

Arizona Health Care Cost Containment System – Medicare Cost Sharing Program

TITLE 9. HEALTH SERVICES

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

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ARTICLE 1. DEFINITIONS

R9-29-101. Location of Definitions

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

<u>Definition</u>	<u>Section or Citation</u>
“Federal poverty level” or “FPL”	A.R.S. § 36-2981
“Medicare Cost Sharing”	R9-29-101
“Non-QMB Dual”	R9-29-101
“QI-1”	R9-29-101
“QMB Dual”	R9-29-101
“QMB Only”	R9-29-101
“SLMB”	R9-29-101

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

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

“Non-QMB Dual” means a person who qualifies to receive both Medicare and Medicaid services, but does not qualify for the QMB program.

“QI-1” means a person who qualifies as a Medicare beneficiary and for cost sharing assistance with the person’s Part B premium known as Qualified Individual-1 (QI-1). This person does not qualify for QMB due to the person’s income exceeding the QMB and SLMB FPL level.

“QMB Dual” means a person determined eligible under Article 2 of this Chapter for Qualified Medicare Beneficiary (QMB) and eligible for Acute Care services provided for in 9 A.A.C. 22 or ALTCS services provided for in 9 A.A.C. 28. A QMB Dual person receives both Medicare and Medicaid services and cost sharing assistance. For the purpose of Article 2 of this Chapter, QMB includes members defined in A.R.S. § 36-2971(5).

“QMB Only” means a person who qualifies to receive Medicare services only and cost-sharing assistance known as Qualified Medicare Beneficiary program (QMB). For the purpose of Article 2 of this Chapter, QMB includes members defined in A.R.S. § 36-2971(5).

“SLMB” means a person who qualifies as a Medicare beneficiary and for cost sharing assistance with the person’s Part B premium known as Specified Low Income Medicare Beneficiary (SLMB). This person does not qualify for QMB due to the person’s income exceeding the QMB FPL level.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective June 16, 1992 (Supp. 92-2). Amended effective April 14, 1998 (Supp. 98-2). Amended by final rulemaking at 6 A.A.R. 3372, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 7 A.A.R. 4357,

effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-102. Repealed

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Repealed by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

ARTICLE 2. ELIGIBILITY

R9-29-201. General

- A. Eligibility determination. AHCCCS shall determine eligibility for a QMB, SLMB, or QI-1 under this Article.
- B. Confidentiality. The Administration shall maintain the confidentiality of an applicant or member's records and limit the release of safeguarded information under A.A.C. R9-22-512.
- C. The Administration will accept applications for the QI-1 program subject to the availability of funds. If the Director determines that monies may be insufficient for the program, the Administration shall stop processing applications for the program. If the Administration stops processing an application because the monies are insufficient, the Administration shall place an applicant on a waiting list and notify the applicant. After the Administration has verified that funding is sufficient, it will resume processing applications.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2). Amended by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-202. Application Process

- A. The Administration shall provide the opportunity to apply without delay.
- B. To apply for the MCS Program, a person shall submit an application form prescribed by AHCCCS unless the person's application has been referred by the Social Security Administration as part of the Extra Help program described under A.A.C. R9-30-101.
- C. An application shall be submitted by a person listed in A.A.C. R9-22-1406(B) unless the person's application has been referred by the Social Security Administration as part of the Extra Help program described under A.A.C. R9-30-101.
- D. The date of application is the date a signed application is received as described under A.A.C. R9-22-1406 or the date of an application referred by the Social Security Administration as part of the Extra Help program described under A.A.C. R9-30-101.
- E. Applicant's representative. AHCCCS shall allow a person of an applicant's choice to accompany, assist, and represent the applicant in the application process or assistance can be provided by AHCCCS. If requested, AHCCCS shall help a person complete an application.
- F. AHCCCS shall determine whether an application is complete under A.A.C. R9-22-1406.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective June 16, 1992 (Supp. 92-2). Section repealed; new Section adopted effective April 14, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp.

03-4). Amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-203. Assignment of Rights

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

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Section repealed; new Section adopted effective April 14, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-203 repealed; new Section R9-29-203 renumbered from R9-29-207 and amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-204. Eligibility Requirements

To be eligible for MCS a person shall:

1. Provide information necessary to establish paternity and enforce medical support obligations, when requested by AHCCCS for the QMB program,
2. Furnish a SSN or apply for a SSN,
3. Be a United States citizen or a qualified alien under A.R.S. § 36-2903.03,
4. Be a resident of Arizona,
5. Apply for potential benefits that may be available to the person, if requested by AHCCCS,
6. Provide verification, or authorize the release of verification, for all information necessary to complete the determination of eligibility, and
7. Receive Medicare Part A benefits or be determined conditionally entitled to Medicare Part A benefits by the Social Security Administration.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Repealed effective April 14, 1998 (Supp. 98-2). New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). R9-29-204 repealed; new Section R9-29-204 made by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-205. Income Standards

- A. To be eligible, a person's income shall meet the following federal poverty levels (FPL), adjusted annually:
 1. QMB. Income is equal to or less than 100 percent of the FPL.
 2. SLMB. Income is greater than 100 percent but equal to or less than 120 percent of the FPL.
 3. QI-1. Income is at least 120 percent but equal to or less than 135 percent of the FPL.
- B. AHCCCS shall calculate income under A.A.C. R9-22-1503.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-205 repealed; new Section R9-29-205 renumbered from R9-29-213 and amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-206. Institutionalized Person

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

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-206 repealed; new Section R9-29-206 renumbered from

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R9-29-215 by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-207. Resources

Resources such as, cash, financial accounts, real property, vehicles, trusts, and life insurance are not considered in determining a person's QMB, SLMB or QI-1 eligibility.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-207 renumbered to R9-29-203; new Section R9-29-207 made by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-208. Eligibility Determination

- A. AHCCCS shall make an eligibility determination within 45 days of the date of application, except when:
1. The agency cannot reach a decision because the applicant delays or fails to take a required action, or
 2. When there is an administrative or other emergency beyond the agency's control.
- B. AHCCCS shall not use the time to determine eligibility as a waiting period before determining eligibility; or as a reason for denying eligibility when a determination has not been made within the time standards.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-208 repealed; new Section R9-29-208 renumbered from R9-29-219 and amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-209. Notice of Eligibility Determination

- A. Notice. AHCCCS shall send an applicant written notice of the eligibility decision. The notice shall include a statement of the action and an explanation of the person's hearing rights specified in Article 5.
- B. Approval. If AHCCCS determines that the applicant is eligible, the notice shall contain the effective date of eligibility.
- C. Denial. If AHCCCS determines that the applicant is not eligible, the notice shall contain:
1. The effective date of the decision;
 2. A statement detailing the reason for the decision, including specific financial calculations and the financial eligibility standard if applicable; and
 3. The legal authority supporting the decision.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-209 repealed; new Section R9-29-209 renumbered from R9-29-220 by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-210. Effective Date of Eligibility

- A. QMB. The effective date of eligibility is the first day of the month following the month in which AHCCCS makes the eligibility decision.
- B. SLMB. Eligibility is effective on the first day of the month that all eligibility requirements are met, including the prior quarter period.
- C. QI-1. Eligibility is effective on the first day of the month that all eligibility requirements are met, including the prior quarter period and no earlier than the first day of the current calendar year. QI-1 members are entitled to receive cost sharing assistance through the end of the calendar year in which they qualified for the program.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-210 repealed; new Section R9-29-210 renumbered from R9-29-221 and amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4). Amended by final rulemaking at 19 A.A.R. 3323, November 30, 2014 (Supp. 13-4).

R9-29-211. Discontinuance

- A. Discontinuance. AHCCCS shall discontinue a person's eligibility if any of the conditions of eligibility under this Article are not met.
- B. Notice. AHCCCS shall follow the discontinuance notice requirements under A.A.C. R9-22-1415, except where it states "Department" replace the term with "Administration."

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-211 repealed; new Section R9-29-211 renumbered from R9-29-222 and amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-212. Renewals

- A. QMB and SLMB. AHCCCS shall renew a person's eligibility for QMB or SLMB at least one time every 12 months.
- B. QI-1. A person receiving QI-1 benefits shall reapply every 12 months.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-212 repealed; new Section R9-29-212 made by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-213. Reporting Changes

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

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

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-213 renumbered to R9-29-205; new Section R9-29-213 renumbered from R9-29-224 by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-214. Repealed**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-

214 repealed by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-215. Renumbered

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-215 renumbered to R9-29-206 by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-216. Repealed

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-216 repealed by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-217. Repealed

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-217 repealed by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-218. Repealed

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-218 repealed by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-219. Renumbered

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-219 renumbered to R9-29-208 by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-220. Renumbered

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-220 renumbered to R9-29-209 by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-221. Renumbered

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-221 renumbered to R9-29-210 by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-222. Renumbered

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-222 renumbered to R9-29-211 by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-223. Repealed

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-223 repealed by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-224. Renumbered

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-224 renumbered to R9-29-213 by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

ARTICLE 3. BENEFITS AND SERVICES

R9-29-301. QMB Only

- A.** QMB benefits. For a person determined eligible as a QMB Only, the Administration shall provide payment of:
1. Medicare Part A premium,
 2. Medicare Part B premium, and
 3. Medicare coinsurance and Medicare deductible for Medicare services covered under Title XVIII of the Social Security Act to the provider.
- B.** Payment of QMB Only benefits. The Administration shall not pay coinsurance or deductible to a member.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2). Amended by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-302. QMB Dual Member

- A.** Covered services. A person determined to be a QMB Dual eligible member shall receive medical services provided under 9 A.A.C. 22, Article 2, or services provided under 9 A.A.C. 28, Article 2, in addition to the Medicare-related payments under R9-29-301(A).
- B.** Premiums. The Administration pays Medicare part A and B premiums for a QMB Dual member enrolled with a contractor in a plan or AHCCCS Fee-For-Service.
- C.** The Administration's payment responsibilities.
1. The Administration shall pay the following costs for members not enrolled with contractors. When services are received from an AHCCCS registered provider and the service is covered:
 - a. By Medicare only, the Administration shall pay the Medicare coinsurance and deductible.
 - b. By Medicaid only, the Administration shall pay the lesser of billed charges or the Capped Fee-For-Service Schedule rate for the services covered under 9 A.A.C. 22, Article 2 and 9 A.A.C. 28, Article 2.
 - c. By both Medicare and Medicaid, the Administration shall pay Medicare coinsurance and deductible.
 2. When services are received from a non-registered provider and the service is covered, the Administration shall not pay the Medicare coinsurance and deductible.
- D.** The contractor's payment responsibilities. Unless the subcontract with the provider sets forth different terms, when the enrolled member receives services from an AHCCCS registered provider in or out of network and the service is covered:
1. By Medicare only, the contractor shall pay the Medicare coinsurance and deductible.
 2. By Medicaid only, the contractor shall pay the provider in accordance with the contract.
 3. By both Medicare and Medicaid, the contractor shall pay the lesser of:
 - a. The Medicare copay, coinsurance or deductible, or
 - b. The difference between the Health plan contracted rate and the Medicare paid amount.
- E.** Member responsibilities. A QMB Dual eligible member who receives services under 9 A.A.C. 22, Article 2 or 9 A.A.C. 28,

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Article 2 from a registered provider is not liable for any Medicare copay, coinsurance or deductible associated with those services and is not liable for any balance of billed charges.

- F.** Coordination of prescription drug benefit with Medicare Part D. Notwithstanding subsections (A) through (D), services do not include pharmaceutical services to the extent limited under 42 U.S.C. 1396u-5(d). A contractor is not liable for any Medicare copay, coinsurance or deductible associated with pharmaceutical services subject to the limitation under 42 U.S.C. 1396u-5(d).

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2). Amended by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 864, effective March 7, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-303. Non-QMB Dual Member

- A.** Covered services. A person determined to be a Non-QMB Dual eligible member shall receive medical services and provisions under 9 A.A.C. 22, Article 2, or services and provisions under 9 A.A.C. 28, Article 2.
- B.** Premiums. The Administration pays Medicare part B premiums for a Non-QMB dual member enrolled with a contractor in a plan or AHCCCS Fee-For-Service for the following individuals:
1. An individual described in 42 CFR 431.625;
 2. An individual enrolled in ALTCS but who does not qualify as a QMB, SLMB or QI;
 3. An individual who is eligible for Medicaid under a mandatory or optional Title XIX coverage group for the aged, blind, or disabled (SSI-MAO);
 4. An individual who is eligible for continued coverage while eligibility redetermination is pending as described under 42 CFR 435.1003;
 5. An individual who is in the guaranteed enrollment period described in 42 CFR 435.212 and the state was paying the individual's Part B premium before eligibility terminated.
- C.** The Administration's payment responsibilities.
1. The Administration shall pay the following costs for members not enrolled with contractors. When services are received from an AHCCCS registered provider and the service is covered up to the limitations described within 9 A.A.C. 22, Article 2:
 - a. By Medicare only, the Administration shall not pay the Medicare copay, coinsurance or deductible.
 - b. By Medicaid only, the Administration shall pay the lesser of billed charges or the Capped Fee-For-Service Schedule rate for the services covered under 9 A.A.C. 22, Article 2 and 9 A.A.C. 28, Article 2.
 - c. By both Medicare and Medicaid, the Administration shall pay the Medicare copay, coinsurance or deductible.
 2. When services are received from a non-registered provider and the service is covered, the Administration shall not pay the Medicare copay, coinsurance or deductible.
- D.** The contractor's payment responsibilities.
1. When an enrolled member receives services within the network of contracted providers and the service is covered up to the limitations described within 9 A.A.C. 22, Article 2:
 - a. By Medicare only, the contractor shall not pay the Medicare copay, coinsurance or deductible.

- b. By Medicaid only, the contractor shall pay the provider in accordance with the subcontract.
 - c. By both Medicare and Medicaid, unless the subcontract with the provider sets forth different terms, the contractor shall pay the lesser of:
 - i. The Medicare copay, coinsurance or deductible, or
 - ii. Any amount remaining after the Medicare paid amount is deducted from the subcontracted rate.
2. When an enrolled member receives services from a non-contracting provider and the service is covered:
- a. By Medicare only, the contractor has no responsibility for payment.
 - b. By Medicaid only, and the contractor has not referred the member to the provider or has not authorized the provider to render services and the services are not emergent, the contractor has no responsibility for payment.
 - c. By Medicaid only, and the contractor has referred the member to the provider or has authorized the provider to render services or the services are emergent, the contractor shall pay in accordance with A.A.C. R9-22-705.
 - d. By both Medicare and Medicaid, and the contractor has not referred the member to the provider or has not authorized the provider to render services and the services are not emergent, the contractor has no responsibility for payment.
 - e. By both Medicare and Medicaid, and the contractor has referred the member to the provider or has authorized the provider to render services or the services are emergent, the contractor shall pay the lesser of:
 - i. The Medicare copay, coinsurance or deductible, or
 - ii. Any amount remaining after the Medicare paid amount is deducted from the amount otherwise payable under A.A.C. R9-22-705.
- E.** Member responsibilities.
1. A Non-QMB Dual eligible member who receives covered services under 9 A.A.C. 22, Article 2 or 9 A.A.C. 28, Article 2 from a provider within the contractor's network is not liable for any Medicare copay, coinsurance or deductible associated with those services and is not liable for any balance of billed charges unless services have reached the limitations described within 9 A.A.C. 22, Article 2.
 2. When an enrolled member chooses to receive services out of network that are covered by both Medicare and Medicaid, the member is responsible for any Medicare copay, coinsurance or deductible associated with those services unless the contractor is responsible as described in A.A.C. R9-22-705 and the provider has complied with A.A.C. R9-22-702.
- F.** Coordination of prescription drug benefit with Medicare Part D. Notwithstanding subsections (A) through (D), services do not include pharmaceutical services to the extent limited under 42 U.S.C. 1396u-5(d). A contractor is not liable for any Medicare copay, coinsurance or deductible associated with pharmaceutical services subject to the limitation under 42 U.S.C. 1396u-5(d).

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-303 repealed; new Section R9-29-303 made by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-304. SLMB and QI-1

AHCCCS shall pay the Medicare Part B premiums.

Historical Note

New Section made by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

ARTICLE 4. REPEALED**R9-29-401. Repealed****Historical Note**

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2). Amended by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-401 repealed by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-402. Repealed**Historical Note**

Adopted effective May 23, 1990 (Supp. 90-2). Repealed effective April 14, 1998 (Supp. 98-2).

R9-29-403. Repealed**Historical Note**

Adopted effective May 23, 1990 (Supp. 90-2). Repealed effective April 14, 1998 (Supp. 98-2).

R9-29-404. Repealed**Historical Note**

Adopted effective May 23, 1990 (Supp. 90-2). Repealed effective April 14, 1998 (Supp. 98-2). Repealed text removed from Section Supp. 01-2.

ARTICLE 5. GRIEVANCE SYSTEM PROCESS**R9-29-501. General Provisions for a Grievance and a Request for Hearing**

A request for hearing under this Chapter shall comply with 9 A.A.C. 34. For the purposes of this Article, "hearing" means an administrative hearing under Title 41, Chapter 6, Article 10.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3372, effective August 7, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-502. Repealed**Historical Note**

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3372, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4).

R9-29-503. Repealed**Historical Note**

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3372, effective August 7, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-503 repealed by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-504. Repealed**Historical Note**

Adopted effective May 23, 1990 (Supp. 90-2). Repealed effective April 14, 1998 (Supp. 98-2).

ARTICLE 6. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES**R9-29-601. First- and Third-party Liability and Recoveries**

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

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2). Amended by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-602. Repealed**Historical Note**

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2). Section repealed by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4).