any amounts distributed under subsection (D)(5):

1. The amount that results from multiplying the total number of eligible residents allocated to the hospital under subsection (B)(4)(d)(ii) by 12 by the per resident per month conversion factor determined under subsection (D)(4)(b);
2. The amount calculated for the hospital at subsection (D)(4)(b)(v);
3. The median of all amounts calculated at subsection (D)(4)(b)(v) if the hospital does not have an indirect medical education payment calculated on the Medicare Cost Report because it is a new training hospital; or
4. If the hospital does not have an indirect medical education payment calculated on the Medicare Cost Report because it is a children's hospital, the median Medicaid indirect medical education payment costs shall be calculated as follows:
 - a. For each hospital with indirect medical education costs on the Medicare Cost Report, determine a per resident total indirect medical education cost by dividing the total indirect medical education costs determined under subsection (D)(4)(b) by the number of filled resident positions under subsection (B)(2).
 - b. Determine the median per resident amount under subsection (F)(4)(a).
 - c. For each hospital without an indirect medical education component on the Medicare cost report, multiply the median per resident amount under subsection (F)(4)(b) by the number of filled resident positions under subsection (B)(2) for that hospital and by the Medicaid utilization percent for that hospital determined in subsection (B)(4)(c)(i).

Historical Note

New Section made by final rulemaking at 13 A.A.R. 1782, effective June 30, 2007 (Supp. 07-2). Amended by exempt rulemaking at 13 A.A.R. 4032, effective November 1, 2007 (Supp. 07-4). Amended by final rulemaking at 21 A.A.R. 3469, effective January 30, 2016 (Supp. 15-4). Amended by final rulemaking at 24 A.A.R. 185, effective January 9, 2018 (Supp. 18-1). Amended by final rulemaking at 24 A.A.R. 3321, effective January 5, 2019 (Supp. 18-4).

R9-22-712.06. Reserved**R9-22-712.07. Rural Hospital Inpatient Fund Allocation**

- A.** For purposes of this Section, the following words and phrases have the following meanings unless the context specifically requires another meaning:
1. "Calculated inpatient costs" means the sum of inpatient covered charges multiplied by the Milliman study's implied cost-to-charge ratio of .8959.
 2. "Claims paid amount" means the sum of all claims paid by the Administration and contractors, as reported by the contractor to the Administration, to a rural hospital for covered inpatient services rendered for dates of service during the previous state fiscal year.
 3. "Fund" means any state funds appropriated by the Legislature for the purposes set forth in A.R.S. § 36-2905.02

and any federal funds that are available for matching the state funds.

4. "Inpatient covered charges" means the sum of all covered charges billed by a hospital to the Administration or contractors, as reported by the contractors to the Administration, for inpatient services rendered during the previous state fiscal year.
 5. "Milliman study" means the report issued by Milliman USA on March 11, 2004, to the Arizona Hospital and Healthcare Association that updated a portion of a cost study entitled "Evaluation of the AHCCCS Inpatient Hospital Reimbursement System" prepared by Milliman USA for AHCCCS on November 15, 2002. A copy of each report is on file with the Administration.
 6. "Rural hospital" means a health care institution that is licensed as an acute care hospital by the Arizona Department of Health Services for the previous state fiscal year and is not an IHS hospital or a tribally owned or operated facility and:
 - a. Has 100 or fewer PPS beds, not including beds reported as sub provider beds on the hospital's Medicare Cost Report, and is located in a county with a population of less than 500,000 persons, or
 - b. Is designated as a critical access hospital for the majority of the previous state fiscal year.
- B.** Each February, the Administration shall allocate the Fund to the following three pools for the fiscal year:
1. Rural hospitals with 25 or fewer PPS beds not including sub provider beds and all Critical Access Hospitals, regardless of the number of beds in the Critical Access Hospital;
 2. Rural hospitals other than Critical Access Hospitals with 26 to 75 PPS beds not including sub provider beds; and
 3. Rural hospitals other than Critical Access Hospitals with 76 to 100 PPS beds not including sub provider beds.
- C.** The Administration shall allocate the Fund to each pool according to the ratio of claims paid amount for all hospitals assigned to the pool to total claims paid amount for all rural hospitals.
- D.** The Administration shall determine each hospital's claims paid amount and allocate the funds in each pool to each hospital in the pool based on the ratio of each hospital's claims paid amount to the sum of the claims paid amount for all hospitals assigned to the pool.
- E.** The Administration shall not make a Fund payment to a hospital that will result in the hospital's claims paid amount plus that hospital's Fund payment being greater than that hospital's calculated inpatient costs.
1. If a hospital's claims paid amount plus the hospital's Fund payment would be greater than the hospital's calculated inpatient costs, the Administration shall make a Fund payment to the hospital equal to the difference between the hospital's calculated inpatient costs and the hospital's claims paid amount.
 2. The Administration shall reallocate any portion of a hospital's Fund allocation that is not paid to the hospital due to the reason in subsection (E)(1) to the other eligible hospitals in the pool based upon the ratio of the claims paid amount for each hospital remaining in the pool to the sum of the claims paid amount for each hospital remaining in the pool.
- F.** If funds remain in a pool after allocations to each hospital in the pool under subsections (D) and (E), the Administration shall reallocate the remaining funds to the other pools based upon the ratio of each pool's original allocation of the Fund as determined under subsection (C) to the sum of the remaining

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pools' original Fund allocations under subsection (C). The Administration shall allocate remaining funds to the hospitals in the remaining pools under subsection (D) and (E). See Exhibit 1 for an example.

- G. Subject to CMS approval of the method and distribution of the Fund, the administration or its contractors will distribute the

Fund as a lump sum allocation to the rural hospitals in either one or two installments by the end of each state fiscal year.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 2188, effective June 6, 2006 (Supp. 06-2). Amended by final rulemaking at 22 A.A.R. 3476, effective January 30, 2016 (Supp. 15-4).

Exhibit 1. Pool Example

Pool A receives \$2,000,000. Pool B receives \$7,000,000. Pool C receives \$3,000,000. If all of the funds in Pool B are paid to eligible hospitals and there is \$1,000,000 remaining, the remaining funds would be allocated to Pool A and Pool C based on the ratio of each pool's original allocation (original allocations of \$2,000,000 and \$3,000,000) to the total of their original allocation (\$2,000,000 + \$3,000,000 = \$5,000,000). Pool A would receive 2/5 of the remaining funds (\$400,000) and Pool C would receive 3/5 of the remaining funds (\$600,000).

Historical Note

Exhibit 1 made by final rulemaking at 12 A.A.R. 2188, effective June 6, 2006 (Supp. 06-2).

R9-22-712.08. Reserved

R9-22-712.09. Hierarchy for Tier Assignment through September 30, 2014

| TIER | IDENTIFICATION CRITERIA | ALLOWED SPLITS |
|-------------|---|-----------------------------------|
| MATERNITY | A primary diagnosis defined as maternity 640.xx - 643.xx, 644.2x - 676.xx, v22.xx - v24.xx or v27.xx. | None |
| NICU | Revenue Code of 174 and the provider has a Level II or Level III NICU. | Nursery |
| ICU | Revenue Codes of 200-204, 207-212, or 219. | Surgery Psychiatric Routine |
| SURGERY | Surgery is identified by a revenue code of 36x. To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list. | ICU |
| PSYCHIATRIC | Psychiatric Revenue Codes of 114, 124, 134, 144, or 154 AND primary Psychiatric Diagnosis = 290.xx - 316.xx. If a routine revenue code is present and all diagnoses codes on the claim are equal to 290.xx - 316.xx, classify as a psychiatric claim. | ICU |
| NURSERY | Revenue Code of 17x, not equal to 174. | NICU |
| ROUTINE | Revenue Codes of 100 - 101, 110-113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16x, 206, 213, or 214. | ICU |

Historical Note

New Section made by final rulemaking at 11 A.A.R. 3231, effective October 1, 2005 (Supp. 05-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.10. Outpatient Hospital Reimbursement: General

- A. Effective rule. The outpatient hospital reimbursement rules apply to dates of service beginning July 1, 2005, subject to Laws 2004, Ch. 279, § 19.
- B. Basis For Payment. Except as provided under R9-22-712.30, AHCCCS shall pay for designated outpatient procedures provided to AHCCCS members according to the AHCCCS Outpatient Capped Fee-For-Service Schedule as defined in R9-22-712.20.
- C. Data. AHCCCS shall use Medicare Cost Report and adjudicated claim and encounter data from non-IHS acute care hospitals located in the state of Arizona to develop fees for the AHCCCS Outpatient Capped Fee-For-Service Schedule.
- D. Hospital Services Subject To Fees. AHCCCS shall reimburse services, in the following outpatient hospital categories under the AHCCCS Outpatient Capped Fee-For-Service Schedule:
 1. Surgery,
 2. Emergency Department,
 3. Laboratory,
 4. Radiology,
 5. Clinic, and
 6. Other services.
- E. Reimbursement. AHCCCS shall reimburse outpatient hospital services by procedure codes, in proper combination with revenue codes, as prescribed by AHCCCS.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

R9-22-712.11. Reserved

R9-22-712.12. Reserved

R9-22-712.13. Reserved

R9-22-712.14. Reserved

R9-22-712.15. Outpatient Hospital Reimbursement: Affected Hospitals

Except as provided in R9-22-712(G), the AHCCCS Outpatient Capped Fee-For-Service Schedule shall apply to AHCCCS payments for outpatient services in all non-IHS acute hospitals.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

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R9-22-712.16. Reserved

R9-22-712.17. Reserved

R9-22-712.18. Reserved

R9-22-712.19. Reserved

R9-22-712.20. Outpatient Hospital Reimbursement: Methodology for the AHCCCS Outpatient Capped Fee-For-Service Schedule

A. To establish the AHCCCS Outpatient Capped Fee-for-service Schedule for all claims with a begin date of service on or before September 30, 2011, AHCCCS shall:

1. Define the dataset of claims and encounters that shall be used to establish the AHCCCS Outpatient Capped Fee-for-service Schedule.
2. Identify all the claims and encounters from non-IHS acute hospitals located in Arizona for services to be paid under the AHCCCS Outpatient Capped Fee-for-service Schedule.
3. Match the revenue code on each detail of each claim and encounter to the ancillary line item CCR as reported on hospital-specific mapping documents and hospital-specific Medicare Cost Report for those hospitals that have submitted Medicare Cost Reports FYE 2002.
4. Multiply the line item CCR from subsection (A)(3) by the covered billed charge for that revenue code to establish the cost for the service.
5. Inflate the cost for the service from subsection (A)(4) using Global Insight Health-care Cost Review inflation factors from date of service month to the midpoint of the rate year in which the fees are initially effective.
6. Include associated costs under R9-22-712.25 to calculate the rates for emergency room and surgery services.
7. Combine data from all Arizona hospitals identified in subsection (A)(3) for each procedure code to establish the statewide median cost for each procedure.
8. Group procedure codes according to the Ambulatory Payment Classification (APC) System groups as listed in 69 FR 65682, November 15, 2004, and establish a statewide median cost for each APC. Multiply each statewide median APC cost by 116 percent to establish the AHCCCS-based fee for each procedure in that specific APC group. AHCCCS shall assign each procedure in the group the same fee.
9. For those procedure codes that are not grouped into any APC, establish a procedure-specific fee using either:
 - a. The AHCCCS Non-hospital Capped Fee-for-service Fee Schedule,
 - b. 116 percent of the procedure-specific median cost AHCCCS-based fee, or
 - c. The Medicare Clinical Laboratory Fee Schedule for laboratory services.
10. Compare the AHCCCS-based fee established in subsections (A)(8) and (9) against the comparable Medicare fee established for the Medicare APC group as listed in the 69 FR 65682, November 15, 2004. The fee for each procedure shall be the greater of the AHCCCS-based fee or the Medicare fee but no more than 150 percent of the AHCCCS-based fee; however, for those laboratory services for which a limit is established in the Medicare Clinical Laboratory Fee Schedule, the fee shall not exceed that limit.
11. Assign the 2005 Medicare fee in the AHCCCS Outpatient Capped Fee-for-service Schedule for those procedures for which there are fewer than 20 occurrences of the procedure

code in the dataset, either independently, or, if applicable, for all procedure codes within an APC Group.

- B. For all claims with a begin date of service on or after October 1, 2011, the AHCCCS Outpatient Capped Fee-for-Service Schedule shall be derived from the CMS Medicare Outpatient Prospective Payment System (OPPS) fee schedule modified by an Arizona conversion factor determined annually.
 1. When clinic services are billed using 51X revenue codes, the reimbursement to the hospital is the difference between the facility and non-facility rates payable to the practitioner for the procedures listed in the Administration's Capped Fee-for-service Schedule under R9-22-710.
 2. Observation services, when not billed in conjunction with a service for which a single payment is made under R9-22-712.25, are reimbursed at an hourly rate published in the Outpatient Capped Fee-for-service Schedule. This hourly rate includes reimbursement for associated services.
- C. The AHCCCS Outpatient Capped Fee-for-service Schedule including the effective date of any changes to the listing are on file and posted on AHCCCS' web site.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4).

R9-22-712.21. Reserved

R9-22-712.22. Reserved

R9-22-712.23. Reserved

R9-22-712.24. Reserved

R9-22-712.25. Outpatient Hospital Fee Schedule Calculations: Associated Service Costs

- A. AHCCCS shall include the costs of associated services, as defined by revenue codes and procedure codes, when determining the specific fees for the outpatient hospital procedures for emergency department and surgery services.
- B. Payment made under subsection (A) or R9-22-712.20(B)(2) is inclusive of all services on the claim regardless of whether the services are provided on one or more days.
- C. A complete listing of the revenue codes and procedure codes for associated costs included in the payment for emergency and surgery services including the effective date of any changes to the listing are on file and posted on AHCCCS' web site.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3).

R9-22-712.26. Reserved

R9-22-712.27. Reserved

R9-22-712.28. Reserved

R9-22-712.29. Reserved

R9-22-712.30. Outpatient Hospital Reimbursement: Payment for a Service Not Listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule

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- A. AHCCCS shall calculate a statewide CCR for a service where a specific fee cannot be determined under R9-22-712.20.
- B. For claims with a begin date of service on or before September 30, 2011, the statewide CCR shall be calculated based on the costs and covered charges associated with a service under subsection (A) for all Arizona hospitals, using the method specified in R9-22-712.20(A)(3).
- C. For all claims with a begin date of service on or after October 1, 2011, the statewide CCR calculation shall equal either the CMS Medicare Outpatient Urban Cost-to-charge Ratio or the CMS Medicare Outpatient Rural Cost-to-charge Ratio published by CMS for the state of Arizona. AHCCCS shall use the urban cost-to-charge ratio for hospitals located in a county of 500,000 residents or more and for out-of-state hospitals. AHCCCS shall use the rural cost-to-charge ratio for hospitals located in a county of fewer than 500,000 residents. On October 1st of each year, AHCCCS shall adjust urban and rural CCRs to the CCRs as published by CMS in the *Federal Register* on or before August 1st of that year.
- D. To determine the payment amount for procedures where a specific fee is not determined under R9-22-712.20, the statewide CCR is multiplied by the covered charges.
- E. Reductions to payments for outpatient hospital services not listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule. Outpatient hospital services not listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rate published by CMS pursuant to subsection (C) of this Section.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4).

R9-22-712.31. Reserved**R9-22-712.32. Reserved****R9-22-712.33. Reserved****R9-22-712.34. Reserved****R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees**

- A. For all claims with a begin date of service on or before September 30, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule established under R9-22-712.20 (except for laboratory services and out-of-state hospital services) for the following hospitals submitting any claims:
- By 48 percent for public hospitals on July 1, 2005, and hospitals that were public anytime during the calendar year 2004;
 - By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
 - By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
 - By 115 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the criteria during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
5. By 113 percent for a Freestanding Children's Hospital with at least 110 pediatric beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective; or
6. By 14 percent for a University Affiliated Hospital which is a hospital that has a majority of the members of its board of directors appointed by the Board of Regents during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective.
- B. For all claims with a begin date of service on or after October 1, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services) for the following hospitals. A hospital shall receive an increase from only one of the following categories:
- By 73 percent for public hospitals;
 - By 31 percent for hospitals in counties other than Maricopa and Pima with more than 100 licensed beds as of October 1 of that contract year;
 - By 37 percent for hospitals in counties other than Maricopa and Pima with 100 or fewer licensed beds as of October 1 of that contract year;
 - By 100 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the critical access criteria;
 - By 78 percent for a Freestanding Children's Hospital with at least 110 pediatric beds as of October 1 of that contract year; or
 - By 41 percent for a University Affiliated Hospital, this is a hospital that has a majority of the members of its board of directors appointed by the Arizona Board of Regents.
- C. In addition to subsections (A) and (B), an Arizona Level 1 trauma center as defined by R9-22-2101 shall receive a 50 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services and out-of-state hospital services) for Level 2 and 3 emergency department procedures.
- D. Hospitals with greater than 100 pediatric beds not receiving an increase under subsection (B) shall receive an 18 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services).
- E. For outpatient services with dates of service from October 1, 2019 through September 30, 2020, the payment otherwise required for outpatient hospital services provided by qualifying hospitals shall be increased by a percentage established by the Administration. The percentage is published on the Administration's public website as part of its fee schedule subsequent to the public notice published no later than September 1, 2019. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.
- A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsections (E)(1)(a), (b), (c), (d), or (e):
 - By May 15, 2019, a hospital which did not receive Differential Adjusted Payments from October 1, 2018 through September 30, 2019, submits a Letter of Intent to AHCCCS and a qualifying Health Information Exchange (HIE) organization in which the hospital agrees to achieve all of the following:
 - By July 31, 2019, execute an agreement with a qualifying HIE organization;

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- ii. By October 31, 2019, approve and authorize a formal scope of work with a qualifying HIE to develop and implement the data exchange necessary to meet the requirements in subsections (E)(1)(c) and (E)(1)(d);
 - iii. By March 31, 2020, electronically submit admission, discharge, and transfer information (including data from the hospital emergency department) to a qualifying HIE;
 - iv. By June 30, 2020, electronically submit laboratory, radiology, transcription, and medication information, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination to a qualifying HIE;
- b. By May 15, 2019, a hospital which received Differential Adjusted Payments October 1, 2018 through September 30, 2019, submits a Letter of Intent to AHCCCS and a qualifying HIE organization in which the hospital agrees to achieve all of the following:
 - i. By July 1, 2019, submit actual patient identifiable immunization data to the production environment of a qualifying HIE organization;
 - ii. By October 1, 2019, approve and authorize a formal scope of work with a qualifying HIE organization to initiate and complete a data quality profile to be produced by a qualifying HIE organization;
 - iii. By December 31, 2019, complete the initial data quality profile with a qualifying HIE organization;
 - iv. By March 31, 2020 complete the data quality scope of work by producing the final data quality profile with a qualifying HIE organization;
 - c. Meet or exceed the statewide average on April 30, 2019 for the Severe Sepsis/Septic Shock (SEP-1) performance measure from the Medicare Hospital Compare website;
 - d. By April 30, 2019, be a participant in the Improving Pediatric Sepsis Outcomes collaborative;
 - e. By May 1, 2019 hold a Pediatric-Prepared Emergency Care certification from the Arizona Chapter of the American Academy of Pediatrics;
2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets the criteria specified in subsections (E)(2)(a), (b), or (c):
 - a. By May 15, 2019, a hospital which received Differential Adjusted Payments October 1, 2018 through September 30, 2019, submits a Letter of Intent to AHCCCS and a qualifying HIE organization in which the hospital agrees to achieve all of the following:
 - i. By July 1, 2019, submit actual patient identifiable immunization data to the production environment of a qualifying HIE organization;
 - ii. By October 1, 2019, approve and authorize a formal scope of work with a qualifying HIE organization to initiate and complete a data quality profile to be produced by a qualifying HIE organization;
 - iii. By December 31, 2019, complete the initial data quality profile with a qualifying HIE organization;
 - iv. By March 31, 2020, complete the data quality scope of work by producing the final data quality profile with a qualifying HIE organization;
 - b. By May 15, 2019, a hospital which received Differential Adjusted Payments October 1, 2018 through September 30, 2019, submits a Letter of Intent to AHCCCS and a qualifying HIE organization in which the hospital agrees to achieve all of the following:
 - i. By July 1, 2019, submit actual patient identifiable immunization data to the production environment of a qualifying HIE organization;
 - ii. By October 1, 2019, approve and authorize a formal scope of work with a qualifying HIE organization to initiate and complete a data quality profile to be produced by a qualifying HIE organization;
 - iii. By December 31, 2019, complete the initial data quality profile with a qualifying HIE organization;
 - iv. By March 31, 2020, complete the data quality scope of work by producing the final data quality profile with a qualifying HIE organization;
 - c. On April 30, 2019 is identified as a Medicare Annual Payment Update recipients on the QualityNet.org website;
3. A hospital designated as type: hospital, subtype: long term, psychiatric, or rehabilitation by the Arizona Department of Health Services Division of Licensing Services will qualify for an increase if it meets the criteria specified in subsections (E)(3)(a), (b), (c), (d), or (e):
 - a. By May 15, 2019, a hospital which did not receive Differential Adjusted Payments from October 1, 2018 through September 30, 2019, submits a Letter of Intent to AHCCCS and a qualifying HIE organization in which the hospital agrees to achieve all of the following:
 - i. By July 31, 2019, execute an agreement with a qualifying HIE organization;
 - ii. By October 31, 2019, approve and authorize a formal scope of work with a qualifying HIE to develop and implement the data exchange necessary to meet the requirements in subsections (E)(1)(c) and (E)(1)(d);
 - iii. By March 31, 2020, electronically submit admission, discharge, and transfer information (including data from the hospital emergency department) to a qualifying HIE;
 - iv. By June 30, 2020, electronically submit laboratory, radiology, transcription, and medication information, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination to a qualifying HIE;
 - b. By May 15, 2019, a hospital which received Differential Adjusted Payments October 1, 2018 through September 30, 2019, submits a Letter of Intent to AHCCCS and a qualifying HIE organization in which the hospital agrees to achieve all of the following:
 - i. By July 1, 2019, submit actual patient identifiable immunization data to the production environment of a qualifying HIE organization;
 - ii. By October 1, 2019, approve and authorize a formal scope of work with a qualifying HIE organization to initiate and complete a data quality profile to be produced by a qualifying HIE organization;
 - iii. By December 31, 2019, complete the initial data quality profile with a qualifying HIE organization;
 - iv. By March 31, 2020, complete the data quality scope of work by producing the final data quality profile with a qualifying HIE organization;

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- d. On April 30, 2019 meets or falls below the national average for the rate of pressure ulcers that are new or worsened from the Medicare Long Term Hospital Compare website;
- e. On April 30, 2019 meets or falls below the national average for the rate of pressure ulcers that are new or worsened from the Medicare Inpatient Rehabilitation Facility Compare website.
- F. If a hospital submits a Letter of Intent to AHCCCS and received the Differential Adjusted Payments October 1, 2018 through September 30, 2019, but fails to achieve or maintain one or more of the required criteria by the specified date, that hospital will be ineligible to receive any Differential Adjusted Payments for dates of service from October 1, 2019 through September 30, 2020 if a Differential Adjusted Payment is available at that time.
- G. Fee adjustments made under subsections (A), (B), (C), (D), and (E) are on file with AHCCCS and current adjustments are posted on AHCCCS' website.
- 1. Annually by multiplying the rates effective during the prior year by the Global Insight Prospective Hospital Market Basket Inflation Index; or
- 2. In a particular year the director may substitute the increases in subsection (C)(1) by calculating the dollar value associated with the inflation index in subsection (C)(1), and applying the dollar value to adjust rates at varying levels.
- D. Reductions to the Outpatient Capped Fee-For-Service Schedule. Claims paid using the Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rates in effect on September 30, 2011, subject to the annual adjustments to procedure codes and APCs under this Section.
- E. Rebase. AHCCCS shall rebase the outpatient fees every five years.
- F. Statewide CCR:
 - 1. For begin dates of service on or before September 30, 2011, the statewide CCR calculated in R9-22-712.30 shall be recalculated at the time of rebasing. When rebasing, AHCCCS may recalculate the statewide CCR based on the costs and charges for services excluded from the outpatient hospital fee schedule.
 - 2. For begin dates of service on or after October 1, 2011, the statewide CCR shall be set under R9-22-712.30(C).
- G. Other Updates. In addition to the other updates provided for in this Section, the Administration may adjust the Outpatient Capped Fee-For-Service Fee Schedule and the Statewide CCR to the extent necessary to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 3584, effective October 1, 2007 (Supp. 07-4). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2338, effective October 1, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2851, effective October 1, 2018 (Supp. 18-3). Amended by final rulemaking at 25 A.A.R. 3114, effective October 1, 2019 (Supp. 19-4).

- R9-22-712.36. **Reserved**
- R9-22-712.37. **Reserved**
- R9-22-712.38. **Reserved**
- R9-22-712.39. **Reserved**

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

- A. Procedure codes. When procedure codes are issued by CMS and added to the Current Procedural Terminology published by the American Medical Association, AHCCCS shall add to the Outpatient Capped Fee-for-Service Schedule the new procedure codes for covered outpatient services and shall either assign the default CCR under R9-22-712.40(F)(2), the Medicare rate, or calculate an appropriate fee.
- B. APC changes. AHCCCS may reassign procedure codes to new or different APC groups when APC groups are revised by CMS. AHCCCS may reassign procedure codes to a different APC group than Medicare. If AHCCCS determines that utilization of a procedure code within the Medicare program is substantially different from utilization of the procedure code in the AHCCCS program, AHCCCS may choose not to assign the procedure code to any APC group. For procedure codes not grouped into an APC by Medicare, AHCCCS may assign the code to an APC group when AHCCCS determines that the cost and resources associated with the non-assigned code are substantially similar to those in the APC group.
- C. Annual update for Outpatient Hospital Fee Schedule. Beginning October 1, 2006, through September 30, 2011, AHCCCS shall adjust outpatient fee schedule rates:

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 3584, effective October 1, 2007 (Supp. 07-4). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

- R9-22-712.41. **Reserved**
- R9-22-712.42. **Reserved**
- R9-22-712.43. **Reserved**
- R9-22-712.44. **Reserved**
- R9-22-712.45. **Outpatient Hospital Reimbursement: Outpatient Payment Restrictions**
 - A. AHCCCS shall not reimburse hospitals for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis if the member is admitted as an inpatient to the same hospital directly from the emergency room, observation, or other outpatient department.
 - B. AHCCCS shall include payment for the emergency room, observation, and other outpatient hospital services provided to the member before the hospital admission in the AHCCCS Inpatient Tiered Per Diem Capped Fee-For-Service Schedule under Article 7 of this Chapter.
 - C. Same day admit and discharge.

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1. For discharges before September 30, 2014. Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.
 2. For discharge dates on and after October 1, 2014. Same day admit and discharge claims are paid for through the outpatient fee schedule.
- D. Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to quick pay discounts and slow pay penalties under A.R.S. 36-2904.
 - E. Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to the Urban Hospital Reimbursement Program under R9-22-718.
 - F. For purposes of this Section and sections R9-22-712.61 through R9-22-712.81:
 1. "DRG National Average length of stay" means the national arithmetic mean length of stay published in the All Patient Refined Diagnosis Related Group (APR-DRG) classification established by 3M Health Information Systems.
 2. "Length of stay" means the total number of calendar days of an inpatient stay beginning with the date of admission through discharge, but not including the date of discharge (including the date of a discharge to another hospital, i.e., a transfer) unless the member expires.
 3. "Medicare" means Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.
 4. "Medicare labor share" means a hospital's labor costs as a percentage of its total costs as determined by CMS for purposes of the Medicare Inpatient Prospective Payment System.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.46. Reserved**R9-22-712.47. Reserved****R9-22-712.48. Reserved****R9-22-712.49. Reserved****R9-22-712.50. Outpatient Hospital Reimbursement: Billing**

To receive appropriate reimbursement, hospitals shall:

1. Bill outpatient hospital services on the CMS approved Uniform Billing Form or in electronic format using the appropriate HIPAA transaction.
2. Follow the UB Manual Guidelines, as published by the National Uniform Billing Committee, and use the appropriate revenue code and procedure code combination as prescribed by AHCCCS and on file and online with AHCCCS.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

R9-22-712.51. Reserved**R9-22-712.52. Reserved****R9-22-712.53. Reserved****R9-22-712.54. Reserved****R9-22-712.55. Reserved****R9-22-712.56. Reserved****R9-22-712.57. Reserved****R9-22-712.58. Reserved****R9-22-712.59. Reserved****R9-22-712.60. Diagnosis Related Group Payments**

- A. Inpatient hospital services with discharge dates on or after October 1, 2014, shall be reimbursed using the diagnosis related group (DRG) payment methodology described in this Section and sections R9-22-712.61 through R9-22-712.81.
 - B. Payments made using the DRG methodology shall be the sole reimbursement to the hospital for all inpatient hospital services and related supplies provided by the hospital. Services provided in the emergency room, observation area, or other outpatient departments that are directly followed by an inpatient admission to the same hospital are not reimbursed separately. Are reimbursed through the DRG methodology and not reimbursed separately.
 - C. Each claim for an inpatient hospital stay shall be assigned a DRG code and a DRG relative weight based on the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health Information Systems. The applicable version of the APR-DRG classification system shall be available on the agency's website.
- B. Notwithstanding R9-22-712.60, claims for inpatient services that are covered by a RBHA or TRBHA, where the principal

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.61. DRG Payments: Exceptions

- A. Notwithstanding R9-22-712.60, claims for inpatient services from the following hospitals shall be paid on a per diem basis, including provisions for outlier payments, where rates and outlier thresholds are included in the capped fee schedule published by the Administration on its website and available for inspection during normal business hours at 701 E. Jefferson, Phoenix, Arizona. If the covered costs per day on a claim exceed the published threshold for a day, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the outlier CCR. The outlier CCR will be the sum of the urban or rural default operating CCR appropriate to the location of the hospital and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS. The resulting amount will be the total reimbursement for the claim. There is no provision for outlier payments for hospitals described under subsection (A)(3).
 1. Hospitals designated as type: hospital, subtype; rehabilitation in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website in March of each year;
 2. Hospitals designated as type: hospital, subtype; long term in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;
 3. Hospitals designated as type: hospital, subtype; psychiatric in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;
- B. Notwithstanding R9-22-712.60, claims for inpatient services that are covered by a RBHA or TRBHA, where the principal

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diagnosis on the claim is a behavioral health diagnosis, shall be reimbursed as prescribed by a per diem rate described by a fee schedule established by the Administration; however, if the principal diagnosis is a physical health diagnosis, the claim shall be processed under the DRG methodology described in this Section, even if behavioral health services are provided during the inpatient stay. Inpatient claims covered by an AHCCCS payer which is not a RBHA or TRBHA, with a principal diagnosis of behavioral health, will be reimbursed under the DRG methodology as administrative days for claims with principal diagnosis of behavioral health meeting inpatient medical criteria with dates of discharge on and after October 1, 2018, consistent with R9-22-712.75(A)(2).

- C. Notwithstanding R9-22-712.60, claims for services associated with transplant services shall be paid in accordance with the contract between the AHCCCS Administration and the transplant facility.
- D. Notwithstanding R9-22-712.60, claims from an IHS facility or 638 Tribal provider shall be paid the all-inclusive rate on a per visit basis in accordance with the rates published annually by IHS in the Federal Register.
- E. For hospitals that have contracts with the Administration for the provision of transplant services, inpatient days associated with transplant services are paid in accordance with the terms of the contract.
- F. For inpatient services with a date of admission from October 1, 2019 through September 30, 2020, provided by a hospital in subsection (A) that qualifies, the Administration shall pay the hospital an Inpatient Differential Adjusted Payment equal to the sum of the payment otherwise provided for in subsection (A) plus the product of the amount otherwise provided for in subsection (A) and a percentage published on the Administration's public website as part of its fee schedule, subsequent to a public notice published no later than September 1, 2019. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.
1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (F)(1)(a), (i) through (iv); (F)(1)(b), (i) through (iv); (F)(1)(c); (F)(1)(d); or (F)(1)(e):
 - a. By May 15, 2019, a hospital which did not receive Differential Adjusted Payments from October 1, 2018 through September 30, 2019, submits a Letter of Intent to AHCCCS and a qualifying Health Information Exchange (HIE) organization in which the hospital agrees to achieve all of the following:
 - i. By July 31, 2019, execute an agreement with a qualifying HIE organization;
 - ii. By October 31, 2019, approve and authorize a formal scope of work with a qualifying HIE to develop and implement the data exchange necessary to meet the requirements in subsections (E)(1)(c) and (E)(1)(d);
 - iii. By March 31, 2020, electronically submit admission, discharge, and transfer information (including data from the hospital emergency department) to a qualifying HIE;
 - iv. By June 30, 2020, electronically submit laboratory, radiology, transcription, and medication information, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during

the stay, active allergies, and discharge destination to a qualifying HIE;

- b. By May 15, 2019, a hospital which received Differential Adjusted Payments October 1, 2018 through September 30, 2019, submits a Letter of Intent to AHCCCS and a qualifying HIE organization in which the hospital agrees to achieve all of the following:
 - i. By July 1, 2019, submit actual patient identifiable immunization data to the production environment of a qualifying HIE organization;
 - ii. By October 1, 2019, approve and authorize a formal scope of work with a qualifying HIE organization to initiate and complete a data quality profile to be produced by a qualifying HIE organization;
 - iii. By December 31, 2019, complete the initial data quality profile with a qualifying HIE organization;
 - iv. By March 31, 2020, complete the data quality scope of work by producing the final data quality profile with a qualifying HIE organization;
 - c. Meet or exceed the statewide average on April 30, 2019 for the Severe Sepsis/Septic Shock (SEP-1) performance measure from the Medicare Hospital Compare website;
 - d. By April 30, 2019, be a participant in the Improving Pediatric Sepsis Outcomes collaborative;
 - e. By May 1, 2019, hold a Pediatric-Prepared Emergency Care certification from the Arizona Chapter of the American Academy of Pediatrics;
2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets the criteria specified in subsection (F)(2)(a), (i) through (iv); (F)(2)(b); or (F)(2)(c):
 - a. By May 15, 2019, a hospital which received Differential Adjusted Payments October 1, 2018 through September 30, 2019, submits a Letter of Intent to AHCCCS and a qualifying HIE organization in which the hospital agrees to achieve all of the following:
 - i. By July 1, 2019, submit actual patient identifiable immunization data to the production environment of a qualifying HIE organization;
 - ii. By October 1, 2019, approve and authorize a formal scope of work with a qualifying HIE organization to initiate and complete a data quality profile to be produced by a qualifying HIE organization;
 - iii. By December 31, 2019, complete the initial data quality profile with a qualifying HIE organization;
 - iv. By March 31, 2020, complete the data quality scope of work by producing the final data quality profile with a qualifying HIE organization;
 - b. Have a Level I-IV trauma center and be located less than five miles from Interstate 10;
 - c. By May 1, 2019, hold a Pediatric-Prepared Emergency Care certification from the Arizona Chapter of the American Academy of Pediatrics.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R.

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2338, effective October 1, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2851, effective October 1, 2018 (Supp. 18-3). Amended by final rulemaking at 25 A.A.R. 3111 and at 25 A.A.R. 3114, effective October 1, 2019 (Supp. 19-4).

R9-22-712.62. DRG Base Payment

- A. The initial DRG base payment is the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code assigned to the claim, and any applicable provider and service policy adjusters.
- B. The DRG base rate for each hospital is the statewide standardized amount of which the hospital's labor-related share of that amount is adjusted by the hospital's wage index. The hospital's labor share is determined based on the labor share for the Medicare inpatient prospective payment system published in Volume 81 of the Federal Register at page 57312 published August 22, 2016. The hospital's wage index is determined based on the wage index tables reference in Volume 81 of the Federal Register at page 57311 published August 22, 2016. The statewide standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.
- C. Claims shall be assigned both a DRG code derived from all diagnosis and surgical procedure codes included on the claim (the "pre-HCAC" DRG code) and a DRG code derived excluding diagnosis and surgical procedure codes associated with the health care acquired conditions that were not present on admission or any other provider-preventable conditions (the "post-HCAC" DRG code). The DRG code with the lower relative weight shall be used to process claims using the DRG methodology.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.63. DRG Base Payments Not Based on the Statewide Standardized Amount

- A. Notwithstanding Section R9-22-712.62, a select specialty hospital standardized amount shall be used in place of the statewide standardized amount in subsection R9-22-712.62(B) to calculate the DRG base rate for the following hospitals:
 1. Hospitals located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2011 Medicare Cost Report are reimbursed by Medicare.
 2. Hospitals designated as type: hospital, subtype: short-term that has a license number beginning "SH" in the Provider & Facility Database for Arizona Medical Facilities posted by the ADHS Division of Licensing Services on its website for March of each year.
- B. The select specialty hospital standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.64. DRG Base Payments and Outlier CCR for Out-of-State Hospitals

- A. DRG Base payment:

1. For high volume out-of-state hospitals defined in subsection (C), the wage adjusted DRG base payment is determined as described in R9-22-712.62.
 2. Notwithstanding subsection R9-22-712.62 the wage adjusted DRG base rate for out-of-state hospitals that are not high volume hospitals shall be included in the AHCCCS capped fee schedule available on the agency's website.
- B. Outlier CCR:
 1. Notwithstanding subsection R9-22-712.68, the CCR used for the outlier calculation for out-of-state hospitals that are not high volume hospitals shall be the sum of the statewide urban default operating cost-to-charge ratio and the statewide capital CCR in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS.
 2. The CCR used for the outlier calculation for high volume out-of-state hospitals is the same as in-state hospitals as described in R9-22-712.68.
 - C. A high volume out-of-state hospital is a hospital not otherwise excluded under R9-22-712.61, that is located in a county that borders the State of Arizona and had 500 or more AHCCCS covered inpatient days for the fiscal year beginning October 1, 2015.
 - D. Other than as required by this Section, DRG reimbursement for out-of-state hospitals is determined under R9-22-712.60 through R9-22-712.81.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.65. DRG Provider Policy Adjustor

- A. After calculating the DRG base payment as required in sections R9-22-712.62, R9-22-712.63, or R9-22-712.64, for claims from a high-utilization hospital, the product of the DRG base rate and the DRG relative weight for the post-HCAC DRG code shall be multiplied by a provider policy adjustor that is included in the AHCCCS capped fee schedule available on the agency's website.
- B. A hospital is a high-utilization hospital if the hospital had:
 1. Covered inpatient days subject to DRG reimbursement, determined using adjudicated claim and encounter data during the fiscal year beginning October 1, 2015, equal to at least four hundred percent of the statewide average number of AHCCCS-covered inpatient days at all hospitals;
 2. A Medicaid inpatient utilization rate greater than 30% calculated as the ratio of AHCCCS-covered inpatient days to total inpatient days as reported in the hospital's Medicare Cost Report for the fiscal year ending 2016; and,
 3. Received less than \$2 million in add-on payment for outliers under R9-22-712.68, based on adjudicated claims and encounters for fiscal year beginning October 1, 2015.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.66. DRG Service Policy Adjustor

In addition to Section R9-22-712.65, for claims with DRG codes in the following categories, the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code, and the DRG

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provider policy adjustor shall be multiplied by the service policy adjustor listed in the AHCCCS capped fee schedule, available on the agency's website, corresponding to the following DRG codes:

1. Normal newborn DRG codes,
2. Neonates DRG codes,
3. Obstetrics DRG codes,
4. Psychiatric DRG codes,
5. Rehabilitation DRG codes,
6. Burn DRG codes.
7. Claims for members under age 19 assigned DRG codes other than listed above:
 - a. For dates of discharge occurring on or after October 1, 2014 and ending no later than December 31, 2015 regardless of severity of illness level,
 - b. For dates of discharge on or after January 1, 2016, for severity of illness levels 1 and 2,
 - c. For dates of discharge on or after January 1, 2016 and before January 1, 2017, for severity of illness levels 3 and 4.
 - d. For dates of discharge on or after January 1, 2017, and before January 1, 2018 for severity of illness levels 3 and 4.
 - e. For dates of discharge on or after January 1, 2018, for severity of illness levels 3 and 4.
8. Claims for members assigned DRG codes other than listed above.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.67. DRG Reimbursement: Transfers

- A. For purposes of this Section a "transfer" means the transfer of a member from a hospital to a short-term general hospital for inpatient care, a designated cancer center, children's hospital, or a critical access hospital except when a member is moved for the purpose of receiving sub-acute services.
- B. Designated cancer center or children's hospitals are those hospitals identified as such in the UB-04 billing manual published by the National Uniform Billing Committee.
- C. The hospital the member is transferred from shall be reimbursed either the initial DRG base payment or the transfer DRG base payment, whichever is less.
- D. The transfer DRG base payment is an amount equal to the initial DRG base payment, as determined after making any provider or service policy adjustors, divided by the DRG National Average length of stay for the DRG code multiplied by the sum of one plus the length of stay.
- E. The hospital the member is transferred to shall be reimbursed under the DRG payment methodology without a reduction due to the transfer.
- F. Unadjusted DRG base payment. The unadjusted DRG base payment is either the initial DRG base payment, as determined after making any provider or service policy adjustors, or the transfer DRG base payment, whichever is less.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4).

R9-22-712.68. DRG Reimbursement: Unadjusted Outlier Add-on Payment

- A. Claims for inpatient hospital services qualify for an outlier add-on payment if the claim cost exceeds the outlier cost threshold.
- B. The claim cost is determined by multiplying covered charges by an outlier CCR as described by the following subsections:
 1. For hospitals designated as type: hospital, subtype: children's in the Provider & Facility Database for Arizona Medical Facilities posted by the ADHS Division of Licensing Services on its website for March of each year. The outlier CCR will be calculated by dividing the hospital total costs by the total charges using the most recent Medicare Cost Report available as of September 1 of that year.
 2. For Critical Access Hospitals the outlier CCR will be the sum of the statewide rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS.
 3. For all other hospitals the outlier CCR will be the sum of the operating cost-to-charge ratio and the capital cost-to-charge ratio established for each hospital in the impact file established as part of the Medicare Inpatient Prospective Payment System by CMS.
- C. AHCCCS shall update the CCRs described in subsection (B) to conform to the most recent CCRs established by CMS as of September 1 of each year, and the CCRs so updated shall be used for claims with dates of discharge on or after October 1 of that year.
- D. The outlier threshold is equal to the sum of the unadjusted DRG base payment plus the fixed loss amount. The fixed loss amount for critical access hospitals and for all other hospitals are included in the AHCCCS capped fee schedule available on the agency's website.
- E. For those inpatient hospital claims that qualify for an outlier add-on payment, the payment is calculated by subtracting the outlier threshold from the claim cost and multiplying the result by the DRG marginal cost percentage. The DRG marginal cost percentage for claims assigned DRG codes associated with the treatment of burns and for all other claims are included in the AHCCCS capped fee schedule available on the agency's website.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.69. DRG Reimbursement: Covered Day Adjusted DRG Base Payment and Covered Day Adjusted Outlier Add-on Payment

Adjustments to the payments are made to account for days not covered by AHCCCS as follows:

1. A covered day reduction factor unadjusted is determined if the member is not eligible on the first day of the inpatient stay but is eligible for subsequent days during the inpatient stay. In this case, a covered day reduction factor unadjusted is calculated by dividing the number of AHCCCS covered days by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of days the member is eligible during the inpatient stay.
2. A covered day reduction factor unadjusted is also determined if the member is eligible on the first day of the inpatient stay but is determined ineligible for one or more days prior to the date of discharge. In this case, a covered day reduction factor unadjusted is calculated by adding

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one to the number of AHCCCS covered days and dividing the result by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of days the member is eligible during the inpatient stay.

3. If the covered day reduction factor unadjusted is greater than one, then the covered day reduction factor final is one; otherwise, the covered day reduction factor final is equal to the covered day reduction factor unadjusted.
4. The covered day adjusted DRG base payment is an amount equal to the product of the unadjusted DRG base payment and the covered day reduction factor final.
5. The covered day adjusted DRG outlier add-on payment is an amount equal to the product of the unadjusted DRG outlier add-on payment and the covered day reduction factor final.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.70. Covered Day Adjusted DRG Base Payment and Covered Day Adjusted Outlier Add-on Payment for FES members

In addition to the covered day reduction factor in R9-22-712.69, a covered day reduction factor unadjusted is determined for an inpatient stay during which an FES member receives services for the treatment of an emergency medical condition and also receives services once the condition no longer meets the criteria as an emergency medical condition described in R9-22-217.

1. A covered day reduction factor unadjusted is calculated by adding one to the AHCCCS covered days and dividing the result by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of inpatient days during which an FES member receives services for an emergency medical condition as described in R9-22-217. For purposes of this adjustment, any portion of a day during which the FES member receives treatment for an emergency medical condition is counted as an AHCCCS covered day.
2. If the covered day reduction factor unadjusted is greater than one, then the covered day reduction factor final is one; otherwise, the covered day reduction factor final is equal to the covered day reduction factor unadjusted.
3. The covered day adjusted DRG base payment is an amount equal to the product of the unadjusted DRG base payment and the covered day reduction factor final.
4. The covered day adjusted DRG outlier add-on payment is an amount equal to the product of the unadjusted DRG outlier add-on payment and the covered day reduction factor final.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.71. Final DRG Payment

The final DRG payment is the sum of the final DRG base payment, the final DRG outlier add-on payment, and the Differential Adjusted Payment.

1. The final DRG base payment is an amount equal to the product of the covered day adjusted DRG base payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.

2. The final DRG outlier add-on payment is an amount equal to the product of the covered day adjusted DRG outlier add-on payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.

3. The factor for each hospital and for each federal fiscal year is published as part of the AHCCCS capped fee schedule and is available on the AHCCCS Administration's website and is on file for public inspection at the AHCCCS Administration located at 701 E. Jefferson Street, Phoenix, Arizona.

4. For inpatient services with a date of discharge from October 1, 2019 through September 30, 2020, the Inpatient Differential Adjusted Payment is the sum of the final DRG base payment and the final DRG outlier add-on payment multiplied by a percentage published on the Administration's public website as part of its fee schedule, subsequent to the public notice published no later than September 1, 2019. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.

a. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (4)(a), (i), (ii), (iii), (iv), or (v):

i. By May 15, 2019, a hospital which did not receive Differential Adjusted Payments from October 1, 2018 through September 30, 2019, submits a Letter of Intent to AHCCCS and a qualifying Health Information Exchange (HIE) organization in which the hospital agrees to achieve all of the following:

- (1) By July 31, 2019, execute an agreement with a qualifying HIE organization;
- (2) By October 31, 2019, approve and authorize a formal scope of work with a qualifying HIE to develop and implement the data exchange necessary to meet the requirements in subsections (E)(1)(c) and (E)(1)(d);
- (3) By March 31, 2020, electronically submit admission, discharge, and transfer information (including data from the hospital emergency department) to a qualifying HIE;
- (4) By June 30, 2020, electronically submit laboratory, radiology, transcription, and medication information, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination to a qualifying HIE;

ii. By May 15, 2019, a hospital which received Differential Adjusted Payments October 1, 2018 through September 30, 2019, submits a Letter of Intent to AHCCCS and a qualifying HIE organization in which the hospital agrees to achieve all of the following:

- (1) By July 1, 2019, submit actual patient

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- identifiable immunization data to the production environment of a qualifying HIE organization;
- (2) By October 1, 2019, approve and authorize a formal scope of work with a qualifying HIE organization to initiate and complete a data quality profile to be produced by a qualifying HIE organization;
 - (3) By December 31, 2019, complete the initial data quality profile with a qualifying HIE organization;
 - (4) By March 31, 2020, complete the data quality scope of work by producing the final data quality profile with a qualifying HIE organization;
- iii. Meet or exceed the statewide average on April 30, 2019 for the Severe Sepsis/Septic Shock (SEP-1) performance measure from the Medicare Hospital Compare website;
 - iv. By April 30, 2019, be a participant in the Improving Pediatric Sepsis Outcomes collaborative;
 - v. By May 1, 2019, hold a Pediatric-Prepared Emergency Care certification from the Arizona Chapter of the American Academy of Pediatrics;
- b. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets the criteria specified in subsections (4)(b)(i), (ii) or (iii):
- i. By May 15, 2019, a hospital which received Differential Adjusted Payments October 1, 2018 through September 30, 2019, submits a Letter of Intent to AHCCCS and a qualifying HIE organization in which the hospital agrees to achieve all of the following:
 - (1) By July 1, 2019, submit actual patient identifiable immunization data to the production environment of a qualifying HIE organization;
 - (2) By October 1, 2019, approve and authorize a formal scope of work with a qualifying HIE organization to initiate and complete a data quality profile to be produced by a qualifying HIE organization;
 - (3) By December 31, 2019, complete the initial data quality profile with a qualifying HIE organization;
 - (4) By March 31, 2020, complete the data quality scope of work by producing the final data quality profile with a qualifying HIE organization;
 - ii. Have a Level I-IV trauma center and be located less than five miles from Interstate 10;
 - iii. By May 1, 2019, hold a Pediatric-Prepared Emergency Care certification from the Arizona Chapter of the American Academy of Pediatrics.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2338, effective October 1, 2017 (Supp. 17-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January

1, 2018 (Supp. 17-4). Amended by final rulemaking at 24 A.A.R. 2851, effective October 1, 2018 (Supp. 18-3). Amended by final rulemaking at 25 A.A.R. 3114, effective October 31, 2019 (Supp. 19-4).

R9-22-712.72. DRG Reimbursement: Enrollment Changes During an Inpatient Stay

- A. If a member's enrollment changes during an inpatient stay, including changing enrollment from fee-for-service to a contractor, or vice versa, or changing from one contractor to another contractor, the contractor with whom the member is enrolled on the date of discharge shall be responsible for reimbursing the hospital for the entire length of stay under the DRG payment rules in sections R9-22-712.60 through R9-22-712.81. If the member is eligible but not enrolled with a contractor on the date of discharge, then the AHCCCS administration shall be responsible for reimbursing the hospital for the entire length of stay under the DRG payment rules in sections R9-22-712.60 through R9-22-712.81.
- B. When a member's enrollment changes during an inpatient stay, the hospital shall use the date of enrollment with the payer responsible on the date of discharge as the "from" date of service on the claim regardless of the date of admission.
- C. Interim claims submitted to a payer other than the payer responsible on the day of discharge shall be processed in the same manner as other interim claims as described in R9-22-712.76.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.73. DRG Reimbursement: Inpatient Stays for Members Eligible for Medicare

If the hospital receives less than the full Medicare payment for a member eligible for benefits under Part A of Medicare because the member has exceeded the maximum benefit permitted under Part A of Medicare, the hospital shall submit a separate claim for services performed after the date the maximum Medicare Part A benefit is exceeded. The claim may include all diagnosis codes for the entire inpatient stay, but the hospital is only required to include revenue codes, surgical procedure codes, service units, and charges for services performed after the date the Medicare Part A benefit is exceeded. A claim so submitted shall be reimbursed using the DRG payment methodology.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.74. DRG Reimbursement: Third Party Liability
DRG payments are subject to reduction based on cost avoidance under Section R9-22-1003 and other rules regarding first-and third-party liability under Article 10 of this Chapter including cost avoidance for claims for ancillary services covered under Part B of Medicare.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.75. DRG Reimbursement: Payment for Administrative Days

- A. Categories of Administrative Days. Administrative days fall into one of two categories, either subsection (A)(1) or (A)(2).
 1. Administrative days due to lack of appropriate placement options and not meeting inpatient medical criteria.

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Administrative days are days in which a member is admitted as an inpatient to an acute care hospital, does not meet the criteria for an acute inpatient stay, but is admitted or not discharged because; (1) an appropriate placement outside the hospital is not available, (2) the member cannot be safely discharged or transferred, or (3) the Administration or the contractor failed to provide for the appropriate placement outside the hospital in a timely manner.

- a. Administrative days may occur prior to an acute care episode, for example, when a woman with a high-risk pregnancy is admitted to a hospital while awaiting delivery.
 - b. Administrative days may also occur at the end of an acute care episode, for example, when a member is not discharged while awaiting placement in a nursing facility or other sub-acute or post-acute setting.
 - c. Administrative days may also include days in a receiving hospital when the member has been discharged from one acute care hospital for the purpose of receiving sub-acute services at the receiving hospital.
 - d. Administrative days do not include days when the member is awaiting appropriate placement or services that are currently available but the hospital has not transferred or discharged the member because of the hospital's administrative or operational delays.
 - e. Administrative days include inpatient claims covered by a RBHA or TRBHA that otherwise meet the criteria in subsection (A)(1).
2. Administrative days for claims with the principal diagnosis of behavioral health meeting inpatient medical criteria. Administrative days are days with dates of discharge on or after October 1, 2018, in which a member is admitted as an inpatient to an acute care hospital, meets the criteria for an acute inpatient stay, and the principal diagnosis on the hospital claim is a behavioral health diagnosis. Inpatient claims covered by a RBHA or TRBHA are not considered administrative days under subsection (A)(2) regardless of the principal diagnosis on the hospital claim.

B. Reimbursement of Administrative Days.

1. Administrative days under subsection (A)(1) are reimbursed at the rate the claim would have paid had the services not been provided in an inpatient hospital setting but had been provided at the appropriate level of care such as the rate paid for stays at a nursing facility.
2. Administrative days under subsection (A)(2) are reimbursed at the daily rate found on the Inpatient Behavioral Health Capped Fee-For-Service Schedule meeting the criteria of "Service Description – Psychiatric Stay," regardless of revenue code.

C. Prior authorization is required for administrative days.

- D. A hospital shall submit a claim for administrative days separate from any claim for reimbursement for the inpatient stay otherwise reimbursable under the DRG payment methodology.**

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 25 A.A.R. 3111, effective October 1, 2019 (Supp. 19-4).

R9-22-712.76. DRG Reimbursement: Interim Claims

- A. For inpatient stays with a length of stay greater than 29 days, a hospital may submit interim claims for each 30 day period during the inpatient stay.
- B. Hospitals shall be reimbursed for interim claims at a per diem rate of \$500 per day.
- C. Following discharge, the hospital shall void all interim claims. In such circumstances, the hospital shall submit a claim to the payer with whom the member is enrolled on the date of discharge, whether the Administration or a contractor, for the entire inpatient stay for which the final claim shall be reimbursed under the DRG payment methodology. Interim claims will be recouped.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.77. DRG Reimbursement: Admissions and Discharges on the Same Day

- A. Except as provided for in subsection (B), for any claim for inpatient services with an admission date and discharge date that are the same calendar date, the contractor or the Administration shall process the claim as an outpatient claim and the hospital shall be reimbursed under R9-22-712.10 through R9-22-712.50.
- B. Claims with an admission date and discharge date that are the same calendar date that also indicate that the member expired on the date of discharge shall be reimbursed under the DRG methodology.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.78. DRG Reimbursement: Readmissions

If a member is readmitted without prior authorization to the same hospital that the member was discharged from within 72 hours and the DRG code assigned to the claim for the prior admission has the same first three digits as the DRG code assigned to the claim for the readmission, then payment for the claim for the readmission will be disallowed only if the readmission could have been prevented by the hospital.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.79. DRG Reimbursement: Change of Ownership

The administration shall not change any of the components of the calculation of reimbursement for inpatient services using the DRG methodology based upon a change in the hospital's ownership except to the extent those components would change under the methodology had the hospital not changed ownership (e.g., updating the hospital's cost-to-charge ratio as of September 1 of each year under R9-22-712.68).

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.80. DRG Reimbursement: New Hospitals

- A. DRG base payment for new hospitals. For any hospital that does not have a labor share or wage index published by CMS as described in subsection R9-22-712.62(B) because the hospital was not in operation, the DRG base rate described in subsection R9-22-712.62(B) shall be calculated as the statewide standardized amount after adjusting that amount for the labor-related share and the wage index published by CMS as described in subsection R9-22-712.62(B) that is appropriate to

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the location of the hospital published by CMS as described in subsection R9-22-712.62(B).

- B. Outlier calculations for new hospitals. For any hospital that does not have an operating cost-to-charge ratio listed in the impact file described in subsection R9-22-712.68(B) because the hospital was not in operation prior to the publication of the impact file, the statewide urban or rural default operating cost-to-charge ratio appropriate to the location of the hospital and the statewide capital cost-to-charge ratio shall be used to determine the unadjusted outlier add-on payment. The statewide urban or rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio shall be based on the ratios published by CMS and updated by the Administration as described in subsection R9-22-712.68(C).
- C. In addition to the requirement of this Section, DRG reimbursement for new hospitals is determined under R9-22-712.60 through R9-22-712.79.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.81. DRG Reimbursement: Updates

In addition to the other updates provided for in sections R9-22-712.60 through R9-22-712.80, the Administration may update the version of the APR-DRG classification system established by 3M Health Information Systems, adjust the statewide standardized amount in Section R9-22-712.62, the base payments in sections R9-22-712.63 and R9-22-712.64, the provider policy adjustor in section R9-22-712.65, service policy adjustors Section R9-22-712.66, and the fixed loss amounts and marginal cost percentages used to calculate the outlier threshold in Section R9-22-712.68 to the extent necessary to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. The Administration shall publish any proposed classification system on the agency's website at least 30 days prior to the effective date, to ensure a sufficient period for public comment, as required by 42 C.F.R. § 447.205. In addition, the public notice shall be available for inspection during normal business hours at 701 E. Jefferson, Phoenix, Arizona. The requirements of 42 CFR § 447.205 as of November 2, 2015 are incorporated by reference and do not include any later amendments.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.90. Reimbursement of Hospital-based Freestanding Emergency Departments

- A. "Hospital-based freestanding emergency department" (hospital-based FSED) means an outpatient treatment center, as defined in R9-10-101, that: (1) provides emergency room services under R9-10-1019, (2) is subject to the requirements of 42 CFR 489.24, and (3) shares an ownership interest with a hospital, regardless of whether the outpatient treatment center operates under a hospital's single group license as described in A.R.S. § 36-422.
- B. A hospital-based FSED shall register with the Administration separately from the hospital with which an ownership interest is shared and shall obtain a separate provider identification number. The Administration shall not charge a separate provider enrollment fee for registration of a hospital-based FSED.

The Administration shall accept a hospital's compliance with the provider screening and enrollment requirements of 42 CFR Part 455 as compliance by the hospital-based FSED.

- C. For dates of service on and after March 1, 2017, and except as provided in subsection (D), services provided by a hospital-based FSED for evaluation and management CPT codes 99281 through 99285 shall be reimbursed at the following percentages of the amounts otherwise reimbursable under sections R9-22-712.20 through R9-22-712.30. All other covered codes shall be reimbursed in accordance with sections R9-22-712.20 through R9-22-712.30 without a percentage reduction.
- 60% for a level 1 emergency department visit as indicated by CPT 99281.
 - 80% for a level 2 emergency department visit as indicated by CPT 99282.
 - 90% for a level 3 emergency department visit as indicated by CPT 99283.
 - 100% for a level 4 or 5 emergency department visit as indicated by CPT codes 99284 and 99285.
- D. A hospital-based FSED located in a city or town in a county with less than 500,000 residents, where the only hospital in the city or town operating an emergency department closed on or after January 1, 2015, shall be reimbursed under sections R9-22-712.20 through R9-22-712.35 using the adjustment in R9-22-712.35 associated with the nearest hospital with which the freestanding emergency department shares an ownership interest.
- E. Services provided by an outpatient treatment center that provides emergency room services under R9-10-1019, but does not otherwise meet the criteria in subsection A, shall be reimbursed based on the non-hospital AHCCCS capped fee-for-service schedule under R9-22-710.
- F. The Administration shall not reimburse a hospital for services provided at a hospital-based FSED if the member is admitted directly from a hospital-based FSED to a hospital with an ownership interest in the hospital-based FSED. As provided in R9-22-712.60(B), payments made for the inpatient stay using the DRG methodology shall be the sole reimbursement.

Historical Note

New Section made by final rulemaking at 23 A.A.R. 22, February 11, 2017 (Supp. 16-4).

R9-22-713. Overpayment and Recovery of Indebtedness

- A. If a contractor or a subcontracting provider receives an overpayment from the Administration or otherwise becomes indebted to the Administration, the contractor or subcontracting provider shall immediately remit the amount of the indebtedness or overpayment to the Administration for deposit in the AHCCCS fund.
- B. If the funds described in subsection (A) are not remitted, the Administration may recover the funds paid by the Administration to a contractor or subcontracting provider through:
- A repayment agreement executed with the Administration;
 - Withholding or offsetting against current or future payments to be paid to the contractor or subcontracting provider; or
 - Enforcement of, or collection against, the performance bond, financial reserve, or other financial security under A.R.S. § 36-2903.

Historical Note

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to the emergency (Supp. 83-3). Former Section R9-22-713 repealed, new

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Section R9-22-713 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-713 renumbered and amended as Section R9-22-714, former Section R9-22-709 renumbered and amended as Section R9-22-713 effective October 1, 1985 (Supp. 85-5). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

R9-22-714. Payments to Providers

- A.** Provider agreement. The Administration or a contractor shall not reimburse a covered service provided to a member unless the provider has signed a provider agreement with the Administration that establishes the terms and conditions of participation and payment under A.R.S. § 36-2904.
- B.** Provider reimbursement. The Administration or a contractor shall reimburse a provider for a service furnished to a member only if:
1. The provider personally furnishes the service to a specific member. For purposes of this Section, services personally furnished by a provider include:
 - a. Services provided by medical residents or dental students in a teaching environment; or
 - b. Services provided by a licensed or certified assistant under the general supervision of a licensed practitioner in accordance with 4 A.A.C. 24, 9 A.A.C. 16, 4 A.A.C. 43, or 4 A.A.C. 45;
 2. The provider verifies that individuals who have provided services described in subsection (B)(1) have not been placed on the List of Excluded Individuals/Entities (LEIE) maintained by the United States Department of Health and Human Services Office of the Inspector General (OIG), located at OIG's web site;
 3. The service contributes directly to the diagnosis or treatment of the member; and
 4. The service ordinarily requires performance by the type of provider seeking reimbursement.
- C.** The Administration or a contractor may make a payment for covered services only:
1. To the provider;
 2. To anyone specified in a reassignment from the provider to a government agency or reassignment by a court order;
 3. To a business agent, if the agent's compensation for the service is:
 - a. Related to the cost of processing the billing;
 - b. Not related on a percentage or other basis to the amount that is billed or collected; and
 - c. Not dependent upon collection of the payment;
 4. To the employer of the provider, if the provider is required as a condition of employment to turn over the provider's fees to the employer;
 5. To the inpatient facility in which the service is provided, if the provider has a contract under which the inpatient facility submits the claim; or
 6. To a foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the foundation, plan or similar organization submits the claim.
- D.** The Administration or a contractor shall not make a payment to or through a factor, either directly or by power of attorney, for a covered service furnished to a member by a provider.
- E.** Reimbursement for a pathology service. Unless otherwise specified in a contract, the Administration or a contractor shall reimburse a pathologist for a pathology service furnished to a member only if the other requirements in this Section are met and the service is:
1. A surgical pathology service;

2. A specific cytopathology, hematology, or blood banking pathology service that requires performance by a physician and is listed in the capped fee-for-service schedule;
3. A clinical consultation service that:
 - a. Is requested by the member's attending physician or primary care physician,
 - b. Is related to a test result that is outside the clinically significant normal or expected range in view of the condition of the member,
 - c. Results in a written narrative report included in the member's medical record,
 - d. Requires the exercise of medical judgment by the consultant pathologist, and
 - e. Is listed in the capped fee-for-service schedule; or
4. A clinical laboratory interpretative service that:
 - a. Is requested by the member's attending physician or primary care physician,
 - b. Results in a written narrative report included in the member's medical record,
 - c. Requires the exercise of medical judgment by the consultant pathologist, and
 - d. Is listed in the capped fee-for-service schedule.

Historical Note

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule is similar to the emergency (Supp. 83-3). Repealed effective October 1, 1983 (Supp. 83-5). Former Section R9-22-713 renumbered and amended as Section R9-22-714 effective October 1, 1985 (Supp. 85-5). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 9 A.A.R. 3800, effective October 4, 2003 (Supp. 03-3). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-715. Hospital Rate Negotiations

- A.** A contractor that negotiates with hospitals for inpatient or outpatient services shall reimburse hospitals for services rendered on or after March 1, 1993, as described in A.R.S. § 36-2903.01 and this Article, or at the negotiated rate that, in the aggregate, does not exceed reimbursement levels that would have been paid under A.R.S. § 36-2903.01, and this Article. This subsection does not apply to urban hospitals described under R9-22-718. Contractors may engage in rate negotiations with a hospital at any time during the contract period.
- B.** The Administration may negotiate or contract with a hospital on behalf of a contractor for discounted hospital rates and may require that the negotiated discounted rates be included in a subcontract between the contractor and hospital.

Historical Note

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to the emergency

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(Supp. 83-3). Repealed effective October 1, 1983 (Supp. 83-5). New Section R9-22-715 adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective January 14, 1997 (Supp. 97-1). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-716. Repealed**Historical Note**

Adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Section repealed by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

R9-22-717. Repealed**Historical Note**

Adopted effective July 30, 1993 (Supp. 93-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3).

Editor's Note: The following Section was originally adopted under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council. The agency was required to submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and was required to hold a public hearing. It has since been amended under the regular rulemaking process.

R9-22-718. Urban Hospital Inpatient Reimbursement Program**A. Definitions.** The following definitions apply to this Section:

1. "Contractor" has the same meaning as set forth in A.R.S. § 36-2901, and includes all contractors regardless of whether the GSA's served by the contractor includes urban or rural counties.
2. "Noncontracted Hospital" means an urban hospital, including psychiatric hospitals, which does not have a contract under this Section with a contractor.
3. "Urban Hospital" means a hospital that is not a rural hospital, as defined in R9-22-712.07, and that is physically located in Maricopa or Pima County.

B. General Provisions.

1. This Section applies to an urban hospital who receives payment for inpatient hospital services under A.R.S. §§ 36-2903.01 and 36-2904.
2. AHCCCS shall operate an inpatient hospital reimbursement program under A.R.S. § 36-2905.01 and this Section.

3. Residency of the member receiving inpatient AHCCCS covered services is not a factor in determining which hospitals are required to contract with which contractors.
 4. A contractor shall enter into a contract for reimbursement for inpatient AHCCCS covered services with one or more urban hospitals located in the same county as the contractor.
 5. A noncontracted urban hospital shall be reimbursed for inpatient services by a contractor at 95% of the amount calculated as defined in A.R.S. § 36-2903.01 and this Article, unless otherwise negotiated by both parties.
- C. Contract Begin Date.** A contract under this Article shall cover inpatient acute care hospital services for members with hospital admissions on and after October 1, 2003.
- D. Outpatient urban hospital services.** Outpatient urban hospital services, including observation days and emergency room treatments that do not result in an admission, shall be reimbursed either through an urban hospital contract negotiated between a contractor and an urban hospital, or the reimbursement rates set forth in A.R.S. § 36-2903.01. Outpatient services in an urban hospital that result in an admission shall be paid as inpatient services in accordance with this Section.
- E. Urban Hospital Contract.**
1. Provisions of an urban hospital contracts. The urban hospital contract shall contain but is not limited to the following provisions:
 - a. Required provisions as described in the Request for Proposals (RFP);
 - b. Dispute settlement procedures. If the AHCCCS Grievance System prescribed in A.R.S. § 36-2903.01(B) and rule is not used, then arbitration shall be used;
 - c. Arbitration procedure. If arbitration is used, the urban hospital contract shall identify:
 - i. The parties' agreement on arbitrating claims arising from the contract,
 - ii. Whether arbitration is nonbinding or binding,
 - iii. Timeliness of arbitration,
 - iv. What contract provisions may be appealed,
 - v. What rules will govern arbitrations,
 - vi. The number of arbitrators that shall be used,
 - vii. How arbitrators shall be selected, and
 - viii. How arbitrators shall be compensated.
 - d. Timeliness of claims submission and payment;
 - e. Prior authorization;
 - f. Concurrent review;
 - g. Electronic submission of claims;
 - h. Claims review criteria;
 - i. Payment of discounts or penalties such as quick-pay and slow-pay provisions;
 - j. Payment of outliers;
 - k. Claim documentation specifications under A.R.S. § 36-2904.
 1. Treatment and payment of emergency room services; and
 - m. Provisions for rate changes and adjustments.
 2. AHCCCS review and approval of urban hospital contracts:
 - a. AHCCCS may review, approve, or disapprove the hospital contract rates, terms, conditions, and amendments to the contract;
 - b. The AHCCCS evaluation of each urban hospital contract shall include but not be limited to the following areas:

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- i. Availability and accessibility of services to members,
 - ii. Related party interests,
 - iii. Inclusion of required terms pursuant to this Section, and
 - iv. Reasonableness of the rates.
- F. Quick-Pay/Slow-Pay. A payment made by a contractor to a noncontracted hospital shall be subject to quick-pay discounts and slow-pay penalties under A.R.S. § 36-2904.

Historical Note

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective January 29, 1997; pursuant to Laws 1996, Ch. 288, § 24 (Supp. 97-1). Amended by exempt rulemaking at 10 A.A.R. 500, effective February 1, 2004 (Supp. 04-1). Amended by exempt rulemaking at 13 A.A.R. 3190, effective October 1, 2007 (Supp. 07-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 24 A.A.R. 1515, effective June 30, 2018 (Supp. 18-2).

R9-22-719. Contractor Performance Measure Outcomes

The Administration may retain a specified percentage of capitation reimbursement to distribute to contractors based on their performance measure outcomes under A.R.S. § 36-2904. The Administration shall notify contractors 60 days prior to a new contract year if this methodology is implemented. The Administration shall specify the details of the reimbursement methodology in contract.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

R9-22-720. Reinsurance

- A. Reinsurance is a stop-loss program provided by the Administration to a contractor for partial reimbursement of the cost of covered services for a member with an acute medical condition when the cost of covered services exceeds a pre-determined deductible level amount within a contract year. The Administration self-insures the reinsurance program through a reduction to capitation rates. The reinsurance program also includes a catastrophic reinsurance program for members diagnosed with specific medical conditions.
- B. The Administration shall specify in contract guidelines for claims submission, processing, payment, and the types of care and services that are provided to a member whose care is covered by reinsurance.
- C. When the Administration determines that a contractor does not follow the specified guidelines for care or services and the care or services could have been provided at a lower cost according to the guidelines, the Administration shall reimburse the contractor as if the care or services had been provided as specified in the guidelines.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

R9-22-721. Behavioral Health Inpatient Facilities

“Behavioral health inpatient facility” means a health care institution, other than Arizona State Hospital, that meets the following requirements:

- 1. Provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:
 - a. Have a limited or reduced ability to meet the individual’s basic physical needs;

- b. Suffer harm that significantly impairs the individual’s judgment, reason, behavior, or capacity to recognize reality;
 - c. Be a danger to self;
 - d. Be a danger to others;
 - e. Be persistently or acutely disabled as defined in A.R.S. § 36-501; or
 - f. Be gravely disabled; and
2. Is one of the following facility types:
- a. Psychiatric hospitals;
 - b. Mental health residential treatment centers;
 - c. Secure residential treatment centers with 17 or more beds;
 - d. Non-secure residential treatment centers with 1-16 beds;
 - e. Non-secure residential treatment centers with 17 or more beds;
 - f. Sub-acute facilities with 1-16 beds;
 - g. Sub-acute facilities with 17 or more beds.

Historical Note

New Section made by final rulemaking at 25 A.A.R. 3120, effective October 1, 2019 (Supp. 19-4).

R9-22-722. Reserved

R9-22-723. Reserved

R9-22-724. Reserved

R9-22-725. Reserved

R9-22-726. Reserved

R9-22-727. Reserved

R9-22-728. Reserved

R9-22-729. Reserved

Editor’s Note: Amendments to Section R9-22-730 were filed as a final exempt rulemaking. AHCCCS provided an opportunity for public comment on the amended rules under Laws 2013, 1st Special Session, Ch. 10. A proposed exempt rulemaking was published in the Arizona Administrative Register at 21 A.A.R. 1041 (Supp. 15-3).

Editor’s Note: Amendments to Section R9-22-730 were filed as a final exempt rulemaking. AHCCCS provided an opportunity for public comment on the amended rules under Laws 2013, 1st Special Session, Ch. 10. A proposed exempt rulemaking was published in the Arizona Administrative Register at 21 A.A.R. 491 (Supp. 15-2).

R9-22-730. Hospital Assessment

- A. For purposes of this Section, the following terms are defined as provided below unless the context specifically requires another meaning:
 - 1. “2018 Medicare Cost Report” means: The Medicare Cost Report for the hospital fiscal year ending in calendar year 2018 as reported in the CMS Healthcare Provider Cost Reporting Information System (HCRIS) release dated October 9, 2019.
 - 2. “2018 Uniform Accounting Report” means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of November 6, 2019 for the hospital’s fiscal year ending in calendar year 2018.
 - 3. “Quarter” means the three month period beginning January 1, April 1, July 1, and October 1 of each year.
 - 4. A “new hospital” means a licensed hospital that did not hold a license from the Arizona Department of Health Services prior to January 2, 2020.

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5. "Outpatient Net Patient Revenues" means an amount, calculated using data in the hospital's 2018 Uniform Accounting Report, that is equal to the hospital's 2018 total net patient revenue multiplied by the ratio of the hospital's 2018 gross outpatient revenue to the hospital's 2018 total gross patient revenue.
- B.** Beginning January 1, 2014, for each Arizona licensed hospital not excluded under subsection (I) shall be subject to an assessment payable on a quarterly basis. The assessment shall be levied against the legal owner of each hospital as of the first day of the quarter, and except as otherwise required by subsections (D), (E) and (F). For the period beginning July 1, 2020, the assessment for each hospital shall be an amount equal to the sum of: (1) the number of discharges reported on the hospital's 2018 Medicare Cost Report, excluding discharges reported on the Medicare Cost Report as "Other Long Term Care Discharges," multiplied by the following rates appropriate to the hospital's peer group; and (2) the amount of outpatient net patient revenues multiplied by the following rate appropriate to the hospital's peer group:
1. \$612.75 per discharge and 1.2078% of outpatient net patient revenues for hospitals located in a county with a population less than 500,000 that are designated as type: hospital, subtype: short-term.
 2. \$612.75 per discharge and 0.5033% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.
 3. \$153.25 per discharge and 0.5033% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.
 4. \$153.25 per discharge and 0.5033% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the 2018 Medicare Cost Report.
 5. \$490.25 per discharge and 1.3085% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's 2018 Uniform Accounting Report.
 6. \$551.50 per discharge and 1.5098% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with at least 10% but less than 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's 2018 Uniform Accounting Report.
 7. \$612.75 per discharge and 2.0131% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term not included in another peer group.
- C.** Peer groups for the four quarters beginning July 1 of each year are established based on hospital license type and subtype designated in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website January 2, 2020.
- D.** Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's 2018 Medicare Cost Report, are assessed a rate of \$153.25 for each discharge from the psychiatric sub-provider as reported in the 2018 Medicare Cost Report. All discharges other than those reported as discharges from the psychiatric sub-provider are assessed at the rate required by subsection (B).
- E.** Notwithstanding subsection (B), rehabilitative discharges from a hospital that reported having a rehabilitative sub-provider in the hospital's 2018 Medicare Cost Report, are assessed a rate of \$0 for each discharge from the rehabilitative sub-provider as reported in the 2018 Medicare Cost Report. All discharges other than those reported as discharges from the rehabilitative sub-provider are assessed at the rate required by subsection (B).
- F.** Notwithstanding subsection (B), for any hospital that reported more than 24,000 discharges on the hospital's 2018 Medicare Cost Report, discharges in excess of 24,000 are assessed a rate of \$61.50 for each discharge in excess of 24,000. The initial 24,000 discharges are assessed at the rate required by subsection (B).
- G.** Notwithstanding subsection (B), for any hospital with more than \$300,000,000 in outpatient net patient revenues on the hospital's 2018 Uniform Account Report, outpatient revenues greater than \$300,000,000 are assessed a rate of 0.2013% for revenue in excess of \$300,000,000. Revenues at or below \$300,000,000 are assessed at the rate required by subsection (B).
- H.** Assessment notice. On or before the 15th day of the first month of the quarter or upon CMS approval, whichever is later, the Administration shall send to each hospital a notification that the assessment invoice is available to be viewed on a secure website. The invoice shall include the hospital's peer group assignment and the assessment due for the quarter.
- I.** Assessment due date. The assessment must be received by the Administration no later than:
1. The 15th day of the second month of the quarter or
 2. In the event CMS approves the assessment after the 15th day of the first month of the quarter, 30 days after notification by the Administration that the assessment invoice is available.
- J.** Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital's 2018 Medicare Cost Report and Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for January 2, 2020:
1. Hospitals owned and operated by the state, the United States, or an Indian tribe.
 2. Hospitals designated as type: hospital, subtype: short-term that have a license number beginning "SH."
 3. Hospitals designated as type: hospital, subtype: psychiatric that reported fewer than 2,500 discharges on the 2018 Medicare Cost Report.
 4. Hospitals designated as type: hospital, subtype; rehabilitation.
 5. Hospitals designated as type: hospital, subtype: children's.
 6. Hospitals designated as type: med-hospital, subtype: special hospitals.
 7. Hospitals designated as type: hospital, subtype: short-term located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2018 Medicare Cost Report are reimbursed by Medicare.
 8. Hospitals designated as type: hospital, subtype: short-term that have at least 25 percent Medicare swing beds as percentage of total Medicare days, per the 2018 Medicare Cost Report.
- K.** New hospitals. For hospitals that did not file a 2018 Medicare Cost Report because of the date the hospital began operations:
1. If the hospital was open on the January 2 preceding the July assessment start date, the hospital assessment will

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- begin on July 1 following the date the hospital began operating.
2. If the hospital began operating between January 3 and June 30, the assessment will begin on July 1 of the following calendar year.
 3. A hospital is not considered a new hospital based on a change in ownership.
 4. The assessment will be based on the discharges reported in the hospital's first Medicare Cost Report and Uniform Accounting Report, which includes 12 months-worth of data, except when any of the following apply;
 - a. If there is not a complete 12 months-worth of data available, the assessment will be based on the annualized number of discharges from the date hospital operations began through December 31 preceding the July assessment start date. The hospital shall self-report the discharge data and all other data requested by the Administration necessary to determine the appropriate assessment to the Administration no later than January 15 preceding the assessment start date for the new hospitals. "Annualized" means divided by a ratio equal to the number of months of data divided by 12 months.
 - b. If more than 12 months of data is available, the assessment will be based on the most recent 12 months of self-reported data, as of December 31;
 5. For purposes of calculating subpart 4, if a new hospital shares a Medicare Identification Number with an existing hospital, the assessment amount will be based on self-reported data from the new hospital instead of the Medicare Cost Report. The data shall include the number of discharges and all other data requested by the Administration necessary to determine the appropriate assessment.
 6. For hospitals providing self-reported data, described in subpart 4 and 5:
 - a. Psychiatric discharges will be annualized to determine if subsections (B)(4) or (I)(3) apply to the assessment amount.
 - b. Discharges will be annualized to determine if subsection (F) applies to the assessment amount.
- L.** Changes of ownership. The parties to a change of ownership shall promptly provide written notice to the Administration of a change of ownership and any agreement regarding the payment of the assessment. The assessed amount will continue at the same amount applied to the prior owner. Assessments are the responsibility of the owner of record as of the first day of the quarter; however, this rule is not intended to prohibit the parties to a change of ownership from entering into an agreement for a new owner to assume the assessment responsibility of the owner of record as of the first day of the prior quarter.
- M.** Hospital closures. Hospitals that close shall pay a proportion of the quarterly assessment equal to that portion of the quarter during which the hospital operated.
- N.** Required information for the inpatient assessment. For any hospital that has not filed a 2018 Medicare Cost report, or if the 2018 Medicare Cost report does not include the reliable information sufficient for the Administration to calculate the inpatient assessment, the Administration shall use data reported on the 2018 Uniform Accounting Report filed by the hospital in place of the 2018 Medicare Cost report to calculate the assessment. If the 2018 Uniform Accounting Report filed by the hospital does not include reliable information sufficient for the Administration to calculate the inpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2018 Medicare Cost report to calculate the assessment.
- O.** Required information for the outpatient assessment. For any hospital that has not filed a 2018 Uniform Accounting Report, or if the 2018 Uniform Accounting Report does not reconcile to 2018 Audited Financial Statements, the Administration shall use the data reported on 2018 Audited Financial Statements to calculate the outpatient assessment. If the 2018 Audited Financial Statements do not include the reliable information sufficient for the Administration to calculate the outpatient assessment, the Administration all use data reported on the 2018 Medicare Cost report. If the Medicare Cost report does not include reliable information sufficient for the Administration to calculate the outpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2018 Medicare Cost report to calculate the outpatient assessment.
- P.** The Administration will review and update as necessary rates and peer groups periodically to ensure the assessment is sufficient to fund the state match obligation to cover the cost of the populations as specified in A.R.S. § 36-2901.08.
- Q.** Enforcement. If a hospital does not comply with this Section, the director may suspend or revoke the hospital's provider agreement. If the hospital does not comply within 180 days after the hospital's provider agreement is suspended or revoked, the director shall notify the director of the Department of Health Services who shall suspend or revoke the hospital's license.

Historical Note

New Section R9-22-730 made by exempt rulemaking at 20 A.A.R. 281, effective January 15, 2014 (Supp. 14-1).

Amended by exempt rulemaking at 20 A.A.R. 1833, effective July 1, 2014 (Supp. 14-2). Amended by final exempt rulemaking at 21 A.A.R. 637, effective April 15, 2015 (Supp. 15-2). Amended by final exempt rulemaking at 21 A.A.R. 1486, effective July 16, 2015 (Supp. 15-3). Amended by final exempt rulemaking at 22 A.A.R. 2050, effective July 14, 2016 (Supp. 16-4). Amended by final exempt rulemaking at 23 A.A.R. 1945, effective July 1, 2017 (Supp. 17-2). Amended by final exempt rulemaking at 24 A.A.R. 2229, effective July 10, 2018 (Supp. 18-3). Amended by final exempt rulemaking at 25 A.A.R. 1938, effective July 1, 2019 (Supp. 19-3). Amended by final exempt rulemaking at 26 A.A.R. 1702, effective July 1, 2020 (Supp. 20-3).

ARTICLE 8. REPEALED

Article 8, consisting of Sections R9-22-801 through R9-22-804 and Exhibit A, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).

R9-22-801. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-801 adopted as an emergency adoption now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-801 repealed, new Section R9-22-801 adopted effective October 29, 1985 (Supp. 85-5). Amended subsections (C), (F), (H), (I), and (K) effective October 1, 1986 (Supp. 86-5). Change of heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (H) effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-

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3). Section heading amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-801 repealed, new Section R9-22-801 adopted January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-802. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-802 adopted as an emergency adoption now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 29, 1985 (Supp. 85-5). Amended subsections (A), (B), (C) and (D) effective October 14, 1988 (Supp. 88-4). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-802 repealed, new Section R9-22-802 adopted effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-803. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-803 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-803 repealed, new Section R9-22-803 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-803 renumbered and amended as Section R9-22-804. Adopted effective January 31, 1986 (Supp. 86-1). Amended effective September 29, 1992 (Supp. 92-3). Former Section R9-22-803 repealed, new Section R9-22-803 adopted January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-804. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-804 adopted as an emergency adoption now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Former Section R9-22-804 repealed, former Section R9-22-803 renumbered and amended as Section R9-22-804 effective October 29, 1985 (Supp. 85-5). Amended effective October 14, 1988 (Supp. 88-4). Amended subsections (B) and (C) effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-804 repealed, new Section R9-22-804 adopted effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3317, effective

August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

Exhibit A. Repealed**Historical Note**

New Exhibit adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Exhibit repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-805. Repealed**Historical Note**

Former Section R9-22-805 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective January 31, 1986 (Supp. 86-1).

ARTICLE 9. REPEALED**R9-22-901. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-901 adopted as an emergency adoption now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective August 29, 1985 (Supp. 85-4). Amended effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-902. Repealed**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-902 renumbered and amended as Section R9-22-904, former Section R9-22-903 renumbered and amended as Section R9-22-902 effective October 1, 1986 (Supp. 86-5). Former Section R9-22-902 repealed, new Section R9-22-902 adopted effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-903. Repealed

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Historical Note

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-903 renumbered and amended as Section R9-22-902, former Section R9-22-904 renumbered and amended as Section R9-22-903 effective October 1, 1986 (Supp. 86-5). Former Section R9-22-903 repealed, new Section R9-22-903 adopted effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-904. Repealed**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-904 renumbered and amended as Section R9-22-903, former Section R9-22-902 renumbered and amended as Section R9-22-904 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-905. Repealed**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-905 renumbered without change as Section R9-22-908, former Section R9-22-907 renumbered and amended as Section R9-22-905 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-906. Repealed**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Amended effective October 1, 1986 (Supp. 86-5). Amended effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-907. Repealed**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-907 renumbered and amended as Section R9-22-905, former Section R9-22-908 renumbered and amended as Section R9-22-907 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective

October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-908. Repealed**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-908 renumbered and amended as Section R9-22-907, former Section R9-22-905 renumbered without change as Section R9-22-908 effective October 1, 1986 (Supp. 86-5). Former R9-22-908 repealed effective May 30, 1989 (Supp. 89-2). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-909. Repealed**Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

ARTICLE 10. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES**R9-22-1001. Definitions**

In addition to the definitions in A.R.S. §§ 36-2901, 36-2923 and 9 A.A.C. 22, Article 1, the following definitions apply to this Article:

“Absent parent” means an individual who is absent from the home and is legally responsible for providing financial and/or medical support for a dependent child.

“Cost avoid” means to deny a claim and return the claim to the provider for a determination of the amount of first- or third-party liability.

“First-party liability” means the obligation of any insurance plan or other coverage obtained directly or indirectly by a member that provides benefits directly to the member to pay all or part of the expenses for medical services incurred by AHCCCS or a member.

“Third-party” means a person, entity, or program that is, or may be, liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member.

“Third-party liability” means any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished to a member under a state plan.

Historical Note

Former Section R9-22-712 renumbered and amended as Section R9-22-1001 effective October 1, 1985 (Supp. 85-5). Amended subsections (E) through (H) effective October 1, 1986 (Supp. 86-5). Amended subsections (B), (C), (E), and (F) effective December 22, 1987 (Supp. 87-4). Section repealed; new Section adopted effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 21 A.A.R. 1237, effective July 7, 2015 (Supp. 15-3).

R9-22-1002. General Provisions

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AHCCCS is the payor of last resort unless specifically prohibited by applicable state or federal law. AHCCCS is not the payor of last resort when the following entities are the third-party:

1. Indian Health Services (IHS/638), contract health,
2. Title IV-E,
3. Arizona Early Intervention Program (AZEIP),
4. Local educational agencies providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300,
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 USC 300ff et seq., and
6. The Arizona Refugee Resettlement Program operated under 45 CFR Part 400, Subpart (G).

Historical Note

Section R9-22-529 adopted effective October 1, 1985, then renumbered as Section R9-22-1002 effective October 1, 1985 (Supp. 85-5). Amended subsections (C) and (D) effective October 1, 1986 (Supp. 86-5). Amended effective December 22, 1987 (Supp. 87-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed; new Section adopted effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 21 A.A.R. 1237, effective July 7, 2015 (Supp. 15-3).

R9-22-1003. Cost Avoidance

- A. The Administration's reimbursement responsibility.
 1. The Administration shall pay no more than the difference between the Capped Fee-For-Service schedule and the amount of the third-party liability, unless Medicare is the third-party.
 2. If Medicare is the third-party that is liable, the Administration shall pay the Medicare copayment, coinsurance, and deductible regardless of the Capped Fee-For-Service Schedule, as described under 9 A.A.C. 29, Article 3.
- B. The Contractor's reimbursement responsibility.
 1. If the contract between the contractor and the provider does not state otherwise, a contractor shall pay no more than the difference between the contracted rate and the amount of the third-party liability.
 2. If the provider does not have a contract with the contractor, a contractor shall pay no more than the difference between the Capped Fee-For-Service rate and the amount of the third-party liability.
- C. The following parties shall take reasonable measures to identify potentially legally liable first- or third-party sources:
 1. AHCCCS, the Administration, or a contractor;
 2. A provider;
 3. A noncontracting provider; and
 4. A member.
- D. Except as specified under subsection (E), the Administration or a contractor shall cost avoid a claim for AHCCCS covered services under Article 2 if the Administration or a contractor has established the probable existence of a liable party at the time the claim is filed. Establishing liability takes place when the Administration or the contractor receives confirmation that another party is legally responsible for payment of a health care service under Article 2.
- E. The Administration or contractor shall pay the full amount of the claim according to the Capped-Fee-For-Service Schedule or the contracted rate as described under subsection (B), and

then seek reimbursement from any liable parties if the claim is for:

1. Prenatal care for pregnant women,
2. Preventive pediatric services, including E.P.S.D.T. and administration of vaccines to children under the Vaccines for Children (VFC) program; or
3. Services covered by third-party liability that is derived from an absent parent whose obligation to pay support is being enforced by the Division of Child Support Enforcement.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 3012, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 21 A.A.R. 1237, effective July 7, 2015 (Supp. 15-3).

R9-22-1004. Member Participation

A member shall cooperate in identifying potentially legally liable first- or third-parties and timely assist the Administration and a contractor, provider, or noncontracting provider in pursuing any first- or third-party who may be liable to pay for covered services.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

R9-22-1005. Collections

- A. Parties that notify AHCCCS. A provider or noncontracting provider shall cooperate with AHCCCS by identifying all potential sources of first- or third-party liability and notify AHCCCS of these sources.
- B. Parties that pursue collection or reimbursement. AHCCCS, a provider, or noncontracting provider shall pursue collection or reimbursement from all potential sources of first- or third-party liability.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

R9-22-1006. AHCCCS Monitoring Responsibilities

AHCCCS shall monitor first- or third-party liability payments to a provider or noncontracting provider, which include but are not limited to payments by or for:

1. Private health insurance;
2. Employment-related disability and health insurance;
3. Long-term care insurance;
4. Other federal programs not excluded by statute from recovery;
5. Court ordered or non-court ordered medical support from an absent parent;
6. State worker's compensation;
7. Automobile insurance, including underinsured and uninsured motorists insurance;
8. Court judgment or settlement from a liability insurer including settlement proceeds placed in a trust;
9. First-party probate estate recovery;
10. Adoption-related payment; or
11. A tortfeasor.

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Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

R9-22-1007. Notification for Perfection, Recording, and Assignment of AHCCCS Liens

- A.** Hospital requirements. A hospital providing medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a first- or third-party shall within 30 days after a member's discharge:
1. Notify AHCCCS via facsimile or mail under R9-22-1008, or
 2. Mail AHCCCS a copy of the lien the hospital proposes to record or has recorded under A.R.S. § 33-932.
- B.** Provider and noncontracting provider requirements. A provider or noncontracting provider, other than a hospital, rendering medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a first- or third-party shall notify AHCCCS via facsimile or mail under R9-22-1008 within 30 days after providing the service.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

R9-22-1008. Notification Information for Liens

- A.** Except as provided in subsection (B), a hospital, provider, and noncontracting provider identified in R9-22-1007 shall provide the following information to AHCCCS in writing:
1. Name of the hospital, provider or noncontracting provider;
 2. Address of the hospital, provider or noncontracting provider;
 3. Name of member;
 4. Member's Social Security Number or AHCCCS identification number;
 5. Address of member;
 6. Date of member's admission or date service is provided;
 7. Amount estimated to be due for care of member;
 8. Date of discharge, if member has been discharged;
 9. Name of county in which injuries were sustained; and
 10. Name and address of all persons, firms, and corporations and their insurance carriers identified by the member or legal representative as being liable for damages.
- B.** If the date of discharge is not known at the time the information in subsection (A) is provided, a party identified in subsection (A) shall notify AHCCCS of the date of discharge within 30 days after the member has been discharged.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

R9-22-1009. Notification of Health Insurance Information

A provider or noncontracting provider shall notify AHCCCS, in writing, of the following health insurance information within 10 days of receipt of the health insurance information:

1. Name of member,
2. Member's Social Security Number or AHCCCS identification number,
3. Insurance carrier name,
4. Insurance carrier address,

5. Policy number or insurance holder's Social Security Number,
6. Policy begin and end dates, and
7. Insurance holder's name.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS**R9-22-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims; Definitions**

- A.** Scope. This Article applies to prohibited acts as described under A.R.S. § 36-2918(A), and submissions of encounters to the Administration. The Administration considers a person who aids and abets a prohibited act affecting any of the AHCCCS programs or Health Care Group to be engaging in a prohibited act under A.R.S. § 36-2918(A).
- B.** Purpose. This Article describes the circumstances AHCCCS considers and the process that AHCCCS uses to determine the amount of a penalty, assessment, or penalty and assessment as required under A.R.S. § 36-2918. This Article includes the process and time-frames used by a person to request a State Fair Hearing.
- C.** Definitions. The following definitions apply to this Article:
1. "Assessment" means a monetary amount that does not exceed twice the dollar amount claimed by the person for each service.
 2. "Claim" means a request for payment submitted by a person for payment for a service or line item of service, including a submission of an encounter.
 3. "Day" means calendar day unless otherwise specified.
 4. "File" means the date that AHCCCS receives a written acceptance, request for compromise, request for a counter proposal, or a request for a State Fair Hearing as established by a date stamp on the written document or other record of receipt.
 5. "Penalty" means a monetary amount, based on the number of items of service claimed or reported, that does not exceed \$2,000 times the number of line items of service.
 6. "Person" means an individual or entity as described under A.R.S. § 1-215.
 7. "Reason to know" or "had reason to know" means that a person, acts in deliberate ignorance of the truth or falsity of, or with reckless disregard of the truth or falsity of information. No proof of specific intent to defraud is required.

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5). Amended subsection A. effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective June 9, 1998 (Supp. 98-2). Amended by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1102. Determining the Amount of a Penalty and an Assessment

- A.** AHCCCS shall determine the amount of a penalty and assessment according to A.R.S. § 36-2918(B) and (C), R9-22-1104, and R9-22-1105.
- B.** AHCCCS shall include in the amount of the penalty and assessment the cost incurred by AHCCCS for conducting the following:
1. An investigation,

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2. Audit, or
3. Inquiry.

Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5).
Amended effective December 13, 1993 (Supp. 93-4).
Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).
Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1103. Repealed**Historical Note**

Adopted effective October 1, 1986 (Supp. 86-5).
Amended effective December 13, 1993 (Supp. 93-4).
Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).
Section repealed by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1104. Mitigating Circumstances

AHCCCS shall consider any of the following to be mitigating circumstances when determining the amount of a penalty, assessment, or penalty and assessment.

1. Nature and circumstances of a claim. The following are mitigating circumstances:
 - a. All the services are of the same type,
 - b. All the dates of services occurred within six months or less,
 - c. The number of claims submitted is less than 25,
 - d. The nature and circumstances do not indicate a pattern of inappropriate claims for the services, and
 - e. The total amount claimed for the services is less than \$1,000.
2. Degree of culpability. The degree of culpability of a person who presents or causes to present a claim is a mitigating circumstance if:
 - a. Each service is the result of an unintentional and unrecognized error in the process that the person followed in presenting or in causing to present the service,
 - b. Corrective steps were taken promptly by the person after the error was discovered, and
 - c. The person had a fraud and abuse control plan that was operating effectively at the time each claim was presented or caused to be presented.
3. Financial condition. The financial condition of a person who presents or causes to present a claim is a mitigating circumstance if the imposition of a penalty, assessment, or penalty and assessment without reduction will render the provider incapable to continue providing services. AHCCCS shall consider the resources available to the person when determining the amount of the penalty, assessment, or penalty and assessment.
4. Other matters as justice may require. AHCCCS shall take into account other circumstances of a mitigating nature, if in the interest of justice, the circumstances require a reduction of the penalty, assessment, or penalty and assessment.

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5).
Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).

R9-22-1105. Aggravating Circumstances

AHCCCS shall consider any of the following to be aggravating circumstances when determining the amount of a penalty, assessment, or penalty and assessment.

1. Nature and circumstances of each claim. The nature and circumstances of each claim and the circumstances under which the claim is presented or caused to be presented are aggravating circumstances if:
 - a. A person has forged, altered, recreated, or destroyed records;
 - b. The person refuses to provide pertinent documentation to AHCCCS for a claim or refuses to cooperate with investigators;
 - c. The services are of several types;
 - d. All the dates of services did not occur within six months or less;
 - e. The number of claims submitted is greater than 25;
 - f. The nature and circumstances indicate a pattern of inappropriate claims for the services; and
 - g. The total amount claimed for the services is \$5,000 or greater.
2. Degree of culpability. The degree of culpability of a person who presents or causes to present each claim is an aggravating circumstance if:
 - a. The person knows or had reason to know that each service was not provided as claimed,
 - b. The person knows or had reason to know that no payment could be made because the person had been excluded from reimbursement by AHCCCS, or
 - c. The person knows or had reason to know that the payment would violate the terms of an agreement between the person and AHCCCS system.
3. Prior offenses. The prior offenses of a person who presents or causes to present each claim are an aggravating circumstance if:
 - a. At any time before the submittal of the claim the person was held criminally or civilly liable for any act, or
 - b. The person had received an administrative sanction in connection with:
 - i. A Medicaid program,
 - ii. A Medicare program, or
 - iii. Any other public or private program of reimbursement for medical services.
4. Effect on patient care. The adverse effect on patient care that resulted, or could have resulted, from the failure to provide medically necessary care by a person in connection with a claim.
5. Other matters as justice may require. AHCCCS shall take into account other circumstances of an aggravating nature, if in the interest of justice, the circumstances require an increase of the penalty, assessment, or penalty and assessment.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).
Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1106. Notice of Intent

If AHCCCS imposes a penalty, assessment, or a penalty and assessment, AHCCCS shall hand deliver or send by certified mail return receipt requested or Federal Express to the person, a written Notice

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of Intent to impose a penalty, assessment, or a penalty and assessment. The Notice of Intent shall include:

1. The statutory basis for the penalty, assessment, or the penalty and assessment;
2. Identification of the state or federal regulation and state or federal law that AHCCCS alleges has been violated;
3. The factual basis for AHCCCS' determination that the penalty, assessment, or the penalty and assessment should be imposed;
4. The amount of the penalty, assessment, or penalty and assessment;
5. The process for the person to accept or request a compromise of the penalty, assessment, or penalty and assessment; and
6. The process for requesting a State Fair Hearing.

Historical Note

New Section made by final rulemaking at 10 A.A.R.

3056, effective September 11, 2004 (Supp. 04-3).

Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1107. Reserved**R9-22-1108. Request for a Compromise**

- A. To request a compromise, the person shall file a written request with AHCCCS within 30 days from the date of receipt of the Notice of Intent. The written request for compromise shall contain the person's reasons for the reduction or modification of the penalty, assessment, or penalty and assessment.
- B. Within 30 days from the date of receipt of the request for compromise from the person, AHCCCS shall send a Notice of Compromise Decision that accepts, denies, or offers a counter proposal to the person's request for compromise. If AHCCCS offers a counter proposal the amount of the counter proposal shall represent the penalty, assessment, or penalty and assessment.
 1. If AHCCCS does not withdraw the Notice of Intent under R9-22-1112 or denies the request for compromise the original penalty, assessment, or penalty and assessment is upheld.
 2. To dispute the Compromise Decision, the person shall file a request for a State Fair Hearing under R9-22-1110 within 30 days from the date of receipt of the Notice of Compromise Decision.

Historical Note

New Section made by final rulemaking at 10 A.A.R.

3056, effective September 11, 2004 (Supp. 04-3).

Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1109. Failure to Respond to the Notice of Intent

If a person fails to respond timely to the Notice of Intent, AHCCCS shall uphold the original penalty, assessment, or penalty and assessment.

Historical Note

New Section made by final rulemaking at 10 A.A.R.

3056, effective September 11, 2004 (Supp. 04-3).

Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1110. Request for State Fair Hearing

- A. To request a State Fair Hearing regarding a dispute concerning a penalty, assessment, or penalty and assessment, the person shall file a written request for a State Fair Hearing with AHCCCS within 60 days from the date of the receipt of the Notice of Intent under R9-22-1106 or within 30 days from the date of

receipt of the Notice of Compromise Decision under R9-22-1108, if applicable.

- B. AHCCCS shall mail a Notice of Hearing under A.R.S. § 41-1092.05 if AHCCCS receives a timely request for a State Fair Hearing from the person.
- C. AHCCCS shall mail a Director's Decision to the person no later than 30 days after the date the Administrative Law Judge sends the decision of the Office of Administrative Hearings (OAH) to AHCCCS.
- D. AHCCCS shall accept a written request for withdrawal of a hearing request if the written request for withdrawal is received from the person before AHCCCS mails a Notice of Hearing under A.R.S. § 41-1092 et seq. If AHCCCS mailed a Notice of Hearing under A.R.S. § 41-1092 et seq., a person may withdraw the hearing request only by sending a written request for withdrawal to OAH.

Historical Note

New Section made by final rulemaking at 10 A.A.R.

3056, effective September 11, 2004 (Supp. 04-3).

Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1111. Issues and Burden of Proof

- A. Preponderance of evidence. In any State Fair Hearing conducted under R9-22-1110, AHCCCS shall prove by a preponderance of the evidence that a person presented or caused to be presented each claim in violation of this Article and any aggravating circumstances under R9-22-1105. A person shall bear the burden of producing and proving by a preponderance of the evidence any circumstance that would justify reducing the amount of the penalty, assessment, or penalty and assessment.
- B. Statistical sampling.
 1. In meeting the burden of proof described in subsection (A), AHCCCS may introduce the results of a statistical sampling study as evidence of the number and amount of claims that were presented or caused to be presented by the person. A statistical sampling study constitutes prima facie evidence of the number and amount of claims if computed by valid statistical methods.
 2. The burden of proof shall shift to the person to produce evidence reasonably calculated to rebut the findings of the statistical sampling study once AHCCCS has made a prima facie case as described in subsection (B)(1). AHCCCS shall be given the opportunity to rebut this evidence.

Historical Note

New Section made by final rulemaking at 10 A.A.R.

3056, effective September 11, 2004 (Supp. 04-3).

Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1112. Withdrawal and Continuances

AHCCCS may withdraw the Notice of Intent at any time. Prior to referring a matter to the Office of Administrative Hearings the parties may mutually agree to a continuance.

Historical Note

New Section made by final rulemaking at 10 A.A.R.

3056, effective September 11, 2004 (Supp. 04-3).

ARTICLE 12. BEHAVIORAL HEALTH SERVICES**R9-22-1201. Definitions**

Definitions. The following definitions apply to this Article:

"Adult behavioral health therapeutic home" as defined in 9 A.A.C. 10, Article 1.

"Agency" for the purposes of this Article means a behavioral health facility, a classification of a health care institution,

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including a mental health treatment agency defined in A.R.S. § 36-501, that is licensed to provide behavioral health services according to A.R.S. Title 36, Chapter 4.

“Assessment” means an analysis of a patient’s need for physical health services or behavioral health services to determine which services a health care institution will provide to the patient.

“Behavior management services” means services that assist the member in carrying out daily living tasks and other activities essential for living in the community, including personal care services.

“Behavioral health therapeutic home care services” means interactions that teach the client living, social, and communication skills to maximize the client’s ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services indicated by the client’s treatment plan, as appropriate.

“Behavioral health services” means medical services, nursing services, health-related services, or ancillary services provided to an individual to address the individual’s behavioral health issue.

“Behavioral health technician” means an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution’s policies and procedures that:

If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and

Are provided with clinical oversight by a behavioral health professional.

“Case management” for the purposes of this Article, means services and activities that enhance treatment, compliance, and effectiveness of treatment.

“Certified psychiatric nurse practitioner” means a registered nurse practitioner who meets the psychiatric specialty area requirements under A.A.C. R4-19-505(C).

“Clinical oversight” means as described under 9 A.A.C. 10.

“Cost avoid” means to avoid payment of a third-party liability claim when the probable existence of third-party liability has been established under 42 CFR 433.139(b).

“Court-ordered evaluation” has the same meaning as “evaluation” in A.R.S. § 36-501.

“Court-ordered pre-petition screening” has the same meaning as “pre-petition screening” in A.R.S. § 36-501.

“Court-ordered treatment” means treatment provided according to A.R.S. Title 36, Chapter 5.

“Crisis services” means immediate and unscheduled behavioral health services provided to a patient to address an acute behavioral health issue affecting the patient.

“Direct supervision” has the same meaning as “supervision” in A.R.S. § 36-401.

“Emergency medical services provider” has the same meaning as in A.R.S. § 36-2201.

“Health care institution” has the same meaning as defined in A.R.S. § 36-401.

“Health care practitioner” means a:

Physician;

Physician assistant;

Nurse practitioner; or

Other individual licensed and authorized by law to use and prescribe medication and devices, as defined in A.R.S. § 32-1901.

“Licensee” means the same as in 9 A.A.C. 10, Article 1.

“Medical practitioner” means a physician, physician assistant, or nurse practitioner.

“Partial care” means a day program of services provided to individual members or groups that is designed to improve the ability of a person to function in a community, and includes basic, therapeutic, and medical day programs.

“Physician assistant” means the same as in A.R.S. § 32-2501 except that when providing a behavioral health service, the physician assistant shall be supervised by an AHCCCS-registered psychiatrist.

“Psychiatrist” means a physician who meets the licensing requirements under A.R.S. § 32-1401 or a doctor of osteopathy who meets the licensing requirements under A.R.S. § 32-1800, and meets the additional requirements of a psychiatrist under A.R.S. § 36-501.

“Psychologist” means a person who meets the licensing requirements under A.R.S. §§ 32-2061 and 36-501.

“Qualified behavioral health service provider” means a behavioral health service provider that meets the requirements of R9-22-1206.

“Respite” means a period of care and supervision of a member to provide rest or relief to a family member or other person caring for the member. Respite provides activities and services to meet the social, emotional, and physical needs of the member during respite.

“TRBHA” or “Tribal Regional Behavioral Health Authority” means a Native American tribe under contract with ADHS/DBHS to coordinate the delivery of behavioral health services to eligible and enrolled members of the federally-recognized tribal nation.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-1202. ADHS, Contractor, Administration and CRS Responsibilities

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- A.** ADHS responsibilities. ADHS is responsible for payment of behavioral health services provided to members, except as specified under subsection (D). ADHS' responsibility for payment of behavioral health services includes claims for inpatient hospital services, which may include physical health services, when the principal diagnosis on the hospital claim is a behavioral health diagnosis. Behavioral health diagnoses are identified as "mental disorders" in the latest International Classification of Diseases (ICD) code set as required by AHCCCS claims and encounters.
- B.** ADHS/DBHS may contract with a TRBHA for the provision of behavioral health services for American Indian members. American Indian members may receive covered behavioral health services:
1. From an IHS or tribally operated 638 facility,
 2. From a TRBHA, or
 3. From a RBHA.
- C.** Contractor responsibilities. A contractor shall:
1. Refer a member to a RBHA under the contract terms;
 2. Provide EPSDT developmental and behavioral health screening as specified in R9-22-213;
 3. Coordinate a member's transition of care and medical records; and
 4. Be responsible for providing covered inpatient hospital services, which may include behavioral health inpatient hospital services, when the principal diagnosis on the hospital claim is not a behavioral health diagnosis.
- D.** Administration and CRS responsibilities.
1. The Administration shall be responsible for payment of behavioral health services provided to an ALTCS FFS or an FES member and for behavioral health services provided by IHS and tribally operated 638 facilities. The Administration is also responsible for payment of behavioral health services provided to these members during prior quarter coverage.
 2. CRS shall be responsible for payment of behavioral health services provided to members enrolled with CRS.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended to correct typographical errors, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4). Amended by final rulemaking at 21 A.A.R. 1225, effective July 7, 2015 (Supp. 15-3).

R9-22-1203. Eligibility for Covered Services

Title XIX members. A member determined eligible under A.R.S. § 36-2901(6)(a) or (g) except for the failure to meet U.S. citizenship or qualified alien status requirements, shall receive medically necessary covered services under Article 12 and Article 2.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-1204. General Service Requirements

- A.** Services. Behavioral health services include mental health, substance abuse, and physical services. Medically necessary services shall be covered and service requirements met as described under Article 2 and Article 5.
- B.** Notification to Administration for American Indians enrolled with a tribal contractor. A provider shall notify the Administration no later than 72 hours after an American Indian member enrolled with a tribal contractor presents to a behavioral health hospital for inpatient emergency behavioral health services.
- C.** Restrictions and limitations. Room and board is not a covered service unless provided in a behavioral health inpatient facility under R9-22-1205.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective January 1, 1996; filed with the Secretary of State December 22, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-1205. Scope and Coverage of Behavioral Health Services

- A.** Inpatient behavioral health services. The following inpatient services are covered subject to the limitations and exclusions in this Article and Article 2.
1. Covered inpatient behavioral health services include all behavioral health services, medical detoxification, accommodations and staffing, supplies, and equipment, if the service is provided under the direction of a physician in a Medicare-certified:
 - a. General acute care hospital,

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- b. Inpatient psychiatric unit in a general acute care hospital, or
 - c. Behavioral health hospital.
 - 2. Inpatient service limitations:
 - a. Inpatient services, other than emergency services specified in this Section, are not covered unless prior authorization is obtained.
 - b. Inpatient services and room and board are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
 - i. A licensed psychiatrist,
 - ii. A certified psychiatric nurse practitioner,
 - iii. A licensed physician assistant,
 - iv. A licensed psychologist,
 - v. A licensed clinical social worker,
 - vi. A licensed marriage and family therapist,
 - vii. A licensed professional counselor,
 - viii. A licensed independent substance abuse counselor, and
 - ix. A medical practitioner.
- B. Behavioral Health Inpatient facility for children.** Services provided in a Behavioral Health Inpatient facility for children as defined in 9 A.A.C. 10, Article 3 are covered subject to the limitations and exclusions under this Article.
- 1. Behavioral Health Inpatient facility for children services are not covered unless provided under the direction of a licensed physician in a licensed Behavioral Health Inpatient facility for children accredited by an AHCCCS-approved accrediting body as specified in contract.
 - 2. Covered Behavioral Health Inpatient facility for children services include room and board and treatment services for behavioral health and substance abuse conditions.
 - 3. Inpatient Behavioral Health Inpatient facility for children service limitations.
 - a. Services are not covered unless prior authorized, except for emergency services as specified in this Section.
 - b. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
 - i. A licensed psychiatrist,
 - ii. A certified psychiatric nurse practitioner,
 - iii. A licensed physician assistant,
 - iv. A licensed psychologist,
 - v. A licensed clinical social worker,
 - vi. A licensed marriage and family therapist,
 - vii. A licensed professional counselor,
 - viii. A licensed independent substance abuse counselor, and
 - ix. A medical practitioner.
 - 4. The following may be billed independently if prescribed by a provider as specified in this Section who is operating within the scope of practice:
 - a. Laboratory services, and
 - b. Radiology services.
- C. Covered Inpatient sub-acute agency services.** Services provided in a inpatient sub-acute facility as defined in 9 A.A.C. 10, Article 1 are covered subject to the limitations and exclusions under this Article.
- 1. Inpatient sub-acute facility services are not covered unless provided under the direction of a licensed physician in a licensed inpatient sub-acute facility that is accredited by an AHCCCS-approved accrediting body.
- 2. Covered Inpatient sub-acute facility services include room and board and treatment services for behavioral health and substance abuse conditions.
 - 3. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
 - a. A licensed psychiatrist,
 - b. A certified psychiatric nurse practitioner,
 - c. A licensed physician assistant,
 - d. A licensed psychologist,
 - e. A licensed clinical social worker,
 - f. A licensed marriage and family therapist,
 - g. A licensed professional counselor,
 - h. A licensed independent substance abuse counselor, and
 - i. A medical practitioner.
 - 4. The following may be billed independently if prescribed by a provider specified in this Section who is operating within the scope of practice:
 - a. Laboratory services, and
 - b. Radiology services.
- D. Behavioral health residential facility services.** Services provided in a licensed behavioral health residential facility as defined in 9 A.A.C. 10, Article 1 are covered subject to the limitations and exclusions under this Article.
- 1. Behavioral health residential facility services are not covered unless provided by a licensed behavioral health residential facility.
 - 2. Covered services include all non-prescription drugs as defined in A.R.S. § 32-1901, non-customized medical supplies, and clinical oversight or direct supervision of the behavioral health residential facility staff, whichever is applicable. Room and board are not covered services.
 - 3. The following licensed and certified providers may bill independently for services:
 - a. A licensed psychiatrist,
 - b. A certified psychiatric nurse practitioner,
 - c. A licensed physician assistant,
 - d. A licensed psychologist,
 - e. A licensed clinical social worker,
 - f. A licensed marriage and family therapist,
 - g. A licensed professional counselor,
 - h. A licensed independent substance abuse counselor, and
- E. Partial care.** Partial care services are covered subject to the limitations and exclusions in this Article.
- 1. Partial care services are not covered unless provided by a licensed and AHCCCS-registered behavioral health agency that provides a regularly scheduled day program of individual member, group, or family activities that are designed to improve the ability of the member to function in the community. Partial care services include basic, therapeutic, and medical day programs.
 - 2. Partial care services. Educational services that are therapeutic and are included in the member's behavioral health treatment plan are included in per diem reimbursement for partial care services.
- F. Outpatient services.** Outpatient services are covered subject to the limitations and exclusions in this Article and Article 2.
- 1. Outpatient services include the following:
 - a. Screening provided by a behavioral health professional or a behavioral health technician as defined in R9-22-1201;

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- b. A behavioral health assessment provided by a behavioral health professional or a behavioral health technician;
 - c. Counseling including individual therapy, group therapy, and family therapy provided by a behavioral health professional or a behavioral health technician;
 - d. Behavior management services as defined in R9-22-1201; and
 - e. Psychosocial rehabilitation services as defined in R9-22-201.
2. Outpatient service limitations.
- a. The following licensed or certified providers may bill independently for outpatient services:
 - i. A licensed psychiatrist;
 - ii. A certified psychiatric nurse practitioner;
 - iii. A licensed physician assistant as defined in R9-22-1201;
 - iv. A licensed psychologist;
 - v. A licensed clinical social worker;
 - vi. A licensed professional counselor;
 - vii. A licensed marriage and family therapist;
 - viii. A licensed independent substance abuse counselor;
 - ix. A medical practitioner; and
 - x. An outpatient treatment center or substance abuse transitional facility licensed under 9 A.A.C. 10, Article 14, that is an AHCCCS-registered provider.
 - b. A behavioral health practitioner not specified in subsections (F)(2)(a)(i) through (x), who is contracted with or employed by an AHCCCS-registered behavioral health agency shall not bill independently.
- G.** Emergency behavioral health services are covered subject to the limitations and exclusions under this Article. In order to be covered, behavioral health services shall be provided by qualified service providers under R9-22-1206. ADHS/DBHS shall ensure that emergency behavioral health services are available 24 hours per day, seven days per week in each GSA for an emergency behavioral health condition for a non-FES member as defined in R9-22-201.
- H.** Other covered behavioral health services. Other covered behavioral health services include:
- 1. Case management as defined in 9 A.A.C. 10, Article 1;
 - 2. Laboratory and radiology services for behavioral health diagnosis and medication management;
 - 3. Medication;
 - 4. Monitoring, administration, and adjustment for psychotropic medication and related medications;
 - 5. Respite care as described within subsection (J);
 - 6. Behavioral health therapeutic home care services provided by a RBHA in a professional foster home defined in 6 A.A.C. 5, Article 58 or in an adult behavioral health therapeutic home as defined in 9 A.A.C. 10, Article 1;
 - 7. Other support services to maintain or increase the member's self-sufficiency and ability to live outside an institution.
- I.** Transportation services. Transportation services are covered under R9-22-211.
- J.** Limited Behavioral Health services. Respite services are limited to no more than 600 hours per benefit year.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to

Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by exempt rulemaking at 17 A.A.R. 1870, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-1206. Repealed**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Repealed by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-1207. General Provisions for Payment

- A.** Claims submissions.
- 1. A provider of behavioral health services shall submit a claim for non-emergency behavioral health services provided to a member to the appropriate RBHA.
 - 2. A provider of behavioral health services shall submit a claim for non-inpatient emergency behavioral health services provided to a member to the appropriate RBHA.
 - 3. A provider of behavioral health services shall submit a claim for non-inpatient emergency behavioral health services provided to a member enrolled in a TRBHA to the Administration.
 - 4. A provider of behavioral health services shall submit a claim for non-emergency behavioral health services provided to a member enrolled in a TRBHA to the Administration.
 - 5. A provider of emergency behavioral health services, that are the responsibility of ADHS/DBHS or a contractor, shall submit a claim to the entity responsible for emergency behavioral health services under R9-22-210.01(A).
 - 6. A provider shall comply with the time-frames and other payment procedures in Article 7 of this Chapter, if applicable, and A.R.S. § 36-2904.
 - 7. ADHS/DBHS or a contractor, whichever entity is responsible for covering behavioral health services, shall cost avoid any behavioral health service claims if it establishes the existence or probable existence of first-party liability or third-party liability.

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- B. Prior authorization. Payment to a provider for behavioral health services or items requiring prior authorization may be denied if a provider does not obtain prior authorization from a RBHA, ADHS/DBHS, a TRBHA, the Administration or a contractor.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-1208. Repealed**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4).

ARTICLE 13. CHILDREN'S REHABILITATIVE SERVICES (CRS)

Article 13, consisting of Sections R9-22-1301 through R9-22-1306, made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3).

Article 13, consisting of Sections R9-22-1301 through R9-22-1306, made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Exemption to promulgate rules repealed under Laws 2012, Chapter 299, Section 7 (Supp. 13-3).

Article 13, consisting of Sections R9-22-1301 through R9-22-1309, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 13 is now in 9 A.A.C. 34 (Supp. 04-1).

R9-22-1301. Children's Rehabilitative Services (CRS) related Definitions

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

“Active treatment” means there is a current need for treatment of the CRS qualifying condition(s) or it is anticipated that treatment or evaluation for continuing treatment of the CRS qualifying condition(s) will be needed within the next 18 months from the last date of service for treatment of any CRS qualifying condition.

“CRS application” means a submitted form with any additional documentation required by the Administration to determine whether an individual is medically eligible for CRS.

“CRS condition” means a list of medical condition(s) in R9-22-1303 and which are referred to as covered conditions in A.R.S. § 36-2912.

“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 provider.

“Medically eligible” means meeting the medical eligibility requirements of R9-22-1303.

“Redetermination” means a decision made by the Administration regarding whether a member continues to meet the requirements in R9-22-1302.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 21 A.A.R. 2022, effective October 1, 2015 (Supp. 15-3).

R9-22-1302. Children's Rehabilitative Services (CRS) Eligibility Requirements

Beginning October 1, 2013, an AHCCCS member who needs active treatment for one or more of the qualifying medical condition(s) in R9-22-1303 shall be given a CRS Designation. An American Indian member can choose to receive CRS services through an American Indian Health Plan or a contractor. A member enrolled in CMDP shall obtain CRS services through CMDP. The contractor shall provide covered services necessary to treat the condition(s) and other services described within the contract. The effective date of the CRS Designation shall be as specified in contract.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

R9-22-1303. Medical Eligibility

The following lists identify those medical condition(s) that do qualify for CRS services as well as those that do not qualify for CRS services. The list of condition(s) that qualify for a CRS Designation is all inclusive. The list of condition(s) that do not qualify for a CRS Designation is not an all-inclusive list.

1. Cardiovascular System
 - a. CRS condition(s) that qualify for CRS medical eligibility:
 - i. Arrhythmia,
 - ii. Arteriovenous fistula,
 - iii. Cardiomyopathy,
 - iv. Conduction defect,
 - v. Congenital heart defect other than isolated small Ventricular Septal Defects (VSD), Patent Ductus Arteriosus (PDA), Atrial Septal Defects (ASD),
 - vi. Coronary artery and aortic aneurysm,
 - vii. Renal vascular hypertension,
 - viii. Rheumatic heart disease, and
 - ix. Valvular disorder.
 - b. Condition(s) not medically eligible for CRS:

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- i. Arteriovenous fistula that is not expected to cause cardiac failure or threaten loss of function;
 - ii. Benign heart murmur;
 - iii. Branch artery pulmonary stenosis;
 - iv. Essential hypertension;
 - v. Patent foramen ovale (PFO);
 - vi. Peripheral pulmonary stenosis;
 - vii. Postural orthopedic tachycardia; and
 - viii. Premature atrial, nodal or ventricular contractions that are of no hemodynamic significance.
2. Endocrine system:
 - a. CRS condition(s) that qualify for CRS medical eligibility:
 - i. Addison's disease,
 - ii. Adrenogenital syndrome,
 - iii. Cystic fibrosis (including atypical cystic fibrosis),
 - iv. Diabetes insipidus,
 - v. Hyperparathyroidism,
 - vi. Hyperthyroidism,
 - vii. Hypoparathyroidism, and
 - viii. Panhypopituitarism.
 - b. Condition(s) not medically eligible for CRS
 - i. Diabetes mellitus,
 - ii. Hypopituitarism associated with a malignancy and requiring treatment of less than 90 days,
 - iii. Isolated growth hormone deficiency, and
 - iv. Precocious puberty.
 3. Genitourinary system medical condition(s):
 - a. CRS condition(s) that qualify for CRS medical eligibility:
 - i. Ambiguous genitalia,
 - ii. Bladder extrophy,
 - iii. Deformity and dysfunction of the genitourinary system secondary to trauma 90 days or more after the trauma occurred,
 - iv. Ectopic ureter,
 - v. Hydronephrosis, that is not resolved with antibiotics,
 - vi. Polycystic and multicystic kidneys,
 - vii. Pyelonephritis when treatment with drugs or biologicals has failed to cure or ameliorate and surgical intervention is required,
 - viii. Ureteral stricture, and
 - ix. Vesicoureteral reflux, at a grade 3 or higher.
 - b. Condition(s) not medically eligible for CRS:
 - i. Enuresis,
 - ii. Hydrocele,
 - iii. Hypospadias,
 - iv. Meatal stenosis,
 - v. Nephritis, infectious or noninfectious,
 - vi. Nephrosis,
 - vii. Phimosis, and
 - viii. Undescended testicle.
 4. Ear, nose, or throat medical condition(s):
 - a. CRS condition(s) that qualify for CRS medical eligibility:
 - i. Cholesteatoma,
 - ii. Congenital/Craniofacial anomaly that is functionally limiting,
 - iii. Deformity and dysfunction of the ear, nose, or throat secondary to trauma, 90 days or more after the trauma occurred,
 - iv. Mastoiditis that continues 90 days or more after the first diagnosis of the condition,
 - v. Microtia that requires multiple surgical interventions,
 - vi. Neurosensory hearing loss, and
 - vii. Significant conductive hearing loss due to an anomaly in one ear or both ears equal to or greater than a pure tone average of 30 decibels that despite medical treatment, requires a hearing aid.
 - b. Condition(s) not medically eligible for CRS:
 - i. A craniofacial anomaly that is not functionally limiting,
 - ii. Adenoiditis,
 - iii. Cranial or temporal mandibular joint syndrome,
 - iv. Hypertrophic lingual frenum,
 - v. Isolated preauricular tag or pit,
 - vi. Nasal polyp,
 - vii. Obstructive apnea,
 - viii. Perforation of the tympanic membrane,
 - ix. Recurrent otitis media,
 - x. Simple deviated nasal septum,
 - xi. Sinusitis,
 - xii. Tonsillitis, and
 - xiii. Uncontrolled salivation.
 5. Musculoskeletal system medical condition(s):
 - a. CRS condition(s) that qualify for CRS medical eligibility:
 - i. Achondroplasia,
 - ii. Arthrogyrosis (multiple joint contractures),
 - iii. Bone infection that continues 90 days or more after the initial diagnosis,
 - iv. Chondrodysplasia,
 - v. Chondroectodermal dysplasia,
 - vi. Clubfoot,
 - vii. Collagen vascular disease, including but not limited to, ankylosis spondylitis, polymyositis, dermatomyositis, polyarteritis nodosa, psoriatic arthritis, scleroderma, rheumatoid arthritis and lupus,
 - viii. Congenital or developmental cervical spine abnormality,
 - ix. Congenital spinal deformity,
 - x. Diastrophic dysplasia,
 - xi. Enchondromatosis,
 - xii. Femoral anteversion and tibial torsion,
 - xiii. Fibrous dysplasia,
 - xiv. Hip dysplasia,
 - xv. Hypochondroplasia,
 - xvi. Joint infection that continues 90 days or more after the initial diagnosis,
 - xvii. Juvenile rheumatoid arthritis,
 - xviii. Kyphosis (Scheurmann's Kyphosis) 50 degrees or over,
 - xix. Larsen syndrome,
 - xx. Leg length discrepancy of two centimeters or more,
 - xxi. Legg-Calve-Perthes disease,
 - xxii. Limb amputation or limb malformation,
 - xxiii. Metaphyseal and epiphyseal dysplasia,
 - xxiv. Metatarsus adductus,
 - xxv. Muscular dystrophy,
 - xxvi. Orthopedic complications of hemophilia,
 - xxvii. Osgood Schlatter's disease that requires surgical intervention,

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- xxviii. Osteogenesis imperfecta,
 xxix. Rickets,
 xxx. Scoliosis when 25 degrees or greater, or when there is a need for bracing or surgery,
 xxxi. Seronegative spondyloarthropathy such as Reiters, psoriatic arthritis, and ankylosing spondylitis,
 xxxii. Slipped capital femoral epiphysis,
 xxxiii. Spinal muscle atrophy,
 xxxiv. Spondyloepiphyseal dysplasia, and
 xxxv. Syndactyly.
- b. Condition(s) not medically eligible for CRS:
- i. Back pain with no structural abnormality,
 - ii. Benign bone tumor,
 - iii. Bunion,
 - iv. Carpal tunnel syndrome,
 - v. Deformity and dysfunction secondary to trauma or injury,
 - vi. Ehlers Danlos,
 - vii. Flat foot,
 - viii. Fracture,
 - ix. Ganglion cyst,
 - x. Ingrown toenail,
 - xi. Kyphosis under 50 degrees,
 - xii. Leg length discrepancy of less than two centimeters at skeletal maturity,
 - xiii. Polydactyly without bone involvement,
 - xiv. Popliteal cyst,
 - xv. Trigger finger, and
 - xvi. Varus and valgus deformities.
6. Gastrointestinal system medical condition(s):
- a. CRS condition(s) that qualify for CRS medical eligibility:
- i. Anorectal atresia,
 - ii. Biliary atresia,
 - iii. Cleft lip,
 - iv. Cleft palate,
 - v. Congenital atresia, stenosis, fistula, or rotational abnormalities of the gastrointestinal tract,
 - vi. Deformity and dysfunction of the gastrointestinal system secondary to trauma, 90 days or more after the trauma occurred,
 - vii. Diaphragmatic hernia,
 - viii. Gastroschisis,
 - ix. Hirschsprung's disease,
 - x. Omphalocele, and
 - xi. Tracheoesophageal fistula.
- b. Condition(s) not medically eligible for CRS:
- i. Celiac disease,
 - ii. Crohn's disease,
 - iii. Hernia other than a diaphragmatic hernia,
 - iv. Intestinal polyp,
 - v. Malabsorption syndrome, also known as short bowel syndrome,
 - vi. Pyloric stenosis,
 - vii. Ulcer disease, and
 - viii. Ulcerative colitis.
7. Nervous system medical condition(s):
- a. CRS condition(s) that qualify for CRS medical eligibility:
- i. Benign intracranial tumor,
 - ii. Benign intraspinal tumor,
 - iii. Central nervous system degenerative disease,
 - iv. Central nervous system malformation or structural abnormality,
 - v. Cerebral palsy,
 - vi. Craniostylosis requiring surgery,
 - vii. Deformity and dysfunction secondary to trauma in an individual that continues 90 days or more after the incident,
 - viii. Hydrocephalus,
 - ix. Muscular dystrophy or other myopathy,
 - x. Myelomeningocele, also known as spina bifida,
 - xi. Myoneural disorder, including but not limited to, amyotrophic Lateral Sclerosis or ALS, myasthenia gravis, Eaton-Lambert syndrome, muscular dystrophy, troyer sclerosis, polymyositis, dermamyositis, progressive bulbar palsy, polio,
 - xii. Neurofibromatosis,
 - xiii. Neuropathy/polyneuropathy, hereditary or idiopathic,
 - xiv. Residual dysfunction that continues 90 days or more after a vascular accident, inflammatory condition, or infection of the central nervous system,
 - xv. Residual dysfunction that continues 90 days or more after near drowning,
 - xvi. Residual dysfunction that continues 90 days or more after the spinal cord injury, and
 - xvii. Uncontrolled seizure disorder, in which there have been more than two seizures with documented compliance of one or more medications.
- b. Condition(s) not medically eligible for CRS:
- i. Central apnea secondary to prematurity,
 - ii. Febrile seizures,
 - iii. Headaches,
 - iv. Near sudden infant death syndrome,
 - v. Plagiocephaly, and
 - vi. Spina bifida occulta.
8. Ophthalmology:
- a. CRS condition(s) that qualify for CRS medical eligibility:
- i. Cataracts,
 - ii. Disorder of the iris, ciliary bodies, retina, lens, or cornea,
 - iii. Disorder of the optic nerve,
 - iv. Glaucoma,
 - v. Non-malignant enucleation and post-enucleation reconstruction, and
 - vi. Retinopathy of prematurity.
- b. Condition(s) not medically eligible for CRS:
- i. Astigmatism,
 - ii. Ptosis,
 - iii. Simple refraction error, and
 - iv. Strabismus.
9. Respiratory system medical condition(s):
- a. CRS condition(s) that qualify for CRS medical eligibility:
- i. Anomaly of the larynx, trachea, or bronchi that requires surgery, and
 - ii. Nonmalignant obstructive lesion of the larynx, trachea, or bronchi.
- b. Condition(s) not medically eligible for CRS:
- i. Allergies,
 - ii. Asthma,
 - iii. Bronchopulmonary dysplasia,

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- iv. Chronic obstructive pulmonary disease,
 - v. Emphysema, and
 - vi. Respiratory distress syndrome.
10. Dermatological system medical condition(s):
- a. CRS condition(s) that qualify for CRS medical eligibility:
 - i. A burn scar that is functionally limiting,
 - ii. A hemangioma that is functionally limiting that requires laser or surgery,
 - iii. Complicated nevi requiring multiple procedures,
 - iv. Cystic hygroma such as lymphangioma, and
 - v. Malocclusion that is functionally limiting.
 - b. Condition(s) not medically eligible for CRS:
 - i. A deformity that is not functionally limiting,
 - ii. Ectodermal dysplasia,
 - iii. Isolated malocclusion that is not functionally limiting,
 - iv. Pilonidal cyst,
 - v. Port wine stain,
 - vi. Sebaceous cyst,
 - vii. Simple nevi, and
 - viii. Skin tag.
11. Metabolic CRS condition(s) that qualify for CRS medical eligibility:
- a. Amino acid or organic acidopathy,
 - b. Biotinidase deficiency,
 - c. Homocystinuria,
 - d. Inborn error of metabolism,
 - e. Maple syrup urine disease,
 - f. Phenylketonuria, and
 - g. Storage disease.
12. Hemoglobinopathies CRS condition(s) that qualify for CRS medical eligibility:
- a. Sickle cell anemia, and
 - b. Thalassemia.
13. Additional medical/behavioral condition(s) which are not medically eligible for CRS:
- a. Allergies,
 - b. Anorexia nervosa or obesity,
 - c. Attention deficit disorder,
 - d. Autism,
 - e. Cancer,
 - f. Depression or other mental illness,
 - g. Developmental delay,
 - h. Dyslexia or other learning disabilities,
 - i. Failure to thrive,
 - j. Hyperactivity, and
 - k. Immunodeficiency, such as AIDS and HIV.
- A. To refer an individual for a CRS medical eligibility determination a person shall submit to the Administration the following information:
 - 1. CRS application;
 - 2. Documentation from a specialist who diagnosed the individual, stating the individual's diagnosis;
 - 3. Diagnostic test results that support the individual's diagnosis; and
 - 4. Documentation of the individual's need for specialized treatment of the CRS condition through medical, surgical, or therapy modalities.
 - B. The Administration shall notify the CRS applicant, member or authorized representative of the outcome of the determination within 60 days of receipt of information required under subsection (A). The member may appeal the determination under Chapter 34.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 21 A.A.R. 2022, effective October 1, 2015 (Supp. 15-3).

R9-22-1305. CRS Redetermination

- A. Continued eligibility for CRS services shall be redetermined by verifying active treatment status of the CRS qualifying medical condition(s) as follows:
 - 1. The contractor is responsible for notifying the AHCCCS Administration of the date when a member with a CRS Designation is no longer in active treatment for the qualifying condition(s).
 - 2. The Administration may request, at any time, that the contractor submit the medical documentation to the Administration for a CRS medical redetermination within the specified time-frames in contract.
 - 3. The Administration shall notify the member or authorized representative of the outcome of the redetermination.
- B. If the Administration determines that a member is no longer medically eligible for a CRS Designation, the Administration shall provide the member or authorized representative a written notice that informs the member that the Administration is ending the member's CRS Designation. The member may appeal the redetermination under A.A.C. Title 9, Chapter 34.
- C. Upon reaching his or her 21st birthday, the member's CRS Designation will be ended.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 21 A.A.R. 2022, effective October 1, 2015 (Supp. 15-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

R9-22-1304. Referral and Disposition of CRS Medical Eligibility Determination**R9-22-1306. Repealed**

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Historical Note

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Repealed by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

R9-22-1307. Covered Services

The Administration will cover medically necessary services as described within Article 2 unless otherwise specified in contract.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3).

R9-22-1308. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-1309. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR HOUSEHOLDS**R9-22-1401. General Information**

- A. Scope. This Article contains eligibility criteria to determine whether a household or individual is eligible for AHCCCS medical coverage. Eligibility criteria described under Article 3 applies to this Article.
- B. Definitions. In addition to definitions contained in R9-22-101 and A.R.S. § 36-2901, the words and phrases in this Article, Article 3 and Article 15 have the following meanings unless the context explicitly requires another meaning:

“Burial plot” means a space reserved in a cemetery, crypt, vault, or mausoleum for the remains of a deceased person.

Caretaker relative” means:

A parent of a dependent child with whom the child is living;

When the dependent child does not live with a parent or the parent in the home is incapacitated, another relative of the child by blood, adoption, or marriage in the home who assumes primary responsibility for the child’s care; or

A woman in her third trimester of pregnancy with no other dependent children.

“Cash assistance” means a program administered by the Department that provides assistance to needy families with dependent children under 42 U.S.C. 601 et seq.

“Dependent child” means a child under the age of 18, or if age 18 is a full-time student in secondary school or equivalent vocational or technical training, if reasonably expected to complete such school or training before turning age 19.

“MAGI – based income” means Modified Adjusted Gross Income as defined under 42 CFR 435.603(e).

“Medical expense deduction” or “MED” means the cost of the following expenses if incurred in the United States:

A medical service or supply that would be covered if provided to an AHCCCS member of any age under Articles 2 and 12 of this Chapter;

A medical service or supply that would be covered if provided to an Arizona Long-term Care System member under 9 A.A.C. 28, Articles 2 and 11;

Other necessary medical services provided by a licensed practitioner or physician;

Assistance with daily living if the assistance is documented in an individual plan of care by a nurse, social service worker, registered therapist, or dietitian under the supervision of a physician except when provided by the spouse of an applicant or the parent of a minor child;

Medical services provided in a licensed nursing home or in an alternative HCBS setting under R9-28-101;

Purchasing and maintaining an animal guide or service animal for the assistance of a member of the MED family unit under R9-22-1436; and

Health insurance premiums, deductibles, and coinsurance, if the insured is a member of the MED family unit.

“Monthly income” means the gross countable income received or projected to be received during the month or the monthly equivalent.

“Monthly equivalent” means a monthly countable income amount established by averaging, prorating, or converting a person’s income.

“Spendthrift restriction” means a legal restriction on the use of a resource that prevents a payee or beneficiary from alienating the resource.

“Tax dependent” is described under 42 CFR 435.4.

“Taxpayer” means a person who expects to file a tax return, and does not expect to be claimed as a tax dependent by another person.

“Title IV-D” means Title IV-D of the Social Security Act, 42 U.S.C. 651-669, the statutes establishing the child support enforcement and paternity program.

“Title IV-E” means Title IV-E of the Social Security Act 42 U.S.C. 670-679, the statutes establishing the foster care and adoption assistance programs.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section

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repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1402. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1403. Agency Responsible for Determining Eligibility

The Administration or its designee shall determine eligibility under the provisions of this Article. The Administration or its designee shall not discriminate against an applicant or member because of race, color, creed, religion, ancestry, national origin, age, sex, or physical or mental disability.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1404. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1405. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1406. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1407. Deceased Applicants

- A. If an applicant dies while an application is pending, the Administration or Administration's designee shall complete an eligibility determination for all applicants listed on the application, including the deceased applicant.
- B. The Administration or Administration's designee shall complete an eligibility determination on an application filed on behalf of a deceased applicant.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1). Amended by final rulemaking at 19 A.A.R. 3309, November 30, 2013 (Supp. 13-4).

R9-22-1408. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1409. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1410. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1411. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section

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repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1412. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by exempt rulemaking at 10 A.A.R. 23, effective December 9, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1413. Time-frames, Reinstatement of an Application

- A.** The Administration or its designee shall complete an eligibility determination under R9-22-306(A)(1) unless:
1. The applicant is pregnant. The Administration or its designee shall complete an eligibility determination for a pregnant woman within 20 days after the application date unless additional information is required to determine eligibility; or
 2. The applicant is in a hospital as an inpatient at the time of application. Within seven days of the Administration or its designee's receipt of a signed application the Administration or its designee shall complete an eligibility determination if the Administration or its designee does not need additional information or verification to determine eligibility.
- B.** The Administration or its designee shall reopen or reinstate eligibility of an individual who is discontinued for failure to submit the renewal form or necessary information, without requiring a new application, if the individual submits the renewal form or necessary information within 90 days after the date of discontinuance.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1414. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005

(Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1415. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1416. Effective Date of Eligibility

- A.** Except as provided in R9-22-303 and subsections (B), (C) and (D), the effective date of eligibility is the first day of the month that the applicant files an application if the applicant is eligible that month, or the first day of the first eligible month following the application month except for:
1. The MED program under R9-22-1439, and
 2. Eligibility for a newborn under R9-22-1429.
- B.** The effective date of eligibility for an applicant who moves into Arizona is no sooner than the date Arizona residency is established.
- C.** The effective date of eligibility for an inmate applying for medical coverage is the date the applicant no longer meets the definition of an inmate of a public institution.
- D.** The effective date of eligibility for a newborn is no sooner than the date of birth.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1417. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1418. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1419. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section

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repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1419.01. Repealed**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1419.02. Repealed**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1419.03. Repealed**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1419.04. Repealed**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1420. Income Eligibility Criteria

A. Evaluation of income. In determining eligibility, the Administration or its designee shall evaluate the following types of income received by a person identified in subsection (B):

1. Earned income, including in-kind income, before any deductions. For purposes of this Section, in-kind income means room, board, or provision for other needs in exchange for work performed. The person identified in subsection (B) shall ensure that the provider of the in-kind income establishes and verifies the monetary value of the item provided. The provider may be, but is not limited to:
 - a. A landlord who provides all or a portion of rent or utilities in exchange for services;
 - b. A store owner who gives goods such as groceries, clothes, or furniture in exchange for services; or
 - c. An individual who trades goods such as a car, tools, trailer, building material, or gasoline in exchange for services;
2. Self-employment income under R9-22-1424, including gross business receipts minus business expenses; and
3. Unearned income, including deemed income under R9-22-317 from the sponsor of a non-citizen applicant.

B. MAGI income group. The Administration or its designee shall include the following persons in the MAGI income group:

1. When the applicant is a taxpayer include:
 - a. The applicant,
 - b. Everyone the applicant expects to claim as a tax dependent for the current year, and

- c. The applicant's spouse, when living with the applicant.
2. Except as provided in subsection (B)(3), when the applicant expects to be claimed as a tax dependent for the current year include:
 - a. The taxpayer claiming the applicant,
 - b. Everyone else the taxpayer expects to claim as a tax dependent,
 - c. The taxpayer's spouse when living with the taxpayer, and
 - d. The applicant's spouse, when living with the applicant.
3. When any of the following apply, determine the persons whose income is included as described in subsection (4)(a) or (4)(b) based on the applicant's age:
 - a. The applicant expects to be claimed as a tax dependent by someone other than a spouse or natural, adopted or step-parent;
 - b. The applicant is under age 19, expects to be claimed as a tax dependent by a natural, adopted or step-parent, lives with more than one such parent and the parents do not expect to file a joint tax return; or
 - c. The applicant is under age 19 and expects to be claimed as a tax dependent by a non-custodial parent.
4. When the applicant is not a taxpayer, does not expect to be claimed as a tax dependent and is:
 - a. Under age 19. Include the income of the applicant and when living with the applicant, the applicant's:
 - i. Spouse;
 - ii. Natural, adopted and step-children;
 - iii. Natural, adopted and step-parents;
 - iv. Natural, adopted and step-siblings; and
 - b. Age 19 or older. Include the income of the applicant and when living with the applicant, the applicant's:
 - i. Spouse;
 - ii. Natural, adopted and step-children under age 19.
5. When the applicant is a pregnant woman, the Administration or its designee shall also include the number of expected babies only for the pregnant woman's income group.
6. When the taxpayer cannot reasonably establish that a person is the taxpayer's tax dependent, inclusion of the person in the taxpayer's MAGI income group is determined as provided in subsection (B)(4).

C. A person whose income is counted. The Administration or its designee shall count the MAGI-based income of all members of an applicant's MAGI income group with the following exceptions:

1. The income of an individual who is included in the MAGI income group of his or her natural, adoptive or step parent and is not expected to be required to file a tax return for the year in which eligibility for Medicaid is being determined, is not counted whether or not the individual files a tax return.
2. The income of a tax dependent other than the taxpayer's spouse or biological, adopted or stepchild who is not expected to be required to file a tax return for the year in which eligibility for Medicaid is being determined is not counted when the tax dependent is included in the taxpayer's MAGI income group, whether or not the tax dependent files a tax return.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section

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repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1421. MAGI based Income Eligibility

- A.** In determining eligibility, if an individual would otherwise be ineligible under this Article due to excess income, the Administration or its designee shall subtract an amount equivalent to five percentage points of the Federal Poverty Level (FPL) from the household income.
- B.** A person is eligible under this Article when:
1. Subject to subsection (A), the monthly household income does not exceed the appropriate FPL;
 2. If ineligible under (B)(1), the household income determined in accordance with 26 CFR 1.36B-1(e) is below 100 percent FPL; or
 3. For eligibility under R9-22-1437, the person's income during the period defined in R9-22-1437(C) does not exceed the FPL under R9-22-1437(B).
- C.** The Administration or its designee shall consider the following factors when determining the income period to use to determine monthly income:
1. Type of income,
 2. Frequency of income,
 3. If source of income is new or terminated, or
 4. Income fluctuation.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1422. Methods for Calculating Monthly Income

- A.** Projecting income.
1. Description. Projecting income is a method of determining the amount of income that a person will receive.
 2. Calculation. The Administration or its designee shall project income by:
 - a. Converting income to a monthly equivalent,
 - b. Using unconverted income, or
 - c. Prorating income to determine a monthly equivalent.
 3. Exclusion. When calculating projected monthly income, the Administration or its designee shall exclude an unusual variation in income under R9-22-1424(E), except for a month in which the variation is anticipated to occur.
- B.** Averaged income.
1. Description. Averaging income proportionally distributes the person's income received on a regular basis.
 2. Calculation. To average income, the Administration or its designee shall add the amount of the income and divide by the total number of pay periods. If the amount of income received per pay period fluctuates, and the fluctuation is expected to continue, the Administration or its designee shall:
 - a. Use the averaged weekly or bi-weekly amounts to convert weekly or bi-weekly income to a monthly equivalent;
 - b. Use the averaged monthly or semi-monthly amounts to project monthly income; and

- c. Use the averaged hours worked and multiply the average by the current rate of pay. If there is a change in the rate of pay, use the new rate of pay when calculating projected income under subsection (A).

- C.** Prorated income.
1. Description. Prorated income evenly distributes a person's income over the period the income is intended to cover to calculate a monthly equivalent.
 2. Calculation. To prorate income, the Administration or its designee shall divide the total amount of the person's income received during the period by the number of months that the income is intended to cover.
- D.** Converted income.
1. Description. Converted income is income received weekly or biweekly that is changed to a monthly equivalent.
 2. Calculation.
 - a. The Administration or its designee shall average the weekly or bi-weekly income amounts before converting to the monthly equivalent if the person's past income fluctuates and the fluctuation is expected to recur.
 - b. To convert income paid weekly to a monthly equivalent, the Administration or its designee shall multiply the weekly average by 4.3 weeks.
 - c. To convert income paid bi-weekly to a monthly equivalent, the Administration or its designee shall multiply the bi-weekly average by 2.15 weeks.
- E.** Unconverted income.
1. Description. Unconverted income is the actual amount of income received or projected to be received during a month.
 2. Calculation. The Administration or its designee shall sum the actual amount of income received or projected to be received during a month.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1423. Calculations and Use of Methods Listed in R9-22-1422 Based on Frequency of Income

- A.** Monthly income. If otherwise countable income is received monthly or in a lump sum, the Administration or its designee shall use the unconverted method for calculating monthly income.
1. Lump sum means a nonrecurring payment that serves as a complete payment.
 2. Lump sum payments include but are not limited to: rebates or credits; inheritances; insurance settlements; and payments for prior months from such sources as Social Security, Railroad Retirement, or other benefits.
 3. A lump sum payment may include a portion intended for the current month.
- B.** Weekly income. If income is received weekly, the Administration or its designee shall convert the income to a monthly equivalent under R9-22-1422(D).
- C.** Bi-weekly income. If income is received bi-weekly, the Administration or its designee shall convert the income to a monthly equivalent under R9-22-1422(D).

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- D.** Semi-monthly or daily income. If income is received semi-monthly or daily, the Administration or its designee shall use the unconverted method for calculating monthly income under R9-22-1422(E).
- E.** Bimonthly, quarterly, semi-annual, or annual income. If income is received bimonthly, quarterly, semi-annually, or annually, the Administration or its designee shall prorate the income received or projected to be received under R9-22-1422(C).
- Historical Note**
- New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).
- R9-22-1424. Use of Methods Listed in R9-22-1423 Based on Type of Income**
- A. New income.**
1. Description. New income is income received from a new source during the first calendar month that the income is received from the source.
 2. Calculating monthly income.
 - a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
 - b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.
- B. Terminated income.**
1. Terminated income is income received during the last calendar month when no more income is expected to be received from that source.
 2. Calculating monthly income.
 - a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
 - b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.
- C. Break in income.**
1. Description. A break in income is a break in established frequency of income of one calendar month or more.
 2. Calculating monthly income.
 - a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
 - b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.
- D. Contract or regular seasonal income.**
1. Descriptions.
 - a. Contract income is income a person earns under a contract that specifies a length of time the contract covers, the amount of income to be paid, and the frequency of payment.
 - b. Regular seasonal income is income that fluctuates based on season or is only received during a certain season, and can reasonably be anticipated based on history or other verification.
 2. Calculating monthly income.
 - a. When the contract or regular seasonal income will not fluctuate over the 12-month period beginning with the month the application or renewal is submitted, the Administration or its designee shall use the appropriate income calculation method in R9-22-1423 for the frequency of receipt.
 - b. When the contract or regular seasonal income is anticipated to fluctuate over the 12-month period beginning with the month the application or renewal is submitted, the Administration or its designee shall calculate the monthly income as follows:
 - i. For a one-time contract that ends between the month the application or renewal is submitted and the end of the calendar year, divide the income that will be received from the application or renewal month through the end of the calendar year by the number of months in that period to get a monthly equivalent;
 - ii. For contracts that extend into the next calendar year, contracts that are anticipated to be renewed and regular seasonal income, the Administration or its designee shall divide the income that will be received in the 12-month period beginning with the application or renewal month by 12 to get the monthly equivalent.
- E. Unusual variation in the amount of income.**
1. Description. Unusual variation is an amount of income that is different from the established amount received and is not projected to continue or recur.
 2. Calculating monthly income.
 - a. When calculating income for the month in which an unusual variation in income occurs, the Administration or its designee shall include the unusual variation in the income calculation.
 - b. When an unusual variation in income occurs during the month, the Administration or its designee shall use the converted method for calculating monthly income if income is received weekly or bi-weekly.
 - c. When projecting income for the months following the month in which the unusual variation occurs, the Administration or its designee shall exclude the unusual variation in income from the income calculation.
- F. Self-employment income.**
1. Description. Self-employment income is income a person earns from the person's own trade or business less allowable expenses.
 2. Calculating monthly income. The Administration or its designee shall prorate the income under R9-22-1422.
- Historical Note**
- New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).
- R9-22-1425. Repealed**
- Historical Note**
- New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section

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repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1426. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1427. Eligibility Under MAGI

- A. Caretaker Relatives.** An individual is eligible for AHCCCS medical coverage as a Caretaker Relative when the individual meets the following requirements:
1. Is a caretaker relative as defined in R9-22-1401.
 2. The total countable income under R9-22-1420(B) does not exceed 106 percent of the FPL for the number of people in the MAGI income group.
- B. Continued medical coverage.**
1. A caretaker relative eligible under subsection (A) and all dependent children eligible under subsection (D) in the caretaker relative's MAGI income group are entitled to continued AHCCCS coverage for up to 12 months if eligible under subsection (B)(1)(c)(i) and up to four months if eligible under subsection (B)(1)(c)(ii) if the MAGI income group's income exceeds the limit for the income group's size and the following conditions are met:
 - a. The caretaker relative still lives with a dependent child;
 - b. A caretaker relative in the income group received AHCCCS medical coverage under this Section for three calendar months out of the most recent six months; and
 - c. The loss of AHCCCS coverage under this Section is due to:
 - i. Increased earned income of a caretaker relative, or
 - ii. Increased spousal support.
 2. An applicant may be added to the continued medical coverage under subsection (B)(1), if the applicant did not reside in the household at the time continued medical coverage under this Section was determined and the applicant is:
 - a. The spouse or dependent child of a caretaker relative receiving continued medical coverage, or
 - b. The parent of a dependent child who is receiving continued medical coverage.
- C. Pregnant Women.** A pregnant woman is eligible for AHCCCS medical coverage when the total countable income under R9-22-1420(B) does not exceed 156 percent of the FPL for the number of people in the MAGI income group. A pregnant woman who applies for AHCCCS medical coverage during the pregnancy or postpartum period and is determined eligible, remains eligible throughout the postpartum period. The postpartum period begins the day the pregnancy terminates and ends the last day of the month in which the 60th day following pregnancy termination occurs.
- D. Children.** A child less than 19 years of age is eligible for AHCCCS medical coverage when the total countable income under

R9-22-1420(B) does not exceed the following percentage of the FPL for the number of people in the MAGI income group:

1. 147 percent for a child under one year of age,
 2. 141 percent for a child age one through five years of age, or
 3. 133 percent for all other persons.
- E. Adults.** An individual is eligible for AHCCCS medical coverage when the individual meets the following eligibility requirements:
1. Is 19 years of age or older but less than 65 years of age;
 2. Is not pregnant;
 3. Is not eligible for AHCCCS Medical Coverage under any other coverage group listed in 42 U.S.C. 1396a(a)(10)(A)(i);
 4. Is not entitled to or enrolled for Medicare benefits under Part A or Part B;
 5. The total countable income under R9-22-1420(B) does not exceed 133 percent of the FPL for the number of people in the MAGI income group; and
 6. When the individual is a caretaker relative, but has income exceeding the limit in subsection (A)(2), each child under age 19 living with the individual is receiving AHCCCS medical coverage or KidsCare, or is enrolled in minimum essential coverage as defined in 42 CFR 435.4.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Section R9-22-1427 repealed; new Section R9-22-1427 made by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1428. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1429. Eligibility for a Newborn

A child born to a mother eligible for and receiving medical coverage under this Article, Article 15 of the Chapter, or 9 A.A.C. 28, is automatically eligible for AHCCCS medical coverage for a period not to exceed 12 months. Automatic eligibility begins on the child's date of birth and ends with the last day of the month in which the child turns age one.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1). Amended by

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final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1430. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1431. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 2633, effective July 10, 2007 (Supp. 07-3). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1). Repealed by final rulemaking at 21 A.A.R. 1241, effective September 5, 2015 (Supp. 15-3).

R9-22-1432. Young Adult Transitional Insurance

An individual is eligible for AHCCCS medical coverage when the individual meets all of the following eligibility requirements:

1. Is 18 through 25 years of age;
2. Was in the custody of the Department of Economic Security under A.R.S. Title 8, Chapter 5 or Chapter 10 on the individual's 18th birthday;
3. Was eligible for and receiving AHCCCS Medical Coverage on the individual's 18th birthday; and
4. Is not eligible for AHCCCS Medical Coverage under 42 U.S.C. 1396a(a)(10)(A)(i)(I) - (VII).

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1433. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1434. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section

repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Section repealed by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4).

R9-22-1435. Eligibility for a Person With Medical Expenses Whose Income is Over 100 Percent FPL

An applicant who is not eligible for AHCCCS medical coverage due to excess income may become AHCCCS eligible by deducting medical expenses from the applicant's income. This coverage is called Medical Expense Deduction (MED).

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1436. MED Family Unit

- A. For the purpose of this Section, a child is an unmarried person under age 18.
- B. The Department shall consider each of the following to be a family when living together:
 1. A parent and the parent's children;
 2. A married couple without children;
 3. A married couple and the children of either or both spouses;
 4. Unmarried parents who live with at least one child in common, and the parents' other children, whether in common or not; and
 5. A person without children.
- C. If an applicant is pregnant, the family unit includes the number of unborn children.
- D. A child of the children included in subsections (B)(1), (B)(3), or (B)(4) is considered part of the family unit when living together.
- E. The Department shall not include a SSI-cash recipient in the MED family unit even if the SSI-cash recipient is a parent, spouse, or child.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1437. MED Income Eligibility Requirements

- A. Income exclusions. The exclusions in R9-22-1420(C) apply to the MED family unit.
- B. Income standard.
 1. The Department shall divide the annual FPL for the MED family unit that is in effect during each month of the income period by 12 to determine the monthly FPL.
 2. The Department shall add the monthly FPLs for the income period and multiply the resulting amount by 40 percent.
 3. Changes to the annual FPL are implemented in April of each year.
- C. Income period. The income period is the month of application and the next two months. The Department shall add together the three months' income to establish the MED family unit's income amount.

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- D.** Medical expense deduction period. The medical expense deduction period is a three-month period consisting of:
1. For a new application, the month before the application month, the month of application, and month following the application month; or
 2. For a MED eligibility review, the last month of the prior MED eligibility period and the following two months.
- E.** The Department shall calculate the amount of countable monthly income as follows:
1. Subtract a \$90 cost of employment allowance from the gross amount of earned income for each person whose earned income is counted;
 2. Disregard from the remaining earned income an amount billed by the provider for the care of each dependent child under age 18 or incapacitated adult member of the MED family unit if the care is for the purpose of allowing the person to work. If more than one person in the household is responsible for and billed for the care of a dependent child, the disregard may be split between the wage earners if splitting the disregard is to the benefit of the family, but shall not exceed the maximum disregards as follows:
 - a. A maximum of \$200 for a child under age two and \$175 for other dependents for a wage-earner employed full-time (86 or more hours per month); and
 - b. A maximum of \$100 for a child under age two, and \$88 for other dependents for a wage earner employed part-time (less than 86 hours a month);
 3. Add the remaining earned income for each MED family member to the unearned income of all MED family members;
 4. Compare the MED family's unit countable income amount to the income standard in subsection (B). The difference is the amount of medical expenses the family shall incur during the medical expense deduction period to become eligible;
 5. Subtract allowable medical expense deductions that were incurred by:
 - a. A member of the MED family unit;
 - b. A deceased spouse or minor child of a MED family unit if this person would have been a member of the MED unit during the MED expense deduction period;
 - c. A person who was a minor child of a MED family unit member when the expense was incurred but who is no longer a minor child; or
 - d. A minor child, including a child who is a runaway, who left home before the date of application to live with someone other than a parent; and
 6. Compare the net MED family income to the income standard listed in subsection (B).
- F.** The family is eligible if the net income in subsection (E)(6) does not exceed the income standard in subsection (B).

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1438. MED Resource Eligibility Requirements

- A.** Including countable resources. The Department shall include the resources not excluded that belong to and are available to members of the family of a qualified alien under A.R.S. § 36-2903.03 and the sponsor and sponsor's spouse of a person who is a qualified alien.
- B.** Ownership and availability. The Department shall evaluate the ownership of resources to determine the availability of resources to a person listed in subsection (A).
1. Jointly owned resources with ownership records containing the words "and" or "and/or" between the owners' names are available to each owner except if one of the owners refuses to sell. A consent to sale is not required if all owners are members of the MED family unit.
 2. Jointly owned resources with ownership records containing the word "or" between the owners' names are presumed to be available in full to each owner. The applicant or member may rebut the presumption by providing clear and convincing evidence of intent to establish a different type of ownership. If the presumption is rebutted, the resource is available to the owners:
 - a. Consistent with the intent of the owners, or
 - b. Based on each owner's proportionate net contribution if there is not clear and convincing evidence of a different allocation.
 3. The Department shall establish availability of a trust under 42 U.S.C. 1396p(d)(4)(A) or (C).
- C.** Unavailability. The Department shall consider the following resources unavailable:
1. Property subject to spendthrift restriction, such as:
 - a. Accounts established by the SSA, Veteran's Administration, or similar sources that mandate that the funds in the account be used for the benefit of a person not residing with the MED family unit; or
 - b. Trusts established by a will or funded solely by the income and resources of someone other than a member of the MED family unit.
 2. A resource being disputed in a divorce proceeding or probate matter;
 3. Real property located on a Native American reservation;
 4. A resource held by a conservator to the extent court-imposed restrictions make the resource unavailable to the applicant, member, or member of the family unit for:
 - a. Medical care,
 - b. Food,
 - c. Clothing, or
 - d. Shelter.
- D.** Resource exclusion. The Department shall exclude the following resources from the calculation of resources under subsection (E):
1. One burial plot for each person listed in R9-22-1436;
 2. Household furnishings and personal items that are necessary for day-to-day living;
 3. Up to \$1500 of the value of one prepaid funeral plan for each person listed in R9-22-1436 that specifically covers only funeral-related expenses as evidenced by a written contract;
 4. The value of one motor vehicle regularly used for transportation. If the MED family unit owns more than one vehicle, the exclusion is applied to the vehicle with the highest equity value;
 5. The value of a vehicle used to earn income and not used simply for transportation to and from employment;
 6. The value of a vehicle in which a SSI-cash recipient has an ownership interest; and
 7. The value of any vehicle used for medical treatment, employment, or transportation of a SSI-cash disabled child, and that is excluded by SSI for that reason.
 8. Funds set aside in an Individual Development Account under 6 A.A.C. 12, Article 4; and
 9. Any other resource specifically excluded by federal law.
- E.** Calculation of resources. The Department shall determine the value of all household resources as follows:
1. Calculate the total amount of countable liquid resources;

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2. Calculate the equity value of each countable non-liquid resource. The Department shall determine the equity value of a countable non-liquid resource by subtracting the amount of valid encumbrances on that resource from:
 - a. The market value of real property if there is no assessor's evaluation of the property,
 - b. The market value of real property if the assessor's value of the real property does not include the value of permanent structures on that property,
 - c. The assessor's full cash value if subsections (E)(2)(a) and (E)(2)(b) do not apply, and
 - d. The market value of a non-liquid resource that is not real property;
 3. Not assign an equity value to a resource that is less than zero; and
 4. Determine the MED family unit's resources by adding the totals determined in subsections (1) and (2).
- F.** Resource standard to be eligible for MED. A person is not eligible for MED if the resources determined in subsection (E) exceed \$100,000 or if more than \$5,000 are liquid resources.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1439. MED Effective Date of Eligibility

- A.** A MED family unit is eligible on the day the income and resource eligibility requirements are met but no earlier than the first day of the month of application. If the family unit meets the income requirements in the application month but does not meet the resource limit until the following month, the family unit's effective date of eligibility is the first day of the month following the month of application.
- B.** The Department shall adjust the effective date of eligibility under subsection (A) to an earlier date if:
1. A member presents verification of additional allowable medical expenses incurred on an earlier date during the medical expense deduction period that allow the member to meet the income requirements, and
 2. The member presents the verification within 60 days of approval of eligibility under this Section.
- C.** The Department shall not adjust an effective date of eligibility more than one time per application.
- D.** The Department shall adjust the effective date no later than 30 days after the end of the 60-day period under subsection (B)(2).
- E.** The Department shall deny an application and provide the applicant a denial notice when the applicant does not meet the MED requirements under this Article during the month of application or the month following the month of application.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1440. MED Eligibility Period

The Department shall approve eligibility for six months. Changes in circumstances do not affect eligibility for the first three months.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1441. Eligibility Appeals

- A.** Adverse actions. An applicant or member may appeal by requesting a hearing from the Department concerning any of the following adverse actions:
1. Complete or partial denial of eligibility under R9-22-1413;

2. Suspension, termination, or reduction of AHCCCS medical coverage under R9-22-1415;
 3. Delay in the eligibility determination beyond the timeframes under this Article;
 4. The imposition of or increase in a premium or copayment; or
 5. The effective date of eligibility.
- B.** Notice of Adverse Action. The Department shall personally deliver or send, by regular mail, a Notice of Adverse Action to the person affected by the action. For the purpose of this Section, the date of the Notice of Adverse Action shall be the date of personal delivery to the applicant or the postmark date, if mailed.
- C.** Automatic change and hearing rights.
1. An applicant or a member is not entitled to a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.
 2. An applicant or a member is entitled to a hearing if a federal or state law requires an automatic change and the applicant or member timely files an appeal that alleges a misapplication of the facts to the law.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1442. Cessation of MED Coverage

The Department shall not approve any individual or family who has applied on or after May 1, 2011 as eligible for MED coverage. With respect to any applications that are pending as of May 1, 2011, the Department shall not approve any individual or family as eligible for MED coverage who has not met all eligibility requirements prior to May 1, 2011.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 1028, effective May 1, 2011 (Supp. 11-2).

R9-22-1443. Closing New Eligibility for Persons Not Covered under the State Plan

- A.** Definition. For purposes of this Section, "AHCCCS Care" refers to the eligibility category that includes individuals encompassed within the expanded definition of "eligible person" under A.R.S. § 36-2901.01 and R9-22-1428(4), but who do not meet eligibility criteria for an optional or mandatory Title XIX coverage group described in the Arizona State Plan for Medicaid.
- B.** General Rule. Except as provided by this Section, neither the Department nor the Administration shall approve an individual for AHCCCS Care with an effective date of eligibility on or after July 8, 2011.
- C.** Exception for pending applications. With respect to any applications that are pending as of July 8, 2011, the Department and the Administration shall approve any individual as eligible for AHCCCS Care who has met all eligibility requirements for AHCCCS Care during or after the month of application but prior to July 8, 2011, and has continuously met all eligibility requirements for AHCCCS Care since that date.
- D.** Exception for children. The Department and the Administration shall approve an individual as eligible for AHCCCS Care on or after July 8, 2011 who:
1. Was determined eligible under the Arizona State Plan for Medicaid based on being under the age of 19;
 2. Would otherwise be discontinued due to reaching the age of 19 on or after July 8, 2011, under subsection (B) of this Section; and
 3. Meets all eligibility requirements for AHCCCS Care on and after reaching age 19.

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- E. Exception for KidsCare. The Department and the Administration shall approve an individual as eligible for AHCCCS Care on or after July 8, 2011 who:
1. Was determined eligible under 9 A.A.C. 31 based on being under the age of 19;
 2. Would otherwise be discontinued due to reaching the age of 19 on or after July 8, 2011, under subsection (B) of this Section; and
 3. Meets all eligibility requirements for AHCCCS Care on and after reaching age 19.
- F. Exception for Young Adult Transitional Insurance (YATI). The Department and the Administration shall approve an individual as eligible for AHCCCS Care on or after July 8, 2011 who:
1. Was determined eligible for YATI under R9-22-1432;
 2. Would otherwise be discontinued due to reaching the age of 21 on or after July 8, 2011 under subsection (A) of this Section; and
 3. Meets all eligibility requirements for AHCCCS Care on and after reaching age 21.
- G. Exception for certain SSI-MAO. The Department and the Administration shall approve as eligible for AHCCCS Care, on or after July 8, 2011, an individual who:
1. Was determined eligible for AHCCCS Care; and
 2. Whose eligibility category is changed on or after June 28, 2011, from AHCCCS Care to eligibility based on R9-22-1501(A)(1) (SSI Medical Assistance Only) because the individual, at the time of the change in eligibility category, is age 65 or over, under the age of 65 with Medicare coverage, or who has been determined by ADHS to have a Serious Mental Illness; but who
 3. Subsequent to the change in eligibility category, is determined not to meet eligibility requirements under Article 15; but only if
 4. The individual meets all eligibility requirements for AHCCCS Care on and after the date the individual is determined not to meet eligibility requirements under Article 15.
- H. Exception for redeterminations. This Section does not prohibit the redetermination of an individual as eligible for AHCCCS Care on or after July 8, 2011, if the individual was determined eligible for AHCCCS Care prior to July 8, 2011 and has remained continuously eligible for AHCCCS Care since July 8, 2011 or the date on which the individual was determined eligible for AHCCCS Care under subsections (C), (D), and (E) of this Section.
- I. Discontinuance for other reasons. Nothing in this Section prohibits or restricts the Department or the Administration from discontinuing AHCCCS Care for an individual who does not meet any other eligibility criteria set forth elsewhere in this Chapter including but not limited to discontinuance based on the individual's failure to verify eligibility information upon an application or redetermination.
- J. Review of anticipated expenditures. At least monthly, the Director shall review the most recent estimate of the anticipated expenditures for the remainder of the state fiscal year as compared to funds remaining in the appropriations made to the agency for the state fiscal year as well as any other known or reasonably anticipated sources of other funding. Based on that review the Director may, subject to approval by the Center for Medicare and Medicaid Services, re-open the AHCCCS Care program to new enrollment otherwise prohibited by this Section.
- K. At least 30 days prior to the effective date of any changes to eligibility for the AHCCCS Care program as described in this Section, public notice shall be provided via publication on the AHCCCS web site unless shorter notice is necessary to maintain a program that is reasonably anticipated to remain within available funding.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 1345, effective July 8, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 2624, effective July 8, 2011 (Supp. 11-4).

ARTICLE 15. AHCCCS MEDICAL COVERAGE FOR PEOPLE WHO ARE AGED, BLIND, OR DISABLED**R9-22-1501. General Information**

- A. General. The Administration shall determine eligibility for AHCCCS medical coverage for the following applicants or members using the eligibility criteria and requirements in this Article:
1. A person who is aged, blind, or disabled and does not receive SSI cash; and
 2. A person terminated from the SSI cash program under R9-22-1505.
- B. Definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:
- “Aged” means a person who is 65 years of age or older as specified in 42 U.S.C. 1382c(a)(1)(A).
- “Blind” means a person who has been determined blind by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(2).
- “Disabled” means a person who has been determined disabled by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E).
- C. Confidentiality. The Administration shall maintain the confidentiality of an applicant's or member's records and limit the release of safeguarded information under R9-22-512.
- D. Application process.
1. A person may apply for AHCCCS medical coverage by submitting a signed application to any Administration office or outstation location under R9-22-1406.
 2. The provisions in R9-22-1406(B), (C), and (E) apply to this Section.
 3. The application date is the date a signed application is received at any Administration office or outstation location approved by the Director.
 4. An applicant who files an application may withdraw the application, either orally or in writing. If an applicant withdraws an application, the Administration shall send the applicant a denial notice under subsection (G).
 5. Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 90 days for an applicant applying on the basis of disability and 45 days for all other applicants.
 6. If an applicant dies while an application is pending, the Administration shall complete an eligibility determination for the deceased applicant.
 7. The Administration shall complete an eligibility determination on an application filed on behalf of a deceased applicant, if the application is filed in the month of the applicant's death.
- E. Redetermination of eligibility for a person terminated from the SSI cash program.
1. Continuation of AHCCCS medical coverage. The Administration shall continue AHCCCS medical coverage for a person terminated from the SSI cash program

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- until a redetermination of eligibility under subsection (E)(2) is completed.
2. Coverage group screening. The Administration shall screen a person for eligibility under any coverage group under A.R.S. §§ 36-2901(6)(a)(i), (ii), (iii), (iv), and (v) and 36-2934.
 - a. If a person files an application for Arizona Long-Term Care System (ALTCS) coverage, the Administration shall determine eligibility under 9 A.A.C. 28, Article 4.
 - b. If an applicant or member is aged, blind, or disabled, but not in need of long-term care services, the Administration shall determine eligibility under this Article.
 - c. For all other persons, the Administration shall refer the applicant's case to the Department for an eligibility decision under Article 14.
 3. Eligibility decision.
 - a. If a person is eligible under this Article or 9 A.A.C. 28, Article 4, the Administration shall send a notice as under subsection (G) informing the applicant that AHCCCS medical coverage is approved.
 - b. If a person is ineligible, the Administration shall send a notice as under subsection (G) to deny AHCCCS medical coverage.
- F.** Eligibility effective date. Eligibility is effective on the first day of the month that all eligibility requirements are met, including the period described under R9-22-303.
- G.** Notice for approval or denial. The Administration shall send an applicant a written notice of the decision regarding the application. This notice shall include a statement of the intended action, and:
1. If approved, the notice shall contain the effective date of eligibility.
 2. If approved under FESP, the notice shall also contain:
 - a. The emergency services certification end date,
 - b. A statement detailing the reason for the denial of full services,
 - c. The legal authority supporting the decision,
 - d. Where the legal authority supporting the decision can be found,
 - e. An explanation of the right to request a hearing, and
 - f. The date by which a request for hearing shall be received by the Administration.
 3. If denied, the notice shall contain:
 - a. The effective date of the denial;
 - b. The reason for the denial, including specific financial calculations and the financial eligibility standard, if applicable;
 - c. Legal authority supporting the decision;
 - d. Where the legal authority supporting the decision can be found;
 - e. An explanation of the right to request a hearing; and
 - f. The date by which a request for hearing shall be received by the Administration.
- H.** Reporting and verifying changes.
1. An applicant or a member shall report to the Administration the following changes for the applicant or member, the applicant's or member's spouse, and the applicant or member's dependent children:
 - a. Change of address;
 - b. Change in the household's members;
 - c. Change in income;
 - d. Death;
 - e. Change in marital status;
 - f. Change in school attendance;
 - g. Change in Arizona state residency; and
 - h. Any other change that may affect the member's or applicant's eligibility.
 2. A member shall report to the Administration the following changes:
 - a. Admission to a penal institution,
 - b. Change in U.S. citizenship or immigrant status,
 - c. Receipt of a Social Security number, and
 - d. Change in first- or third-party liability that may contribute to the payment of all or a portion of the person's medical costs.
 3. A person other than a member or an applicant who reports a change to the Administration either orally or in writing shall include the:
 - a. Name of the affected applicant or member;
 - b. Description of the change;
 - c. Date the change occurred;
 - d. Name of the person reporting the change; and
 - e. Social Security or case number of the applicant or member, if known.
 4. An applicant or a member shall provide verification of changes if requested by the Administration.
 5. An applicant or a member shall report anticipated changes in eligibility to the Administration as soon as the person knows that the change will occur.
 6. An applicant or a member shall report an unanticipated change to the Administration within 10 days following the date the change occurred.
- I.** Processing of changes and redeterminations. If a member receives AHCCCS medical coverage under subsection (A), the Administration shall redetermine the member's eligibility at least once every 12 months or more frequently when changes occur that may affect eligibility.
- J.** Actions that may result from a redetermination or change. In processing a redetermination or change, the Administration shall determine whether there should be:
1. No change in eligibility,
 2. Discontinuance of eligibility if a condition of eligibility is no longer met, or
 3. A change in the program under which a person receives AHCCCS medical coverage.
- K.** Notice of discontinuance.
1. Contents of notice. The Administration shall issue a notice when it takes action to discontinue a member's eligibility. The notice shall contain the following information:
 - a. A statement of the action that is being taken;
 - b. The effective date of the action;
 - c. The reason for the discontinuance, including specific financial calculations and the financial eligibility standard if applicable;
 - d. The legal authority that supports the action proposed by the Administration;
 - e. Where the legal authority supporting the decision can be found;
 - f. An explanation of the right to request a hearing; and
 - g. The date by which a hearing request shall be received by the Administration and the right to continue medical coverage pending appeal.
 2. Advance notice of changes in eligibility. Advance notice means a notice of proposed action that is issued to the member at least 10 days before the effective date of the proposed action. Except under subsection (K)(3), the Administration shall issue an advance notice when an adverse action is taken to suspend, reduce or discontinue eligibility.

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3. Exceptions from advance notice. The Administration shall issue a notice to a member to discontinue eligibility no later than the effective date of the action if:
- The member provides to the Administration a clearly written statement, signed by that member, that:
 - Services are no longer wanted; or
 - Gives information that requires a discontinuance or reduction of services and indicates that the member understands that this is the result of supplying the information;
 - The member provides information to the Administration that requires a discontinuance of eligibility and a member signs a written statement waiving advance notice;
 - The member cannot be located and mail sent to the member's last known address has been returned as undeliverable under 42 CFR 431.213(d) subject to reinstatement of discontinued eligibility;
 - The member has been admitted to a public institution where a member is ineligible for coverage;
 - The member has been approved for Medicaid in another state; or
 - The Administration receives information confirming the death of the member.
- L.** Request for hearing. An applicant or member may request a hearing under Chapter 34 for any of the following adverse actions:
- Complete or partial denial of eligibility,
 - Discontinuance or reduction of AHCCCS medical coverage, or
 - Delay in the eligibility determination beyond the timeframes listed in R9-22-1501(D).
- M.** Assignment of rights. A person determined eligible assigns rights to all types of medical benefits to which the person is entitled under operation of law under A.R.S. § 36-2903.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 23, effective December 9, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1). Amended by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

R9-22-1502. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1503. Financial Eligibility Criteria

- A.** General income eligibility. Except as provided under subsection (B) of this rule, the Administration or its designee shall

count the identified income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K.

B. Exceptions.

- In-kind support and maintenance under 42 U.S.C. 1382a(a)(2)(A) is excluded.
- For a person living with a spouse, the Administration or its designee calculates net income for an eligible couple under 20 CFR 416.1160 as of April 1, 2013, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments, even if the spouse is not eligible for or applying for SSI or coverage under this Article.
- In determining the net income of a married couple living with a child or the net income of a person who is not living with a spouse but living with a child, a child allocation is allowed as a deduction from the combined net income of the couple for each child regardless of whether the child is ineligible or eligible. For the purposes of this Section, a child means a person who is unmarried, natural or adopted, and under age 18 or under age 22 if a full-time student. Each child's allocation deduction is reduced by that child's income, including public income maintenance payments, using the methodology under 20 CFR 416.1163(b)(1) and (2) as of April 1, 2013, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
- In determining the income deemed available to an applicant who is a child from an ineligible parent or parents, an allocation for each eligible or ineligible child of the parent is allowed as a deduction from the parent's income under 20 CFR 416.1165(b). The child's allocation is reduced by that child's income, including public income maintenance payments.
- In determining the income of a person who receives an annual Title II Cost of Living Allowance (COLA) increase, the COLA amount is disregarded from January until the Administration applies the effective income limits under R9-22-1504 based on the FPL for the calendar year.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1504. Eligibility For A Person Who is Aged, Blind, or Disabled

- A.** To be eligible for AHCCCS medical coverage, an applicant shall meet the conditions of eligibility and requirements in this Article and:
- Meet one of the income tests described in subsection (B) or (C), or
 - The special requirements in R9-22-1505.
- B.** The Administration shall determine whether the applicant's countable income, as described in R9-22-1503, is less than or equal to 100 percent of the SSI FBR, as adjusted annually.

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- C. The Administration shall determine whether the applicant's countable income, as described in R9-22-1503, without deducting the amount from earned income under 42 U.S.C. 1382a(b)(4)(B)(iii), is less than or equal to 100 percent FPL as adjusted annually.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1505. Eligibility for Special Groups**A.** The following are considered special groups:

1. A person meeting the requirements in A.R.S. § 36-2903.03 who:
 - a. Is aged, blind, or disabled under 42 CFR 435.520, 42 CFR 435.530, or 42 CFR 435.540 as of October 1, 2012, which are incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
 - b. Received SSI cash or AHCCCS medical coverage under this subsection, or subsections (A)(2), (A)(3), or (A)(4) on or before August 21, 1996;
 - c. Was residing in the United States under color of law on or before August 21, 1996; and
 - d. Meets the requirements under this Article;
2. A disabled child (DC) under 42 U.S.C. 1396a(a)(10)(A)(i)(II). A disabled child is a child who:
 - a. Was receiving SSI cash benefits as a disabled child on August 22, 1996;
 - b. Lost SSI cash benefits effective July 1, 1997, or later, due to a disability determination under Section 211(d) of Subtitle B of P.L. 104-193;
 - c. Continues to meet the disability requirements for a child that were in effect on August 21, 1996; and
 - d. Meets the requirements under this Article;
3. A disabled adult child (DAC), under 42 U.S.C. 1383c(c) who:
 - a. Was determined disabled by the Social Security Administration before attaining the age of 22 years,
 - b. Became entitled to or received an increase in child's insurance benefits under Title II of the Act on the basis of blindness or disability,
 - c. Was terminated from SSI cash benefits due to entitlement to or an increase in income under Title II of the Act,
 - d. Meets the requirements under this Article, and
 - e. Is 18 years of age or older;
4. A disabled widow or widower (DWW) under 42 U.S.C. 1383c(b) and (d) who:
 - a. Is blind or disabled,
 - b. Is ineligible for Medicare Part A benefits,
 - c. Received SSI cash benefits the month before Title II of the Act benefit payments began,
 - d. Meets the requirements under this Article;
 - e. Is at least 50 years of age but under age 65; and
 - f. Is unmarried.
5. Under 42 CFR 435.135, a person who:
 - a. Is aged, blind, or disabled;
 - b. Receives benefits under Title II of the Act;
 - c. Received SSI cash benefits in the past;

- d. Received SSI cash benefits and Title II of the Social Security Act benefits concurrently for at least one month anytime after April 1977;
- e. Became ineligible for SSI cash benefits while receiving SSI and benefits under Title II of the Act concurrently; and
- f. Meets the requirements under this Article.

B. Income for special groups.

1. Except as provided in subsection (B)(2), income eligibility is determined using the income criteria in R9-22-1503.
 2. Exceptions to income for special groups.
 - a. For a person in the DAC coverage group under subsection (A)(3), the applicant's Title II of the Social Security Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(c).
 - b. For a person in the DWW coverage group, under subsection (A)(4), the applicant's Title II of the Social Security Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(b) and (d).
 - c. For an applicant or member in the coverage group under subsection (A)(5), the portion of the applicant's or member's Title II of the Social Security Act benefits attributed to cost-of-living adjustments received by the applicant since the effective date of SSI ineligibility is disregarded in determining income eligibility under 42 CFR 435.135.
- C. 100 percent FBR. As a condition of eligibility for all special groups, countable income shall be equal to or less than 100 percent of the SSI FBR, as adjusted annually.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1).

R9-22-1506. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1507. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1508. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

ARTICLE 16. HOSPITAL PRESUMPTIVE ELIGIBILITY**R9-22-1601. General Eligibility Requirements**

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- A.** Notwithstanding Article 3, a qualified hospital may determine Hospital Presumptive Eligibility (HPE), on the basis of preliminary information, that an individual is eligible for AHCCCS medical coverage during the presumptive eligibility period described in this section, if the individual is a United States citizen or eligible qualified alien, and the individual is:
1. Pregnant with gross household income that does not exceed 156% of the FPL;
 2. An adult who meets the requirements of R9-22-1427(E);
 3. A caretaker relative as defined in R9-22-1401(B) with gross household income that does not exceed 106% of the FPL;
 4. Under age 19 with gross household income that does not exceed the limit set in R9-22-1427(D) for the child's age;
 5. A woman screened for breast or cervical cancer by an Arizona program of the National Breast and Cervical Cancer Early Detection Program who meets the requirements of R9-22-2003(A); or
 6. A former foster care child who meets the requirements of R9-22-1432.
- B.** Definitions. In addition to definitions contained in R9-22-101 and A.R.S. § 36-2901, the words and phrases in this Article have the following meanings unless the context explicitly requires another meaning: "Qualified hospital" means a hospital that has signed an agreement with the Administration to process HPE applications and has not been disqualified.
- C.** Application Process:
1. Right to apply. A person may apply for presumptive eligibility for AHCCCS medical coverage by submitting an Administration-approved application to the qualified hospital.
 2. Application. To initiate the application process, the qualified hospital will accept an application from the applicant, an adult who is in the applicant's household, as defined in 42 CFR 435.603(f), or family, as defined in section 36B(d)(1) of the Internal Revenue Service (IRS) Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant by submitting a written or online application under 42 CFR 435.907.
- D.** To establish presumptive eligibility, an applicant must complete and submit an AHCCCS-approved presumptive eligibility application signed under penalty of perjury to a qualified hospital. The applicant must attest to the name(s), relationship(s), and income of all persons in the household. In addition, the applicant must provide and attest to the following information regarding each household member on whose behalf AHCCCS medical coverage is sought:
1. The individual's date of birth;
 2. Whether the individual is pregnant;
 3. Whether the individual has been determined eligible for Breast and Cervical Cancer Treatment Program, described under Article 20;
 4. Whether the individual is a former foster child, described under R9-22-1432;
 5. The U.S. citizenship status or eligible qualified alien status under A.R.S. 36-2903.03 of the individual; and
 6. The individual's permanent and mailing addresses;
 7. The individual's Arizona residency status; and
 8. Whether the individual has Medicare coverage.
- E.** Presumptive eligibility begins on the date the hospital determines an individual's presumptive eligibility and ends with the earlier of:
1. In the case of an individual on whose behalf an application has been submitted to AHCCCS or its designee under Article 3, the day on which AHCCCS or its designee makes a determination on that application; or
 2. In the case of an individual on whose behalf an application has not been submitted to AHCCCS or its designee under Article 3, on the last day of the following month in which the determination of presumptive eligibility was made by the qualified hospital.
- F.** An individual may not be determined presumptively eligible more often than once every two years.
- G.** Coverage and reimbursement of services.
1. The Administration shall provide coverage of medically necessary services described under Article 2 to persons determined eligible for HPE on a fee-for-service basis.
 2. Providers shall submit claims for services provided to persons determined eligible for HPE to the Administration as described under Article 7.
- H.** A member may withdraw from HPE coverage by notifying the Administration or its designee.
- I.** Upon determining an individual presumptively eligible, the qualified hospital shall:
1. Notify the applicant at the time a determination regarding presumptive eligibility is made, in writing and orally if appropriate, of the determination for each individual on whose behalf presumptive eligibility was requested and the effective date of the presumptive eligibility;
 2. Provide the applicant with a regular AHCCCS-approved application form and inform the applicant that the applicant may file an application for Medicaid with the Administration or its designee;
 3. Notify AHCCCS of the presumptive eligibility determination;
 4. Notify the applicant at the time the determination is made that presumptive eligibility ends with the earlier of:
 - a. In the case of an individual on whose behalf an application has been submitted to AHCCCS or its designee under Article 3, the day on which AHCCCS or its designee makes a determination on that application; or
 - b. In the case of an individual on whose behalf an application has not been submitted to AHCCCS or its designee under Article 3, on the last day of the following month in which the determination of presumptive eligibility was made by the qualified hospital.
- J.** A determination by a qualified hospital that an individual is not presumptively eligible is not appealable under Chapter 34. If a qualified hospital denies an individual presumptive eligibility, the individual may apply for coverage by submitting an application to the Administration or its designee.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4). New Section made by final rulemaking at 20 A.A.R. 3436, effective January 1, 2015 (Supp. 14-4).

R9-22-1602. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by

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expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1615. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1616. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1617. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1618. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1619. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1620. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1621. Reserved**R9-22-1622. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1623. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1624. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1625. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1626. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1627. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1628. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1629. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1630. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1631. Repealed

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Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1632. Reserved**R9-22-1633. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1634. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1635. Reserved**R9-22-1636. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

ARTICLE 17. ENROLLMENT**R9-22-1701. Enrollment-Related Definitions**

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

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

“Auto-assignment algorithm” or “Algorithm” means a formula used by the Administration to assign to a contractor a member who did not make a timely choice under R9-22-1702.

“CMDP” means Comprehensive Medical and Dental Program.

“Disenrollment” means the discontinuance of a person’s entitlement to receive covered services from a contractor of record.

“Enrollment” means the process by which an eligible person becomes a member of a contractor’s plan.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended to correct a typographical error, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1702. Enrollment of a Member with an AHCCCS Contractor

A. General enrollment requirements. The Administration shall enroll a member with a contractor as described in this Section, unless the member has pre-selected a contractor on the application:

1. Except as provided in subsections (A)(3), (A)(5), and (C), a member who is determined to be eligible under this Chapter and resides in an area served by more than one contractor, may choose an available contractor serving the member’s GSA within 30 days from the date of notice of enrollment. A Native American member may select IHS or another available contractor.
 2. If the member does not make a choice under subsection (A)(1), the Administration shall immediately auto-assign the member to:
 - a. IHS if the member is a Native American living on a reservation,
 - b. A contractor based on family continuity, or
 - c. A contractor by using the auto-assignment algorithm.
 3. If the member’s period of ineligibility and disenrollment from the contractor of record is for a period of less than 90 days, the Administration shall enroll the member with the member’s most recent contractor of record, if available, except if:
 - a. The member no longer resides in the contractor’s GSA;
 - b. The contractor’s contract is suspended or terminated;
 - c. The member was previously enrolled with CMDP but at the time of re-enrollment the member is not a foster care child;
 - d. The member chooses another contractor or chooses IHS, if available to the member, during the annual enrollment choice period; or
 - e. The member was previously enrolled with a contractor but at the time of re-enrollment the member is a foster care child.
 4. When the member’s disenrollment period is more than 90 days, the member may select a contractor as described in subsection (A)(1).
 5. The Administration shall not enroll a member with a contractor if a member:
 - a. Is eligible for the FESP under R9-22-1419;
 - b. Is eligible for less than 30 days from the date the Administration receives notification of a member’s eligibility, except for a member who is enrolled with CMDP or IHS;
 - c. Is eligible only for a retroactive period of eligibility, except for a member who is enrolled with CMDP or IHS; or
 - d. Resides in an area not served by a contractor.
- B. Fee-for-service coverage. A member not enrolled with a contractor under subsection (A)(5) shall obtain covered medical services from an AHCCCS-registered provider on a fee-for-service basis under Article 7.
- C. Foster care child. The Administration shall enroll a member with CMDP if the member is a foster care child under A.R.S. § 8-512.
- D. Family Planning Services Extension Program. A member eligible for the Family Planning Services Extension Program under R9-22-1431, shall remain enrolled with the member’s contractor of record or IHS.
- E. Contractor or IHS enrollment change for a member.
1. The Administration shall change a member’s enrollment if the member requests a change to an available contractor or IHS during an annual enrollment period. A Native

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American may change from an available contractor to IHS or from IHS to an available contractor at any time.

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

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

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

- A. Effective date of enrollment. A member's date of enrollment is the date enrollment action is taken by the Administration. However, if a plan change occurs for an annual enrollment choice, the effective date is the month of the member's enrollment anniversary date.
- B. Financial liability of the contractor. The contractor shall be financially liable for an enrolled member's care as specified in contract.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1704. Newborn Enrollment

- A. General.
 1. The Administration shall enroll a newborn child of an eligible mother with an available contractor or IHS, based on the mother's enrollment.
 2. The Administration shall auto-assign a newborn child of an eligible mother who is not enrolled with a contractor or IHS or who is enrolled with CMDP. When a mother enrolled in CMDP has a newborn and the newborn is surrendered to Administration on Children, Youth and Families (ACYF), the newborn is then enrolled with CMDP.
 3. The Administration shall notify the mother of the right to choose a different contractor for her newborn child. The

mother may make her choice within 30 days from the date of notice of enrollment.

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

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended to correct a typographical error, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1705. Guaranteed Enrollment Period

- A. General. Except for members enrolled with IHS or CMDP, the Administration shall provide a guaranteed enrollment period for a one-time period that begins on the effective date of the member's initial enrollment with a contractor and ends on the last day of the fifth full calendar month after the date of the member's initial enrollment.
- B. Exceptions to guaranteed period. The Administration shall not grant a guaranteed enrollment period or shall terminate a guaranteed enrollment period as provided in subsection (C), if the member:
 1. Did not meet the conditions of eligibility when initially enrolled with the contractor;
 2. Except as provided in 9 A.A.C. 22, Article 12, is an inmate of a public institution as defined in 42 CFR 435.1010;
 3. Dies;
 4. Moves out-of-state;
 5. Voluntarily withdraws from the AHCCCS program;
 6. Is adopted; or
 7. Has whereabouts that are unknown.
- C. Disenrollment effective date. The Administration shall terminate any guaranteed enrollment period to which the member is not entitled effective on:
 1. The date the member is admitted to a public institution under subsection (B);
 2. The member's date of death;
 3. The last day of the month in which the Administration receives notification that a member moved out-of-state;
 4. The date the Administration receives written notification of the member's voluntary withdrawal from the AHCCCS program;
 5. The last day of the month in which the Administration receives notification that a member's adoption proceedings are finalized; or
 6. The last day of the month in which the Administration receives notification that a member's whereabouts are unknown.
- D. Retroactive adjustments. The Administration shall adjust the member's eligibility and enrollment retroactively under subsection (C).

Historical Note

New Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

ARTICLE 18. RESERVED**ARTICLE 19. FREEDOM TO WORK**

Article 19, consisting of Sections R9-22-1901 through R9-22-

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1922, made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1901. General Freedom to Work Requirements

Under 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and (XVI), the Administration shall determine eligibility for AHCCCS medical services, under Article 2 of this Chapter, using the eligibility criteria and requirements under this Article for an applicant or member who is:

1. At least 16 years of age, but less than 65 years of age,
2. Employed, and
3. Not income eligible under A.R.S. § 36-2901(6)(a).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1902. General Administration Requirements

The Administration shall comply with the confidentiality rule under R9-22-512(C).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1903. Application for Coverage

- A. A person may apply by submitting an application to an Administration office.
- B. The application date is the date the application is received at an Administration office or outstation location approved by the Director as described under R9-22-1406(A).
- C. The provisions in R9-22-1406(B) and (D) apply to this Section.
- D. The applicant or representative who files the application may withdraw the application for coverage either orally or in writing. An applicant withdrawing an application shall receive a denial notice under R9-22-1904.
- E. Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 45 days.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1904. Notice of Approval or Denial

The Administration shall send an applicant a written notice of the decision regarding the application. This notice shall include a statement of the action, and:

1. If approved, the notice shall contain:
 - a. The effective date of eligibility,
 - b. The amount the person shall pay, and
 - c. An explanation of the person's hearing rights specified in 9 A.A.C. 34.
2. If denied, R9-22-1501(G)(3) applies.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1905. Reporting and Verifying Changes

An applicant or member shall report and verify changes, as described under R9-22-1501(H), to the Administration.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1906. Actions that Result from a Redetermination or Change

The processing of a redetermination or change shall result in one of the following actions:

1. No change in eligibility or premium,
2. Discontinuance of eligibility if a condition of eligibility is no longer met,
3. A change in premium amount, or
4. A change in the coverage group under which a person receives AHCCCS medical coverage.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1907. Notice of Adverse Action Requirements

- A. The requirements under R9-22-1501(K)(1) apply.
- B. Advance notice of a change in eligibility or premium amount. Advance notice means a notice of proposed action that is issued to the member at least 10 days before the effective date of the proposed action. Except under subsection (C), advance notice shall be issued whenever an adverse action is taken to discontinue eligibility, or increase the premium amount.
- C. Exceptions from advance notice. A notice shall be issued to the member to discontinue eligibility no later than the effective date of action if:
 1. A member provides a clearly written statement, signed by that member, that services are no longer wanted.
 2. A member provides information that requires termination of eligibility or reduction of services, indicates that the member understands that this must be the result of supplying that information, and the member signs a written statement waiving advance notice;
 3. A member cannot be located and mail sent to the member's last known address has been returned as undeliverable subject to reinstatement of discontinued services under 42 CFR 431.231(d);
 4. A member has been admitted to a public institution where a person is ineligible for coverage;
 5. A member has been approved for Medicaid in another state; or
 6. The Administration receives information confirming the death of a member.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1908. Request for Hearing

An applicant or member may request a hearing under 9 A.A.C. 34.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1909. Conditions of Eligibility

An applicant or member shall meet the following conditions to qualify for the Freedom to Work program:

1. Furnish a valid Social Security Number (SSN);

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2. Be a resident of Arizona;
3. Be a citizen of the United States, or meet requirements for a qualified alien under A.R.S. § 36-2903.03(B);
4. Be at least 16 years of age, but less than 65 years of age;
5. Have countable income that does not exceed 250 percent of FPL. The Administration shall count the income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K with the following exceptions:
 - a. The unearned income of the applicant or member shall be disregarded,
 - b. The income of a spouse or other family member shall be disregarded, and
 - c. The deduction for a minor child shall not apply;
6. Comply with the member responsibility provisions under R9-22-1502(D) and (F).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). Section repealed; new Section made by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1910. Prior Quarter Eligibility

A person may be made eligible during a prior quarter period when applying for the Freedom to Work program, as described under Article 3.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). New Section made by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

R9-22-1911. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1912. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1913. Premium Requirements

- A. As a condition of eligibility, an applicant or member shall:
 1. Pay the premium required under subsection (B).
 2. Not have any unpaid premiums for more than one month's premium amount.
- B. The Administration shall process premiums under 9 A.A.C. 31, Article 14 with the following exceptions:
 1. A member who has countable income:
 - a. Under \$500, the monthly premium payment shall be \$0.
 - b. Over \$500 but not greater than \$750, the monthly premium payment shall be \$10.
 2. The premium for a member shall be increased by \$5 for each \$250 increase in countable income above \$750.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1914. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1915. Institutionalized Person

A person is not eligible for AHCCCS medical coverage if the person is:

1. An inmate of a public institution if federal financial participation (FFP) is not available, or
2. Age 21 through age 64 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except when allowed under the Administration's Section 1115 IMD waiver or allowed under a managed care contract approved by CMS.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1916. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1917. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1918. Additional Eligibility Criteria for the Basic Coverage Group

An applicant or member shall meet the following eligibility criteria:

1. Disabled. As a condition of eligibility, an applicant or member shall be disabled. Disabled means a person who has been determined disabled by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E), except employment activity, earnings, and substantial gainful activity shall not be considered in determining whether the individual meets the definition of disability.
2. Employed. As a condition of eligibility, an applicant or member shall be employed. Employed means that an applicant or member is paid for working and Social Security or Medicare taxes are paid on the applicant or member's work.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1919. Additional Eligibility Criteria for the Medically Improved Group

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As a condition of eligibility for the Medically Improved Group, a member shall:

1. Be employed. Under this Section, employed means an individual who:
 - a. Earns at least the minimum wage and works at least 40 hours per month, or
 - b. Has gross monthly earnings at least equal to those earned by an individual who is earning the minimum wage working 40 hours per month.
2. Cease to be eligible for medical coverage under R9-22-1918 or a similar Basic Coverage Group program administered by another state because the member, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be disabled; and
3. Continues to have a severe medically determinable impairment, as determined under Social Security Act section 1902(a)(10)(A)(ii)(XVI).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1920. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1921. Enrollment

The Administration shall enroll members under Article 17 of this Chapter. If a member has not paid a required premium, the Administration shall not grant a guaranteed enrollment period.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1922. Redetermination of Eligibility

- A. Redetermination. Except as provided in subsection (B), the Administration shall complete a redetermination of eligibility at least once a year.
- B. Change in circumstance. The Administration may complete a redetermination of eligibility if there is a change in the member's circumstances, including a change in disability or employment that may affect eligibility.
- C. Medical Improvement. If a member is no longer disabled under R9-22-1918, the Administration shall determine if the member is eligible under other coverage groups including the medically improved group.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

ARTICLE 20. BREAST AND CERVICAL CANCER TREATMENT PROGRAM**R9-22-2001. Breast and Cervical Cancer Treatment Program Related Definitions**

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

“AZ-NBCCEDP” means the Arizona programs of the National Breast and Cervical Cancer Early Detection Program. AZ-NBCCEDP provides breast and cervical cancer screening and diagnosis in Arizona.

“Cryotherapy” means the destruction of abnormal tissue using an extremely cold temperature.

“LEEP” means the loop electrosurgical excision procedure that passes an electric current through a thin wire loop.

“Peer-reviewed study” means that, prior to publication, a medical study has been subjected to the review of medical experts who:

Have expertise in the subject matter of the study, Evaluate the science and methodology of the study, Are selected by the editorial staff of the publication, and Review the study without knowledge of the identity or qualifications of the author.

“WWHP” means the Well Women Healthcheck Program administered by the Arizona Department of Health Services. The WWHP is one of the programs within AZ-NBCCEDP that provides breast and cervical cancer screening and diagnosis.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2002. General Requirements

- A. Confidentiality. The Administration shall maintain the confidentiality of a woman's records and shall not disclose a woman's financial, medical, or other confidential information except as allowed under R9-22-512.
- B. Covered services. A woman who is eligible under this Article receives all medically necessary services under Articles 2 and 12 of this Chapter.
- C. Choice of health plan. A woman who is eligible under this Article shall be enrolled with a contractor under Article 17 of this Chapter.
- D. A Native American woman who receives services through Indian Health Service (IHS) or through a tribal health program qualifies for services provided under this Article if all eligibility requirements are met.
- E. A woman qualified under this Article shall pay co-pays as described in R9-22-711.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2003. Eligibility Criteria

- A. General. To be eligible under this Article, a woman shall meet the requirements of this Article and:
 1. Be screened for breast and cervical cancer through AZ-NBCCEDP;
 2. Be less than 65 years of age;
 3. Be ineligible for Title XIX under Articles 14 and 15 in this Chapter;
 4. Receive a positive screen under subsection (A)(1), a confirmed diagnosis through AZ-NBCCEDP, and need treatment for breast cancer or cervical cancer, including a pre-cancerous cervical lesion, as specified in R9-22-2004;
 5. Not be covered under creditable coverage as specified in Section 2701(c) of the Public Health Services Act, 42 U.S.C. 300gg(c). For purposes of this Article, IHS or Tribal health coverage is not considered creditable coverage as specified in 42 U.S.C. 1396a(a)(10)(A)(ii), as amended by the Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2002; and

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6. Meet the requirements under R9-22-1417 and R9-22-1418.
- B. Ineligible woman.** A woman is ineligible under this Article if the woman:
1. Is an inmate of a public institution and federal financial participation (FFP) is not available,
 2. Is at least age 21 but less than age 65 and resides in an Institution for Mental Disease (IMD) as defined in R9-22-112, except if allowed under the Administration's Section 1115 waiver, or
 3. No longer meets an eligibility requirement under this Article.
- C. Metastasized cancer.** The AHCCCS Chief Medical Officer may continue a woman's eligibility under this Article if a metastasized cancer is found in another part of the woman's body and that metastasized cancer is a known or a presumed complication of the breast or cervical cancer as determined by the treating physician.
- D. Reoccurrence of cancer.** A woman shall have eligibility reestablished after eligibility under this Article ends if the woman is screened under the AZ-NBCCEDP program and additional breast cancer or cervical cancer, including a pre-cancerous cervical lesion, is found.
- E. Ineligible male.** A male is precluded from receiving screening and diagnostic services under the AZ-NBCCEDP program and is ineligible under this Article.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Amended by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2004. Treatment

- A. Breast cancer.** Coverage for treatment for breast cancer under this Article shall conclude on the last provider visit for the specific treatment of the cancer or at the end of hormonal therapy for the cancer, whichever is later. For purposes of this subsection treatment means:
1. Lumpectomy or surgical removal of breast cancer;
 2. Chemotherapy;
 3. Radiation therapy; and
 4. A treatment for breast cancer that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.
- B. Pre-cancerous cervical lesion.** Coverage for treatment for a pre-cancerous cervical lesion under this Article, including moderate or severe cervical dysplasia or carcinoma in situ, shall conclude on the last provider visit for specific treatment for the pre-cancerous lesion. For purposes of this subsection treatment means:
1. Conization;
 2. LEEP;
 3. Cryotherapy; and
 4. A treatment for pre-cancerous cervical lesion that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.
- C. Cervical cancer.** Coverage for treatment for cervical cancer under this Article shall conclude on the last provider visit for the specific treatment for the cancer. For purposes of this subsection treatment means:
1. Surgery;
 2. Radiation therapy;
 3. Chemotherapy; and

4. A treatment for cervical cancer that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2005. Application Process

- A. Application.** A woman may apply for eligibility under this Article by submitting a complete application as specified in R9-22-1406.
- B. Submitting the application.** The woman may complete and submit an application at the time of the AZ-NBCCEDP screening. The AZ-NBCCEDP staff may mail or fax the application directly to the Administration.
- C. Date of application.** The date of the application is the date of the diagnostic procedure that results in a positive diagnosis for breast cancer or cervical cancer, including a pre-cancerous cervical lesion.
- D. Responsibility of a woman who is applying or who is a member.** A woman who is applying or who is a member shall:
1. Provide medical insurance information, including any changes in medical insurance; and
 2. Inform the Administration about a change in address, residence, and alienage status.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2006. Approval, Denial, or Discontinuance of Eligibility

- A. Eligibility determination.** The Administration shall determine eligibility under this Article and send the notice under subsection (B) or (C) within seven days of receiving a complete application.
- B. Approval.** If a woman meets all the eligibility requirements in this Article, the Administration shall provide the woman with an approval notice. The approval notice shall contain:
1. The name of the eligible woman, and
 2. The effective date of eligibility.
- C. Denial.** If the Administration denies eligibility, the Administration shall provide the woman with a denial notice. The denial notice shall contain:
1. The name of the ineligible woman,
 2. The specific reason why the woman is ineligible,
 3. The legal citations supporting the reason for the denial,
 4. The location where the woman can review the legal citations, and
 5. Information regarding the woman's appeal and request for hearing rights.
- D. Discontinuance.**
1. Except as specified in subsection (D)(2), if a woman no longer meets an eligibility requirement under this Article, the Administration shall provide the woman a Notice of Action no later than 10 days before the effective date of the discontinuance.
 2. The Administration may mail the Notice of Action no later than the effective date of the discontinuance if the Administration:
 - a. Receives a written statement from the woman voluntarily withdrawing from AHCCCS,

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- b. Receives information confirming the death of the woman,
 - c. Receives returned mail with no forwarding address from the post office and the woman's whereabouts are unknown, or
 - d. Receives information confirming that the woman has been approved for Title XIX services outside the state of Arizona.
3. The Notice of Action shall contain the:
- a. Name of the ineligible woman,
 - b. Effective date of the discontinuance,
 - c. Specific reason why the woman is discontinued,
 - d. Legal citations supporting the reason for the discontinuance,
 - e. Location where the woman can review the legal citations, and
 - f. Information regarding the woman's appeal and request for hearing rights.
- E. Request for hearing. A woman who is denied, or discontinued for the Breast and Cervical Cancer Treatment Program may request a hearing under Chapter 34.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2007. Effective and End Date of Eligibility

- A. Eligibility is effective on the first day of the month that all eligibility requirements are met, including the period described under R9-22-303.
- B. The end date of eligibility:
1. For breast cancer, is 12 months after the last provider visit for a treatment specified in R9-22-2004 for the cancer or at the end of hormonal therapy for the cancer, whichever is later.
 2. For pre-cancerous cervical lesion, is four months after the last provider visit for a treatment specified in R9-22-2004 for the pre-cancerous lesion.
 3. For cervical cancer, is 12 months after the last provider visit for a treatment specified in R9-22-2004 for the cancer.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4). Section amended by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

R9-22-2008. Redetermination of Eligibility

- A. Redetermination. Except as provided in subsection (B), the Administration shall redetermine eligibility at least once a year. If a woman continues to meet the requirements of eligibility for the Breast and Cervical Cancer Treatment Program under this Article, the Administration shall notify the woman of continued eligibility. A woman is not required to be screened for breast and cervical cancer through AZ-NBC-CEDP at redetermination.
- B. Change in circumstance. The Administration shall complete a redetermination of eligibility if there is a change in the woman's circumstances that may affect eligibility, including a change in treatment.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

ARTICLE 21. TRAUMA AND EMERGENCY SERVICES FUND

Article 21, consisting of Sections R9-22-2101 through R9-22-2103, made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).

R9-22-2101. General Provisions

- A. A.R.S. § 36-2903.07 establishes the Administration as the authority to administer the Trauma and Emergency Services Fund.
- B. The Administration shall distribute 90% of monies from the trauma and emergency services fund to a level I trauma center, as defined in subsection (F) of this Section, for unrecovered trauma center readiness costs as defined in subsection (F) of this Section. Reimbursement is limited to no more than the amount of unrecovered trauma center readiness costs as determined in subsections (D) and (E) of this Section. Unexpended funds may be used to reimburse unrecovered emergency room costs under subsection (C) of this Section.
- C. The Administration shall distribute 10% of monies from the trauma and emergency services fund, for unrecovered emergency services costs, to a hospital having an emergency department, using criteria under R9-22-2103. Reimbursement is limited to no more than the amount of unrecovered emergency services costs as determined in R9-22-2103. The Administration may distribute more than 10% of the monies for unrecovered emergency room costs when there are unexpended monies under subsection (B) of this Section.
- D. The Administration shall distribute a reporting tool and guidelines to level I trauma centers to determine, on an annual basis, the unrecovered trauma center readiness costs for level I trauma centers as defined in subsection (F) of this Section. The reporting time-frame is July 1 of the prior year through June 30 of the reporting year. A level I trauma center shall submit the requested data and a copy of the most recently completed uniform accounting report under A.R.S. § 36-125.04 to the Administration no later than October 31 of each reporting year.
- E. When a level I trauma center closes in a county where there are one or more level I trauma center(s) remaining in operation, the following shall occur:
1. The closing level I trauma center shall submit the requested data under subsection (D) of this Section for the months of the reporting time-frame in which it met the definition of a level I trauma center, and
 2. The data under subsection (D) of this Section, which is submitted by the closing level I trauma center, shall be added to the remaining level I trauma center(s) in that county for the current reporting time-frame only.
- F. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:
1. "Level I trauma center" means any acute care hospital designated by the Arizona Department of Health Services as a level I trauma center, a provisional level I trauma center, a pediatric level I trauma center or an initial level I trauma center.
 2. "Unrecovered trauma center readiness costs" means losses incurred treating trauma patients:
 - a. Determined in accordance with Generally Accepted Accounting Principles,
 - b. Based on both clinical and professional costs incurred by a level I trauma center necessary for the provision of level I trauma care, and
 - c. Based on administrative and overhead costs directly associated with providing level I trauma care.

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Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

R9-22-2102. Distribution of Trauma and Emergency Services Fund: Level I Trauma Centers

- A.** On or after November 1, 2003, the Administration shall distribute monies, under R9-22-2101(B), to level I trauma centers using monies available in the trauma and emergency services fund at the time of payment. The Administration shall take into consideration the proportion of those hospitals' trauma case volume. The Administration shall:
1. Recalculate the November 2003 payments in July 2004 using the formula in subsection (B) of this Section;
 2. Recoup November 2003 overpayments by reducing the July 2004 distributions under subsection (C) as appropriate; and
 3. Redistribute recouped funds, with the July 2004 payment, to level I trauma centers underpaid in November 2003.
- B.** On or after January 31 of each year, the Administration shall distribute monies, under R9-22-2101(B), to level I trauma centers using monies available in the trauma and emergency services fund at the time of payment. The Administration shall determine each hospital's unrecovered trauma center readiness costs for the current fiscal year using data from the most recent reporting year as provided under R9-22-2101(D) and (E). The proportion of each hospital's share of the fund for unrecovered trauma center readiness costs is determined after considering:
1. The professional, clinical, administrative, and overhead costs directly associated with providing level I trauma care, and
 2. The volume and acuity of trauma care provided by each hospital.
- C.** On or after July 31 of each year, the Administration shall distribute monies to level I trauma centers using monies, under R9-22-2101(B), available in the trauma and emergency services fund at the time of payment according to the proportions calculated and used for the January payments in the same year, under subsection (B) of this Section.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).

R9-22-2103. Distribution of Trauma and Emergency Services Fund: Emergency Services

On or after June 30 of each year, the Administration shall distribute monies available in the trauma and emergency services fund at the time of payment as follows:

1. As allocated under R9-22-2101(C),
2. To hospitals that had an emergency department from July 1 through June 30 of the prior year, and
3. On a pro rata share of each hospital's cost of uncompensated emergency care as a percentage of the total statewide cost of uncompensated emergency care provided by hospitals under subsection (2) as reported in the uniform accounting reports to the Arizona Department of Health Services under A.R.S. § 36-125.04.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3). Amended by exempt rulemaking at 18 A.A.R. 1748, effective July 1, 2012 (Supp. 12-2).

R9-22-2104. Additional Trauma and Emergency Services Pay-**ments under the Section 1115 Waiver**

- A.** Notwithstanding R9-22-2101(D), for the reporting years ending June 30, 2011 and June 30, 2012, the Administration shall distribute an amount equal to the balance of the Trauma and Emergency Services fund in the following manner:
1. Ninety percent of the amount shall be distributed to Level I trauma centers based upon each center's pro rata share of each center's acuity-adjusted volume as a percentage of the total acuity-adjusted volume for all centers in the state. The acuity-adjusted volume is calculated by multiplying the Injury Severity Score employed by trauma.org by the number of trauma cases at that level treated at the center during the reporting year. Hospitals shall report trauma scores and case volume on a worksheet prescribed by the Administration.
 2. Ten percent of the amount shall be distributed proportionately to hospitals that had an emergency department from July 1 through June 30 of the reporting year based the pro rata share of each hospital's cost of emergency care as a percentage of the total statewide cost of emergency care provided by hospitals as reported on the Worksheet B, column 27, line 61 of the hospital's most current Medicare Cost Report as of January 31 following the end of each reporting year.
- B.** For the reporting years ending June 30, 2011 and June 30, 2012, the Administration shall distribute an amount equal to the federal financial participation made available under the section 1115 waiver for the purpose of making payments for unrecovered trauma and emergency services as follows:
1. Thirty percent of such funds to a Level I trauma center, in amounts calculated in the same manner as described in subsection (A)(1) of this Section, for any unrecovered trauma center readiness costs not reimbursed under subsection (A) of this Section;
 2. Thirty percent of such funds to a hospital having an emergency department from July 1 through June 30 of the reporting year, in amounts calculated in the same manner as described in subsection (A)(2) of this Section, for any unrecovered emergency services costs not reimbursed under subsection (A) of this Section; and
 3. Forty percent of such funds to rural hospitals, as defined in R9-22-718 that are not Level 1 trauma centers as defined in R9-22-2101(F), having an emergency department from July 1 through June 30 of the reporting year, in amounts calculated in the same manner as described in subsection (A)(2) of this Section, for any unrecovered emergency services costs not reimbursed under subsections (A) and (B)(2) of this Section.
- C.** For the reporting years ending June 30, 2011 and June 30, 2012, payments made under this Article shall not be made in an amount that results in aggregate payments to the hospital by the Administration and contractors exceeding of the upper payment limit for the hospital services as calculated in accordance with 42 CFR 447.
- D.** For the reporting years ending June 30, 2011 and June 30, 2012, to ensure compliance with subsection (C), payments under this Article shall be reconciled to the federal fiscal year that is two years subsequent to the payment.
- E.** Any payments that are determined under subsection (D) to exceed the limit in subsection (C) shall be distributed as described in this Article to hospitals that have not received payments in excess of the limit in subsection (C).

Historical Note

New Section made by exempt rulemaking at 18 A.A.R. 1748, effective July 1, 2012 (Supp. 12-2).