NOTICES OF EXEMPT RULEMAKING

The Administrative Procedure Act requires the *Register* include publication of the rules adopted by the state's agencies under an exemption from all or part of the Administrative Procedure Act. Some of these rules are exempted by A.R.S. §§ 41-1005 or 41-1057; other rules are exempted by other statutes; rules of the Corporation Commission are exempt from Attorney General review pursuant to a court decision as determined by the Corporation Commission.

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 30. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PREMIUM SHARING DEMONSTRATION PROJECT

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-30-101	Amend
R9-30-201	Amend
R9-30-205	Amend
R9-30-206	Amend
R9-30-215	Amend
R9-30-301	Amend
R9-30-302	Amend
R9-30-303	Amend
R9-30-304	Amend
R9-30-305	Amend
R9-30-306	Amend
R9-30-701	Amend
R9-30-702	Amend

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

Authorizing statute:	A.R.S. § 36-2923 and Laws 1997, Ch. 186, § 7.
Implementing statute:	Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214, § 21; and Laws 1999, Ch. 313 § 31. Laws 1997, Ch. 186 § 4, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 2. Laws 1997, Ch. 186 § 5.

3. The effective date of the rules:

The date filed in the Office of the Secretary of State.

4. A list of all previous notices appearing in the Register addressing the exempt rule:

Not applicable.

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

Name:	Cheri Tomlinson, Federal and State Policy Administrator
Address:	AHCCCS, Office of Policy Analysis and Coordination
	801 East Jefferson, Mail Drop 4200
	Phoenix, AZ 85034
Telephone Number:	(602) 417-4198
Fax Number:	(602) 256-6756

6. An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from the regular rulemaking procedures:

Laws 1997, Ch. 186, § 7 exempts the Administration from the rulemaking requirements of A.R.S. Title 41, Chapter 6 for the purposes of implementing the Premium Sharing Demonstration Project (PSDP). The Administration amended 4 of the 8 Articles in 9 A.A.C. 30 to comply with recent changes to the PSDP by Laws 1999, Ch. 313, § 31 and to provide additional clarification to the rule language.

7. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study, and other supporting material:

None.

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

Not applicable.

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

The Administration anticipates that the PSA and Premium Share members will benefit from the modifications made to the rule language to conform to recent statutory changes. For example, all parties will more clearly understand the waiting list process detailed in R9-30-301. Other changes made to the rule language also benefit the PSA and Premium Share members with greater flexibility in collecting and making premium payments.

In addition, Premium Share applicants and members benefit from other changes to the rule language. For example, a change to R9-30-302 gives Premium Share applicants an additional 5 days to provide the PSA with information and corresponding verification requested by the PSA.

Premium Share contractors will benefit from the additional clarity provided by the rule language but will not be directly impacted by the changes since contractors do not conduct eligibility. The small business community will not be impacted because none of the 3 Premium Share contractors meet the definition of a small business in A.R.S. § 41-1001(19).

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

Not applicable. The Administration is exempt from filing a Notice of Proposed Rulemaking for 9 A.A.C. 30, under Laws 1997, Ch. 186, § 7.

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

The Administration distributed draft copies of the proposed rule amendments to 9 A.A.C. 30 to interested parties. In accordance with Laws 1997, Ch. 186, § 7, the Administration conducted 2 public hearings on November 23, 1999, including 1 in Casa Grande and a videoconference public hearing in Tucson and Phoenix. No stakeholders attended the public hearings.

The Administration received only 2 letters regarding the proposed rule amendments from the Arizona Department of Economic Security, Division of Children, Youth, and Families, and from Maricopa Integrated Health System. Neither entity had comments on the rule package.

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

Not applicable.

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

None.

14. Was this rule previously adopted as an emergency rule?

No.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 30. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

PREMIUM SHARING DEMONSTRATION PROJECT

ARTICLE 1. DEFINITIONS

Section
R9-30-101. Location of Definitions

ARTICLE 2. SCOPE OF SERVICES

Section
R9-30-201. General Requirements
R9-30-205. Primary Care Provider Services
R9-30-206. Organ and Tissue Transplantation Services ~~for a Chronically Ill Member~~
R9-30-215. Other Medical Professional Services

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

Section
R9-30-301. General Requirements
R9-30-302. Timeframes for Determining Eligibility
R9-30-303. Conditions of Eligibility
R9-30-304. Enrollment
R9-30-305. Disenrollment
R9-30-306. Redetermination

ARTICLE 7. PAYMENT RESPONSIBILITIES

Section
R9-30-701. A Premium Share Member's Payment Responsibilities
R9-30-702. The PSA's Scope of Liability: The PSA's Payment Responsibility to Contractors

ARTICLE 1. DEFINITIONS

R9-30-101. Location of Definitions

A. Location of definitions. Definitions applicable to Chapter 30 are found in the following:

Definition	Section or Citation
1. "AHCCCS"	R9-22-101
2. "Ambulance"	R9-22-102
3. "Applicant"	R9-30-101
4. "Chronic disease"	R9-30-102
5. "Chronically ill" member"	R9-30-102
6. "Clean claim"	A.R.S. § 36-2904
7. "Contract year"	R9-30-101
~~7~~ 8. "Contractor"	R9-22-101
~~8~~ 9. "Copayment"	R9-30-107
~~9~~ 10."Covered services"	R9-30-102
~~10~~ 11."Date of application"	R9-30-103
~~11~~ 12."Day"	R9-22-101
~~12~~ 13."Eligible for AHCCCS benefits"	R9-30-103
14. "Eligible household member"	R9-30-101
~~13~~ 15."Emergency medical services"	R9-22-102
~~14~~ 16."Enrollment"	R9-30-103
~~15~~ 17."E.P.S.D.T. services"	R9-22-102
~~16~~ 18."FPL"	R9-30-103
~~17~~ 19."Fund"	A.R.S. § 36-2923
~~18~~ 20."Grievance"	R9-30-106
~~19~~ 21."Head-of-household"	R9-30-103

~~20~~ 22."Hospital"	R9-22-101
~~21~~ 23."Household income"	R9-30-103
~~22~~ 24."Household unit"	R9-30-103
~~23~~ 25."Inpatient hospital services"	R9-30-101
~~24~~ 26."Life threatening"	R9-27-102
~~25~~ 27."Medical record"	R9-22-101
~~26~~ 28."Medical services"	R9-22-101
~~27~~ 29."Medically necessary"	R9-22-101
~~28~~ 30."Month of application"	R9-30-103
~~29~~ 31."Noncontracting provider"	A.R.S. § 36-2931
~~30~~ 32."Offeror"	R9-22-106
~~31~~ 33."Other health care practitioner"	R9-27-101
~~32~~ 34."Outpatient hospital services"	R9-22-107
~~33~~ 35."Pharmaceutical services"	R9-22-102
~~34~~ 36."Plan"	Laws 1997, Ch.186,
~~35~~ 37."Population"	Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21
~~36~~ 38."Practitioner"	R9-22-102
~~37~~ 39."Premium"	R9-30-107
~~38~~ 40."Premium Share"	R9-30-107
~~39~~ 41."Premium Share member"	R9-30-103
~~40~~ 42."Pre-payment"	R9-30-107
~~41~~ 43."Prescription"	R9-22-102
~~42~~ 44."Primary care provider"	R9-22-102
~~43~~ 45."Prior authorization"	R9-22-102
~~44~~ 46."Providers"	A.R.S. § 36-2901
~~45~~ 47."PSA"	R9-30-101
~~46~~ 48."PSDP"	R9-30-101
~~47~~ 49."Quality management"	R9-22-105
~~48~~ 50."Redetermination"	R9-30-103
~~49~~ 51."Referral"	R9-22-101
~~50~~ 52."RFP"	R9-22-105
~~51~~ 53."Service area"	R9-30-103
~~52~~ 54."Scope of services"	R9-22-101
~~53~~ 55."Subcontract"	R9-22-101
~~54~~ 56."System"	A.R.S. § 36-2901
~~55~~ 57."Utilization management"	R9-22-105

B. General definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.

1. "Applicant" means a person who submits, or on whose behalf is submitted, a signed and dated application for enrollment in the PSDP.
2. "Contract year" means October 1 through September 30.
3. "Eligible household member" means a person in a household unit that is eligible for PSDP coverage under this Chapter.
~~2~~ 4. "Inpatient hospital services" means medically necessary services that require an inpatient stay in an acute hospital. Inpatient hospital services are provided by or under the direction of a physician or other health care practitioner upon referral from a Premium Share member's primary care provider.
~~3~~ 5. "PSA" means the Premium Sharing Administration, which is the entity designated by the AHCCCS Director to carry out the administrative functions of the PSDP under Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.
~~4~~ 6. "PSDP" means Premium Sharing Demonstration Project, which is a 3-year pilot program established under A.R.S. § 36-2923.

ARTICLE 2. SCOPE OF SERVICES

R9-30-201. General Requirements

A. In addition to the requirements and limitations specified in this Chapter, the following general requirements apply:
1. Covered services provided to a Premium Share member shall be medically necessary and provided by or under the direction of a primary care provider or dentist; specialist services shall be provided under referral from and in consultation with the primary care provider.
   a. The role or responsibility of a primary care provider, as defined in these rules, shall not be diminished by the primary care provider delegating the provision of primary care for a Premium Share member to a practitioner.
   b. Behavioral health screening and evaluation services may be provided without referral from a primary care provider. Behavioral health treatment services shall be provided only under referral from, and in consultation with, the primary care provider, or upon authorization by the contractor or its designee.
   c. The contractor may waive the referral requirements.
2. Behavioral health services are limited to 30 days of inpatient care and 30 outpatient visits per contract year as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21~~.~~ ; and Laws 1999, Ch. 313, § 31.
3. Services shall be rendered in accordance with state laws and regulations, the Arizona Administrative Code, and PSA contractual requirements.
4. Experimental services as determined by the Director or services provided primarily for the purpose of research shall not be covered.
5. PSDP services shall be limited to those services that are not covered for a Premium Share member who is covered by another funding source as specified in R9-30-301.
6. Services or items, if furnished gratuitously, are not covered and payment shall be denied.
7. Personal care items are not covered and payment shall be denied.
8. Medical or behavioral health services shall not be covered if provided to:
   a. An inmate of a prison;
   b. A person who is in residence at an institution for the treatment of tuberculosis; or
   c. A person who is in an institution for the treatment of a mental disorder, unless provided under this Article.

B. The PSA may require that providers be AHCCCS registered. Services may be provided by AHCCCS registered personnel or facilities that meet state requirements and are appropriately licensed or certified to provide the services.

C. Payment for services or items requiring prior authorization may be denied if prior authorization is not obtained from the contractor. Emergency services as defined in A.A.C. ~~R9-22-102(7)~~ R9-22-102 do not require prior authorization; however, the Premium Share member ~~must~~ shall notify the contractor as required in ~~R9-30-210(C)~~ R9-30-210.
1. The contractor shall prior authorize services for a Premium Share member based on the diagnosis, complexity of procedures, and prognosis, and be commensurate with the diagnostic and treatment procedures requested by the Premium Share member's primary care provider or dentist.
2. Services for unrelated conditions requiring additional diagnostic and treatment procedures require additional prior authorization.
3. In addition to the requirements of Article 7 of this Chapter, written documentation of diagnosis and treatment may be required for reimbursement for services that require prior authorization.

D. A covered service rendered to a Premium Share member shall be provided within the service area of the Premium Share member's contractor except when:
1. A primary care provider refers a Premium Share member out of the contractor's area for medical specialty care;
2. A covered service that is medically necessary for a Premium Share member is not available within the contractor's service area;
3. A net savings in service delivery costs can be documented without requiring undue travel time or hardship for a Premium Share member or the Premium Share member's household;
4. A Premium Share member is placed in a nursing facility located out of the contractor's service area with health plan approval;
5. The service is otherwise authorized by the contractor based on medical practice patterns, and cost or scope of service considerations; or
6. The service is an emergency service as defined in R9-30-210.

E. When a Premium Share member is traveling or temporarily outside of the service area of the Premium Share member's contractor, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

F. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in these rules and in contract.

G. The Director shall determine the circumstances under which a Premium Share member may receive services, other than emergency services as specified in subsection (E), from service providers outside the Premium Share member's county of residence or outside the state. Criteria considered by the Director in making this determination shall include availability, accessibility of appropriate care, and cost effectiveness.

H. If a Premium Share member is referred out of the contractor's service area to receive an authorized medically necessary service for an extended period of time, the contractor shall also provide all other medically necessary covered services prior authorized by the health plan for the Premium Share member during that time.

I. The restrictions, limitations, and exclusions in this Article shall not apply to the costs associated with providing any noncovered service to a Premium Share member and shall not be included in development or negotiation of capitation.

J. Under A.R.S. § 36-2907 the Director may, upon 30 days advance written notice to contractors, modify the list of services for all Premium Share members.

K. A contractor may withhold nonemergency medical services to a Premium Share member who does not pay a copayment in full at time the service is rendered as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21~~.~~ ; and Laws 1999, Ch. 313, § 31.

R9-30-205. Primary Care Provider Services

A. Primary care provider services shall be furnished by a physician or practitioner and shall be covered for a Premium Share member when rendered within the provider's scope of practice under A.R.S. Title 32. Primary care provider services may be provided in an inpatient or outpatient setting and shall include at a minimum:
1. Periodic health examinations and assessments,
2. Evaluations and diagnostic workups,
3. Medically necessary treatment,
4. Prescriptions for medications and medically necessary supplies and equipment,
5. Referrals to specialists or other health care professionals when medically necessary,
6. Patient education,
7. Home visits when determined medically necessary,
8. Covered immunizations, and
9. Covered preventive health services.

B. The following limitations and exclusions apply to primary care provider services:
1. Specialty care and other services provided to a Premium Share member upon referral from a primary care provider shall be limited to the services or conditions for which the referral is made, or for which authorization is given, unless referral is waived by the contractor;
2. If a physical examination is performed with the primary intent to accomplish 1 or more of the objectives listed in subsection (A), it shall be covered by the Premium Share member's contractor, except if there is an additional or alternative objective to satisfy the demands of an outside public or private agency. Alternative objectives may include physical examinations and resulting documentation for:
   a. Qualification for insurance;
   b. Pre-employment physical evaluation;
   c. Qualification for sports or physical exercise activities;
   d. Pilot's examination (FAA);
   e. Disability certification for establishing any kind of periodic payments;
   f. Evaluation for establishing 3rd-party liabilities; or
   g. Physical ability to perform functions that have no relationship to primary objectives listed in subsection (A);
3. Orthognathic surgery shall be covered only for a Premium Share member who is less than 21 years of age; and
4. The following services shall be excluded from PSDP coverage:
   a. Infertility services, reversal of surgically induced infertility (sterilization), and sex change operations;
   b. Abortion counseling services;
   c. Abortions, unless authorized under state law, as specified in A.R.S. § 36-2903.01;
   d. Services or items furnished solely for cosmetic purposes;
   e. Hysterectomies unless determined to be medically necessary;
   f. Elective surgeries with the exception of voluntary sterilization procedures; and
   g. ~~Services~~ Except for breast reconstruction performed by a contracted health plan following a mastectomy under R9-30-215, services or items provided to reconstruct or improve personal appearance after an illness or injury.

R9-30-206. Organ and Tissue Transplantation Services ~~for a Chronically Ill Member~~

A. A Premium Share member is eligible for the following organ transplantation services if prior authorized and coordinated with the Premium Share member's contractor:
1. Kidney transplantation;
2. Cornea transplantation; and
3. Immunosuppressant medications and other related services including medically necessary dental services required prior to and associated with a kidney or cornea transplant;

~~**A.**~~**B.**~~A~~ In addition to a transplantation service in subsections (A)(1) and (A)(2), a Premium Share member who has a chronic illness as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998,

Ch. 214, § 21~~,~~ ; and Laws 1999, Ch. 313, § 31 is eligible for the following organ and tissue transplantation services as specified in A.R.S. § 36-2907 if prior authorized and coordinated with the Premium Share member's contractor:

~~1. Kidney transplantation;~~
~~2. Cornea transplantation;~~
~~3.~~1. Heart transplantation;
~~4.~~2. Liver transplantation;
~~5.~~3. Autologous and allogeneic bone marrow transplantation;
~~6.~~4. Lung transplantation;
~~7.~~5. Heart-lung transplantation;
~~8.~~6. Other organ transplantation if the transplantation is required by A.R.S. § 36-2907, and if other statutory criteria are met; and
~~9.~~7. Immunosuppressant medications, chemotherapy, and other related services including medically necessary dental services required prior to and associated with a transplant.

~~B.~~**C.** Artificial or mechanical hearts and xenografts are not covered services for organ and tissue transplantation services.

R9-30-215. Other Medical Professional Services

A. The following medical professional services provided to a Premium Share member by a contractor, shall be covered services when provided in an inpatient, outpatient, or office setting within the limitations specified below:
1. Dialysis;
2. Family planning services, including medications, supplies, devices, and surgical procedures provided to delay or prevent pregnancy. Family planning services are limited to:
   a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV/AIDS 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;
3. Certified nurse midwife services provided by a certified nurse practitioner in midwifery;
4. Licensed midwife services for prenatal care and home births in low-risk pregnancies if the contractor chooses to provide such services;
5. Podiatry services when ordered by a Premium Share member's primary care provider;
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 when medically necessary and prior authorized;
10. Rehabilitation services including physical therapy, occupational therapy, audiology and speech therapy within limitations in this Article;
11. Total parenteral nutrition services;
12. Chemotherapy; ~~and~~
13. A Premium Share member is eligible for a maximum 30 days of inpatient and of 30 outpatient behavioral health visits per contract year as specified in Laws 1997, Ch 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21~~.~~; and Laws 1999, Ch. 313, § 31; and
14. Breast reconstruction performed by a contracted health plan following a mastectomy under Laws 1999, Ch. 313, § 31.

B. The following shall be excluded as PSDP covered services:
1. Occupational and speech therapies provided on an outpatient basis for a Premium Share member who is 21 years of age or older;
2. Physical therapy provided only as a maintenance regimen;
3. Abortion counseling; or
4. Services or items furnished solely for cosmetic purposes.

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-30-301. General Requirements

A. Expenditure limit. Enrollment in the PSDP is limited to funding as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, and Laws 1999, Ch. 313, § 31 and Laws 1997, Ch. 186, § 4, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 2. The PSA will accept members subject to the availability of funds. ~~A person determined eligible shall be placed~~ The PSA shall place all eligible household members on a waiting list ~~after it is estimated that 80% of the annual expenditures will be reached.~~ when the PSA projects that the program's appropriation will be expended for Premium Sharing members. For this subsection, "Premium Sharing members" includes persons who have requested a hearing regarding a discontinuance. ~~When funding becomes available,~~

~~persons on the waiting list will be contacted and asked to update the original application if it is more than 60 days old. Spaces will be filled in the order that the applicants are determined eligible.~~

B. Participation. Subject to the expenditure limitation specified in subsection (A), and the cap and waiting list requirements in ~~subsection (D)~~ subsections (D) and (E), a person who meets all eligibility requirements shall be approved and shall pay:
1. A copayment every time a service is received, and
2. A monthly income-based premium.

C. Health history questionnaire. An applicant who has been determined eligible for the PSDP shall receive a health history questionnaire which ~~must~~ shall be completed by each eligible household member and returned with the 1st premium payment for each eligible household member to be enrolled in the PSDP.

D. Chronically ill ~~cap and waiting list.~~ cap.
1. The ~~PSA shall limit the~~ total number of ~~all~~ chronically ill members in the PSDP ~~to~~ shall not exceed 200 persons as specified in Laws 1997, Ch. 186, § 4, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 2. When the PSDP has reached the ~~limitation~~ cap of 200 persons, and subject to the expenditure limit as specified in subsection (A), a household with an eligible chronically ill person ~~persons determined eligible~~ shall be placed on a waiting list. ~~When funding becomes available, persons on the waiting list will be contacted, and asked to update the original application if it is more than 60 days old. Spaces will be filled in the order that the applicants are determined eligible.~~
2. The ~~chronic illness~~ chronically ill cap applies to ~~all~~ each chronically ill ~~persons~~ person whose gross ~~household~~ income ~~does not exceed~~ is less than or equal to 400% ~~of~~ FPL.

E. Waiting list requirements.
1. General requirements.
   a. The PSA shall maintain separate lists for households with an eligible chronically ill person and households with no eligible chronically ill persons.
   b. Until the 200 person cap in subsection (D) has been reached, a household with an eligible chronically ill person takes priority over a household with no eligible chronically ill persons.
   c. Subject to subsections (E)(2) and (E)(3), the PSA shall place all eligible household members on a waiting list in order of the household's eligibility determination date. The eligibility determination date shall be the date that PSA determines that all conditions of eligibility have been met. The PSA shall process mail received at PSA in the order it is received, by calendar date.
   d. The PSA shall enroll an eligible person in a household when sufficient spaces are available to enroll all eligible household members. No later than 45 days from the date of notice from PSA that space is available to cover the number of eligible persons in a household, the household shall submit 2 months' premiums and a complete health history questionnaire under subsection (C). The PSA shall enroll all eligible household members under R9-30-304.
2. Waiting list for households with an eligible chronically ill person.
   a. If a member of an enrolled household with no eligible chronically ill persons is determined chronically ill, that person takes priority over a new application for a household with an eligible chronically ill person.
   b. If a member of an enrolled household with no eligible chronically ill persons is determined chronically ill, the person shall remain in the general population until a chronically ill space is available.
3. Waiting list for households with no eligible chronically ill persons. If a chronically ill member of a household with income equal to or below 200% FPL is determined no longer chronically ill, that person takes priority over a new application for a household with no eligible chronically ill persons.
4. Termination from a waiting list. An eligible person in a household on the waiting list shall be terminated from the waiting list for any of the following reasons:
   a. The person no longer meets the eligibility requirements of this Article;
   b. Verification of the death of a person;
   c. Verification that a person no longer resides in a county in which the PSDP operates;
   d. Voluntary withdrawal of the application for the PSDP;
   e. The person cannot be located and mail sent to the person is returned as undeliverable;
   f. The household fails to pay the 1st 2 months' premiums and complete the health history questionnaire;
   g. Verification of other insurance coverage; or
   h. The PSDP expires.

R9-30-302. Timeframes for Determining Eligibility

A. ~~Within 20 days following receipt of application, the~~ The PSA shall review the application and contact the applicant if additional information and verification is needed to complete the eligibility determination.

B. Provisions of verification:
1. Applicants shall provide the PSA with information and corresponding verification requested in subsection (A) within ~~10~~ 15 days following the date the information and verification was first requested by the PSA.

2. The PSA shall extend the time period by 10 days if before the expiration of the time period allotted in subsection (B)(1) the head-of-household requests additional time.

C. The PSA shall determine eligibility ~~within 20 days from the date~~ in the order that all information necessary to determine eligibility is received by ~~PSA.~~ PSA, by calendar date, and within 30 days of receipt of that information.

R9-30-303. Conditions of Eligibility

A. General eligibility requirements for the chronically ill member and the nonchronically ill member.

1. Citizenship/alien status. An applicant shall meet 1 of the following citizenship requirements:
   a. Be a United States citizen as specified in A.R.S § 36-2903.01 and Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, and Laws 1999, Ch. 313, § 31; or
   b. Be a qualified alien as specified in A.R.S. § 36-2903.01.
2. Residency. An applicant shall be a resident of Arizona as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, and Laws 1999, Ch. 313, § 31, and a primary resident of 1 of the following:
   a. Cochise County;
   b. Maricopa County;
   c. Pima County; or
   d. Pinal County.
3. Income.
   a. The PSA shall determine the annualized gross household income from documentation submitted by the applicant that identifies income received by all household members during the ~~3~~ full calendar ~~months~~ month immediately prior to the month of application.
   b. The PSA shall count the annualized gross income from employment, self-employment, rental, public assistance benefits, and other earned and unearned income.
   c. The following amounts shall be deducted from the gross household income:
      i. Payments paid to cover the costs of doing business, and
      ii. Payments paid to cover the costs of producing income from rental property as specified in the PSDP policy manual, and
      iii. Repayment of advances or overpayments by the same payer when those repayments are deducted directly from the income being considered.
   d. The following ~~in-kind~~ income shall be disregarded:
      i. Food stamps,
      ii. Earned income tax credits, and
      iii. ~~Certain lump sum payments.~~ Any portion of lump-sum income intended to cover a period of time prior to the 1-month income period in R9-30-303.
   e. PSA shall average income if income is received irregularly or regularly but from sources or in amounts which vary as follows:
      i. Add together income from a representative number of weeks or months, and
      ii. Divide the resulting sum by the same number of weeks or months to determine the average monthly amount.
   f. PSA shall prorate income if income received is intended to cover a fixed period of time. The income received shall be averaged over the period of time the income is intended to cover to determine a monthly prorated amount.
   g. PSA shall evaluate income under a fixed-term employment contract as follows:
      i. If contract income is received on a monthly or more frequent basis throughout all months of the contract, count the income in the month received;
      ii. If contract income is received before or during the time the work is performed, but not as specified in subsection (A)(3)(g)(i), prorate the income over the number of months in the contract; or
      iii. If payment is received only upon completion of the work, the PSA shall divide the amount of the contract-payment by the number of months in the contract.
   h. PSA shall use the actual amount of income received in a month if the person:
      i. Receives or expects to receive less than a full month's income from a new source,
      ii. Loses a source of income, or
      iii. Is paid daily.
4. Income limits. The annualized gross household income, less deductions shall not exceed 200% of the FPL as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, and Laws 1999, Ch. 313, § 31 for a nonchronically ill member and 400% FPL for a chronically ill person.
5. Income verification.
   a. The applicant shall provide verification for all sources of income received by all household members from all sources during the ~~3~~ full calendar ~~months~~ month immediately prior to the month of application.

b. If the applicant fails to provide verification of income, the PSA shall deny the ~~application shall be denied.~~ application.

6. Household composition. The PSA determines eligibility by household unit. All members of the household ~~must~~ shall be included on the application. The following persons, when living together, are members of the same household:
   a. Head-of-household;
   b. A legal spouse of the head-of-household. This includes spouses who are temporarily away from the home due to employment or who are seeking ~~employment.~~ employment;
   c. A common-law spouse of the head-of-household. A common-law spouse is a legal spouse when the applicant and spouse have lived together in, and met the requirements for, common-law marriage in a state that recognizes these marriages;
   d. Other parent. The other parent or guardian of a common dependent child when that person is not the spouse of the head-of-household; and
   e. A dependent child. A dependent child who is unmarried, has not reached age 19, and is a biological child, adopted child, a step-child of the head-of-household or spouse or both, or the biological child of another dependent child who is a household member, or a child for whom the head-of-household or spouse is a legal guardian unless that child's adult parent is sharing the residence.
7. Cooperation. An applicant shall cooperate in providing the necessary information to verify eligibility.
8. Fraud. An applicant who has been convicted of fraud or abuse in the following programs in any state is not eligible to participate in the Premium Sharing Demonstration Program:
   a. Temporary Assistance to Needy Families (TANF);
   b. Aid to Families with Dependent Children (AFDC);
   c. General Assistance (GA);
   d. KidsCare;
   e. Food Stamps;
   f. Programs established under Title XIX of the Social Security Act; or
   g. State or county sponsored medical assistance programs.
9. Other health care coverage. ~~Except as provided in subsection (B), an applicant who is currently insured, or who has had health care coverage other than AHCCCS in the 6 months prior to application for the PSDP, is not eligible for coverage under the PSDP, as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.~~
   a. An applicant who has health care coverage or who voluntarily terminated health care coverage in the 6 months prior to application for the PSDP, including but not limited to any of the following applicants, is not eligible for coverage under the PSDP:
      i. An applicant who voluntarily terminated federal or state-funded health care coverage in the 6 months prior to application for the PSDP;
      ii. An applicant who had COBRA in the 6 months prior to application for the PSDP and who terminated COBRA before exhausting COBRA coverage;
      iii. An applicant who had COBRA in the 6 months prior to application for the PSDP and who terminated COBRA due to nonpayment of a premium;
      iv. An applicant who voluntarily terminated employment or was terminated due to gross misconduct or for cause;
      v. An applicant who failed to cooperate with the requirements of federal or state-funded health care coverage; and
      vi. An applicant who terminated health care coverage for non-payment of premiums or copayments.
   b. Exclusions from the 6-month bare requirement. An applicant who involuntarily terminated health care coverage in the 6 months prior to application for the PSDP, including but not limited to any of the following applicants, is excluded from the 6-month bare requirement in subsection (A)(9)(a):
      i. An applicant whose employer terminated the applicant's employment other than for cause or gross misconduct;
      ii. An applicant whose employer altered the applicant's employment status, such as changing the applicant's hours from full-time to part-time;
      iii. An applicant who involuntarily terminated health care coverage due to divorce from an insured spouse;
      iv. An applicant who involuntarily terminated health care coverage due to death of an insured spouse;
      v. An applicant who became ineligible for coverage under the applicant's parent's insurance due to age or student status;
      vi. An applicant who involuntarily terminated health care coverage due to a loss of a job and who did not have the option to participate in COBRA;

vii. An applicant who involuntarily terminated health care coverage due to a loss of a job and who had the option to participate in COBRA but who chose not to participate or pay the initial payment;
viii. An applicant who involuntarily terminated health care coverage due to a loss of a job and who chose to participate in COBRA and exhausted COBRA coverage; and
ix. An applicant who became ineligible for health care coverage by reaching a lifetime cap on expenditures imposed by the applicant's insurer.

10. Other limitations.
    a. Veterans Administration (VA) coverage. An applicant who has VA coverage for a medical condition is not eligible for coverage of only that medical condition or medical conditions under the PSDP.
    b. Medicare benefits. An applicant who has Medicare Part A, Medicare Part B, or both, is not eligible for coverage under the PSDP.
    c. AHCCCS benefits. An applicant who is eligible for AHCCCS medical benefits or KidsCare under A.R.S. Title 11, Chapter 2, or A.R.S. Title 36, Chapter 29, is not eligible for the PSDP. The PSA may screen an application to determine if an applicant is eligible for any of these programs. An applicant shall declare whether the applicant has been determined ineligible for these programs. An applicant is encouraged to apply for AHCCCS benefits or KidsCare prior to approval for the PSDP.
    d. Exceptions to AHCCCS benefits. Women who are eligible for family planning assistance under the Sixth Omnibus Budget Reconciliation Act (SOBRA) may apply for the PSDP as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, and Laws 1999, Ch. 313, § 31.
    e. Payor of last resort. The AHCCCS Administration is the payor of last resort. The PSA contractor shall not be the primary payor for any claim involving worker's compensation, automobile insurance, or homeowner's insurance.

B. Requirements for a chronically ill member.

1. Limited enrollment. There is a 200-space limit for the chronically ill. An applicant shall be placed on a waiting list once the spaces are filled or expenditure limits are reached as specified in ~~subsection (A)(1)~~ R9-30-301 and Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, Laws 1999, Ch. 313, § 31 and Laws 1997, Ch. 186, § 4, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 2.
2. Other health care coverage. The requirements in subsection (A)(9) do not apply to a chronically ill member who has an annual gross household income ~~equal to or~~ greater than 200% but equal to or less than 400% of FPL.
3. Chronic illness coverage. The following limitations shall apply for any applicant who meets the requirements for coverage as a chronically ill member as specified in R9-30-102.
    a. Continuous AHCCCS coverage. As a condition of eligibility, an applicant with an annual gross household income ~~equal to or~~ greater than 200% of FPL and equal to or less than 400% of FPL ~~must~~ shall have been eligible for health care services under A.R.S. § 11-297 for at least 12 ~~consecutive~~ months out of the prior 15 consecutive months immediately preceding the month of application for the PSDP.
    b. Medical verification. A member who is chronically ill shall submit a written statement from a physician indicating that the member's illness meets the definition of chronic disease as specified in R9-30-102.
    c. Premium. A chronically ill member and each household member whose gross household income is equal to or less than 400% ~~of the~~ FPL but greater than 200% ~~of the~~ FPL shall pay the full premium as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, and Laws 1999, Ch. 313, § 31.
    d. Failure to claim chronic disease. A chronically ill member who fails to state that the member has 1 of the chronic diseases as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, Laws 1999, Ch. 313, § 31 and R9-30-102 at the time of application may be denied ~~or~~ , referred to the PSA for potential ~~fraud.~~ fraud, or both.

R9-30-304. Enrollment

~~A Premium Share member~~ A household shall pay the premiums for eligible household members ~~and copayments~~ as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, and Laws 1999, Ch. 313, § 31, for continued enrollment in the PSDP.

1. Health plan choice.
    a. Each eligible household ~~unit~~ shall select a health plan at the time of application.
    b. PSA shall enroll all eligible household members with the same health plan.
    c. Each eligible household ~~unit~~ shall have freedom of choice of a PSDP health plan when there are 1 or more health plans in the service area.
2. Open enrollment. The eligible household ~~unit~~ may change contractors during the annual enrollment choice period.
3. Effective date of enrollment. The PSA shall enroll all eligible household members with the contractor under R9-30-701. Premium Share members shall be ineligible for retroactive coverage.

R9-30-305. Disenrollment

A Premium Share member shall be disenrolled from the PSDP as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, and Laws 1999, Ch. 313, § 31.

1. Reasons for disenrollment. A Premium Share member shall be disenrolled from the PSDP ~~when eligibility criteria, as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, are no longer met:~~ for the following reasons:
   a. Nonpayment of premiums ~~and copayments;~~ for the household;
   b. Moving out of the participating counties served by the PSDP;
   c. Providing false or fraudulent information on the Premium Sharing application;
   ~~d. 1 submissions of a check returned for non-sufficient funds during enrollment;~~
   ~~e~~ d. ~~No~~ The person no longer ~~meeting~~ meets the eligibility requirements~~;~~ identified in R9-30-303 and Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, and Laws 1999, Ch. 313, § 31;
   ~~f~~ e. The PSDP expires; or
   ~~g~~ f. Failure or refusal to cooperate in the eligibility process or provide requested information.
2. Exception. A Premium Share member who is confined to a hospital on the effective date of disenrollment shall continue to receive coverage until the contractor's Medical Director or designee determines that care in the hospital is no longer medically necessary for the condition for which the member was admitted or the Premium Share member is discharged from the hospital.
3. Grievance and ~~appeal~~ request for hearing process. A Premium Share member has a right to file a grievance or ~~appeal~~ request for hearing as specified in ~~R9-30-601 et seq.~~ 9 A.A.C. 30, Article 6.
4. PSDP participation. A Premium Share member who ~~has been disenrolled from the PSDP~~ voluntarily terminates PSDP eligibility shall not ~~be allowed to~~ re-enroll for a period of 12 consecutive months. The 12-month period begins with the date of disenrollment and continues for 12 full calendar months as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, and Laws 1999, Ch. 313, § 31.
   a. Disenrollment from the PSDP for nonpayment of a premium is a voluntary termination and subject to the 12-month period.
   b. Voluntary termination from PSDP does not include a disenrollment from the PSDP because of a change in employment status which causes the member's gross household income to exceed the income limit.
5. Health Insurance Portability and Accountability Act (HIPAA) of 1996. A Premium Share member who has been disenrolled shall be allowed to use enrollment in the PSDP as creditable coverage as defined in P.L. 104-191 as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, and Laws 1999, Ch. 313, § 31.

R9-30-306. Redetermination

A. ~~The~~ Except as provided in subsection (C), the PSA shall conduct a redetermination of eligibility on each Premium Sharing household unit ~~once~~ every ~~6~~12 months as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, and Laws 1999, Ch. 313, § 31, unless the household unit becomes ineligible prior to this time.

B. ~~The 6 -month period shall begin with the month the household unit is enrolled.~~ The 12-month period shall begin with the 1st day of the month following the eligibility determination date as determined under R9-30-301 or the most recent redetermination date.

C. The PSA shall conduct a redetermination on a Premium Share household unit when:
   1. A Premium Share member moves from 1 PSDP county to another participating PSDP county or
   2. The PSA has reason to believe that a Premium Share member's situation has changed and the change may affect eligibility or the premium amount paid by the member or household.

~~**D.** A Premium Share member shall remain enrolled in the PSDP if the member continues to meet the criteria in this Article. The Premium Share member shall have a redetermination completed 6 months from the new date of eligibility.~~

ARTICLE 7. PAYMENT RESPONSIBILITIES

R9-30-701. A Premium Share Member's Payment Responsibilities

A. Premium payment requirement. A Premium Share member shall pay the required premium payment established by the PSA as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21~~.~~ ; and Laws 1999, Ch. 313, § 31.

B. Monthly premium payment based on annual household income equal to or less than 200% ~~of~~ FPL, determined by the ~~3-month~~ 1-month income period. A Premium Share member whose gross household income is equal to or less than 200% ~~of the~~ FPL ~~will~~ shall pay a share of the premium. The Premium Share member ~~will~~ shall pay the share of the premium depending on the number of eligible ~~persons in the household,~~ household members and the gross household income.
   1. For 1 eligible household member, the premium share will be equal to 2.5% of the gross household income;

2. For 2 eligible household members, the premium share will be equal to ~~3.0%~~ 3% of the gross household income;
3. For 3 eligible household members, the premium share will be equal to 3.5% of the gross household income;
4. For 4 or more household members, the premium share will be equal to 4% of the gross household income.

C. Premium payment for chronically ill person with gross household income greater than 200% and equal to or less than 400% of FPL. The PSA will require the chronically ill members and their eligible household members whose gross household income is greater than 200% and equal to or less than 400% of the FPL to pay the full premium as established by the PSA.

D. Premium payment schedule. The PSA requires that upon conditional approval of the application, the Premium Share member ~~must~~ shall pay the premium for the 1st 2 months of coverage. If the PSA receives the premium payment on or before the 15th day of the month, enrollment will begin on the 1st day of the next month. If the PSA receives the premium payment after the 15th day of the month, coverage begins on the 1st day of the 2nd month.

E. When and how to submit premium. The Premium Share member shall submit their monthly premium payment to the PSA at least 30 days in advance of the coverage month.

1. All premiums paid in advance by the Premium Share member are nonrefundable, unless the Premium Share member is disenrolled at least 15 days prior to the month of coverage. Premiums paid during a grievance under ~~R9-30-602(E) will not be reimbursed.~~ R9-30-602 are nonrefundable.
2. A Premium Share member's monthly premium shall be paid with sufficient funds in the form of a:
   a. Cashier's check;
   b. Personal check; ~~or~~
   c. Money order~~.~~ ; or
   d. Other means approved by the PSA.
3. A Premium Share member whose payment is returned for nonsufficient funds shall pay the monthly premium in the form of a:
   a. Cashier's check;
   b. Money order; or
   c. Other means approved by the PSA.

F. Newborns. All newborns shall be enrolled within 31 days of birth to be eligible for coverage. Upon enrollment, the newborn's premium is due to the PSA within 31 days of birth for coverage retroactive to the 1st day of the month in which the birth occurred.

G. Copayment requirements. A Premium Share member shall pay the following copayments as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21~~.~~ ; and Laws 1999, Ch. 313, § 31:

1. $10 for each physician visit;
2. $25 for each emergency room visit. This fee shall be waived if the person is admitted to the hospital;
3. $50 for each inpatient stay;
4. $50 for each emergency room visit that is for a non-emergency situation;
5. $3 for each prescription that is filled with a generic drug, and 50% of the cost of each prescription that is filled with a brand name pharmaceutical, unless a generic drug is unavailable or not medically appropriate, in which case the Premium Share member shall pay $3 for each prescription;
6. $8 for each laboratory visit not to exceed $8 per site per day or a maximum copayment of $10 per day for a laboratory visit made on the same day in conjunction with a physician visit;
7. $8 for each x-ray service not to exceed $8 per site, per day or a maximum copayment of $10 per day for a x-ray service made on the same day in conjunction with a physician visit;
8. $50 for each behavioral health admission to an inpatient behavioral facility. Premium Share members are eligible for a maximum of 30 days of inpatient behavioral health services annually;
9. $10 for individual outpatient behavioral health services. Premium Share members are eligible for a maximum of 30 outpatient behavioral health visits annually;
10. $5 for outpatient behavioral health group services; and
11. The full cost of any nonemergency transportation.

H. A contractor may withhold nonemergency medical services to a Premium Share member who does not pay copayments in full at the time service is rendered as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21~~.~~ ; and Laws 1999, Ch. 313, § 31.

R9-30-702. The PSA's Scope of Liability: The PSA's Payment Responsibility to Contractors

A. Liability for covered services. The AHCCCS Administration and the PSA shall have no liability for the provision of covered services or for the completion of a plan of treatment to a Premium Share member beyond the date of disenrollment except when the Premium Share member is confined to a hospital as specified in ~~R9-30-305(2)~~ R9-30-305. The AHCCCS Administration and the PSA shall be liable until care in the hospital is no longer medically necessary for the condition for which the member was admitted.

B. Subcontracts liability. The AHCCCS Administration and the PSA shall have no liability for subcontracts that a contractor may execute with other parties.

C. Contractor's liability for costs. The contractor shall indemnify and hold the AHCCCS Administration and the PSA harmless from any and all liability arising from the contractor's subcontracts, and shall be responsible for:
1. All costs of defense of any litigation concerning the liability; and
2. Satisfaction in full of any judgment entered against the AHCCCS Administration and the PSA in litigation involving the contractor's subcontracts.

D. Capitation rates. The PSA shall establish actuarially sound capitation rates as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21~~.~~ ; and Laws 1999, Ch. 313, § 31. The PSA may adjust the initial capitation rates, except that any increase exceeding 10% of the established rate ~~must~~ shall 1st be reviewed by the oversight committee as specified in Laws 1997, Ch. 186, § 5.

E. Payments. The PSA shall make all payments to a contractor in accordance with the terms and conditions of the contract executed between the contractor and the PSA and in accordance with these rules.

F. Medical financial risk. The PSA will limit the medical financial risk to contractors associated with the PSDP through a risk sharing reconciliation arrangement as specified in contract.

G. Payments made on behalf of a contractor; recovery of indebtedness. The PSA may make payments on behalf of a contractor in order to prevent a suspension or termination of services as specified in A.A.C. R9-22-713.

H. Specialty contracts and payments. The PSA may at any time negotiate or contract for specialty contracts on behalf of providers, and noncontracting providers. The PSA and a contractor shall meet the requirements in A.A.C. R9-22-716.

I. Charges against a Premium Share member. A contractor, subcontractor, or other provider of services shall not:
1. Charge;
2. Submit a claim; or
3. Demand or otherwise collect payment from a Premium Share member or person acting on behalf of a Premium Share member for any covered service except to collect an authorized copayment or payment for a noncovered service. A contractor who makes a claim for a noncovered service shall not charge more than the actual, reasonable cost for providing the service.

J. Collecting payment. Except for copayments under ~~R9-30-701(F)~~, R9-30-701, a provider shall not bill or make any attempt to collect payment, directly or through a collection agency, from a person claiming to be a Premium Share member without 1st receiving verification from the PSA that the person was ineligible for PSDP on the date of service or that the services provided were not covered by PSDP.

K. Premium Share member withheld information. The prohibition in ~~Section~~ subsection (J) shall not apply if the PSA determines that the Premium Share member willfully withheld information pertaining to the Premium Share member's enrollment with a contractor. A prepaid capitated contractor shall have the right to recover from a Premium Share member that portion of payment made by a 3rd-party to the Premium Share member when the payment duplicates the PSDP benefits and the payment has not been assigned to the contractor.

L. 1st and 3rd-party collections and coordination of benefits. The PSA shall recover all 1st- and 3rd-party collections and coordinate benefits under 9 A.A.C. 22, Article 10 and Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21 ; and Laws 1999, Ch. 313, § 31. The PSA is entitled to all rights for liens and claims under A.R.S. §§ 36-2915 and 36-2916.