NOTICES OF FINAL SUMMARY RULEMAKING

The Administrative Procedure Act allows an agency to use the summary rulemaking procedure instead of the regular rulemaking procedure for repeals of rules made obsolete by repeal or supersession of an agency's statutory authority or the adoption, amendment, or repeal of rules that repeat verbatim existing statutory authority granted to the agency. An agency initiating summary rulemaking shall file the proposed summary rulemaking with the Governor's Regulatory Review Council and the Secretary of State's Office for publication in the next available issue of the *Register*. The proposed summary rule takes interim effect on the date of publication in the *Register*.

NOTICE OF FINAL SUMMARY RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 30. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PREMIUM SHARING PROGRAM

PREAMBLE

1. Sections Affected	Rulemaking Action
Chapter 30	Repeal
Article 1	Repeal
R9-30-101	Repeal
R9-30-102	Repeal
R9-30-103	Repeal
R9-30-106	Repeal
R9-30-107	Repeal
Article 2	Repeal
R9-30-201	Repeal
R9-30-204	Repeal
R9-30-205	Repeal
R9-30-206	Repeal
R9-30-207	Repeal
R9-30-208	Repeal
R9-30-209	Repeal
R9-30-210	Repeal
R9-30-211	Repeal
R9-30-212	Repeal
R9-30-213	Repeal
R9-30-215	Repeal
R9-22-216	Repeal
R9-30-217	Repeal
Article 3	Repeal
R9-30-301	Repeal
R9-30-302	Repeal
R9-30-303	Repeal
R9-30-304	Repeal
R9-30-305	Repeal
R9-30-306	Repeal
Article 5	Repeal
R9-30-501	Repeal
R9-30-502	Repeal
R9-30-504	Repeal
R9-30-507	Repeal
R9-30-509	Repeal
R9-30-510	Repeal
R9-30-511	Repeal
R9-30-512	Repeal
R9-30-513	Repeal
R9-30-514	Repeal

R9-30-518	Repeal
R9-30-520	Repeal
R9-30-521	Repeal
R9-30-522	Repeal
R9-30-523	Repeal
R9-30-524	Repeal
Article 6	Repeal
R9-30-601	Repeal
R9-30-602	Repeal
R9-30-603	Repeal
Exhibit A	Repeal
Article 7	Repeal
R9-30-701	Repeal
R9-30-702	Repeal
R9-30-703	Repeal
Article 8	Repeal
R9-30-801	Repeal
R9-30-802	Repeal
R9-30-803	Repeal
R9-30-804	Repeal
R9-30-805	Repeal
R9-30-806	Repeal
R9-30-807	Repeal
R9-30-808	Repeal
R9-30-809	Repeal
Article 9	Repeal
R9-30-901	Repeal
R9-30-902	Repeal
R9-30-903	Repeal

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

Authorizing statute: A.R.S. § 36-2903.01

Implementing statute: None

3. The permanent effective date of the summary rules:

October 10, 2003, effective April 4, 2004

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

Name: Barbara Ledder

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

Telephone: (602) 417-4580

Fax: (602) 253-9115

E-mail: BCLedder@ahcccs.state.az.us

5. The concise explanatory statement, including an explanation of the rule and the agency's reasons for initiating the rule:

In 1997, the Arizona Legislature passed a bill creating the Premium Sharing Program (PSP). The PSP was established as a three-year pilot program in Cochise, Maricopa, Pima, and Pinal Counties, but expanded statewide on October 1, 2001. The PSP is administered by the Premium Sharing Administration (PSA), a subdivision of the Arizona Health Care Cost Containment System (AHCCCS). The Premium Sharing Program, funded solely with state dollars, offered insurance coverage to low income individuals with income above the Medicaid program if they pay modest co-payments and monthly premiums.

HB 2535 (Laws 2003, Ch. 265, § 32) repealed the Premium Sharing Program.

6. A showing of good cause why the rules are necessary to promote a statewide interest if the rules will diminish a previous grant of authority of a political subdivision of this state:
Not applicable

7. The economic, small business, and consumer impact:
An economic, small business, and consumer impact statement is not required pursuant to A.R.S. § 41-1055(D)(2).

8. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:
Not applicable

9. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rules:
AHCCCS held a public hearing on November 12, 2003. There were no attendees from the public.

10. An explanation of why summary proceedings are justified:
This program was repealed sine die, September 18, 2003 per Laws 2003, Ch. 265, § 32. Statutory authority to maintain this program has been repealed. Consequently, the Administration is repealing the entire Chapter as prescribed by statute.

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
Not applicable

12. Incorporations by reference and their location in the rules:
None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 30. ~~ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PREMIUM SHARING PROGRAM~~ REPEALED

ARTICLE 1. ~~DEFINITIONS~~ REPEALED

Section
R9-30-101. ~~Location of Definitions~~ Repealed
R9-30-102. ~~Scope of Services Related Definitions~~ Repealed
R9-30-103. ~~Eligibility and Enrollment Related Definitions~~ Repealed
R9-30-106. ~~Grievance and Request for Hearing Related Definitions~~ Repealed
R9-30-107. ~~Payment Responsibilities Related Definitions~~ Repealed

ARTICLE 2. ~~SCOPE OF SERVICES~~ REPEALED

Section
R9-30-201. ~~General Requirements~~ Repealed
R9-30-204. ~~Inpatient General Hospital Services~~ Repealed
R9-30-205. ~~Primary Care Provider Services~~ Repealed
R9-30-206. ~~Organ and Tissue Transplantation Services~~ Repealed
R9-30-207. ~~Dental Services~~ Repealed
R9-30-208. ~~Laboratory, Radiology, and Medical Imaging Services~~ Repealed
R9-30-209. ~~Pharmaceutical Services~~ Repealed
R9-30-210. ~~Emergency Medical Services and Emergency Behavioral Health Services~~ Repealed
R9-30-211. ~~Transportation Services~~ Repealed
R9-30-212. ~~Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices~~ Repealed
R9-30-213. ~~Health Risk Assessment and Screening Services~~ Repealed
R9-30-215. ~~Other Medical Professional Services~~ Repealed
R9-22-216. ~~Nursing Facility Services~~ Repealed
R9-30-217. ~~Behavioral Health Services~~ Repealed

ARTICLE 3. ~~ELIGIBILITY AND ENROLLMENT~~ REPEALED

Section
R9-30-301. ~~General Requirements~~ Repealed
R9-30-302. ~~Time-frames for Determining Eligibility~~ Repealed
R9-30-303. ~~Conditions of Eligibility~~ Repealed

R9-30-304. ~~Enrollment~~ Repealed
R9-30-305. ~~Disenrollment~~ Repealed
R9-30-306. ~~Redetermination~~ Repealed

ARTICLE 5. ~~GENERAL PROVISIONS AND STANDARDS~~ REPEALED

Section
R9-30-501. ~~General Authority~~ Repealed
R9-30-502. ~~Availability and Accessibility of Services~~ Repealed
R9-30-504. ~~Marketing~~ Repealed
R9-30-507. ~~Member Record~~ Repealed
R9-30-509. ~~Transition and Coordination of Member Care~~ Repealed
R9-30-510. ~~Transfer of a Member~~ Repealed
R9-30-511. ~~Fraud and Abuse~~ Repealed
R9-30-512. ~~Release of Safeguarded Information by the PSA and a Contractor~~ Repealed
R9-30-513. ~~Discrimination Prohibition~~ Repealed
R9-30-514. ~~Equal Opportunity~~ Repealed
R9-30-518. ~~Information to an Enrolled Member~~ Repealed
R9-30-520. ~~Financial Statements, Periodic Reports, and Information~~ Repealed
R9-30-521. ~~Program Compliance Audits~~ Repealed
R9-30-522. ~~Quality Management/Utilization Management (QM/UM) Requirements~~ Repealed
R9-30-523. ~~Financial Resources~~ Repealed
R9-30-524. ~~Continuity of Care~~ Repealed

ARTICLE 6. ~~GRIEVANCE AND REQUEST FOR HEARING~~ REPEALED

Section
R9-30-601. ~~General Provisions for a Grievance and a Request for Hearing~~ Repealed
R9-30-602. ~~Grievance~~ Repealed
R9-30-603. ~~Eligibility Hearing for an Applicant and a Member~~ Repealed
Exhibit A. ~~Grievance and Request for Hearing Process~~ Repealed

ARTICLE 7. ~~PAYMENT RESPONSIBILITIES~~ REPEALED

Section
R9-30-701. ~~A Member's Payment Responsibilities~~ Repealed
R9-30-702. ~~The Administration's Scope of Liability: The Administration's Payment Responsibility to Contractors~~ Repealed
R9-30-703. ~~Contractor's and Provider's Claims and Payment Responsibilities~~ Repealed

ARTICLE 8. ~~MEMBERS' RIGHTS AND RESPONSIBILITIES FOR EXPEDITED HEARINGS~~ REPEALED

Section
R9-30-801. ~~General Intent and Definitions~~ Repealed
R9-30-802. ~~Denial of a Request for a Service~~ Repealed
R9-30-803. ~~Reduction, Suspension, or Termination of a Service~~ Repealed
R9-30-804. ~~Content of Notice~~ Repealed
R9-30-805. ~~Exceptions from an Advance Notice~~ Repealed
R9-30-806. ~~Notice in a Case of Probable Fraud~~ Repealed
R9-30-807. ~~Expedited Hearing Process~~ Repealed
R9-30-808. ~~Maintenance of Records~~ Repealed
R9-30-809. ~~Member Handbook~~ Repealed

ARTICLE 9. ~~CONTRACT PROCESS~~ REPEALED

Section
R9-30-901. ~~General Provisions~~ Repealed
R9-30-902. ~~Contract Compliance Sanction~~ Repealed
R9-30-903. ~~Contract Protest; Grievance and Request for Hearing~~ Repealed

ARTICLE 1. ~~DEFINITIONS~~ REPEALED

R9-30-101. ~~Location of Definitions~~ Repealed
~~A.~~ ~~Location of definitions. Definitions applicable to Chapter 30 are found in the following:~~

~~Definition~~	~~Section or Citation~~
~~"Abuse"~~	~~R9-30-101~~
~~"Administration"~~	~~A.R.S. § 36-2901~~
~~"AHCCCS"~~	~~R9-22-101~~
~~"Ambulance"~~	~~A.R.S. § 36-2201~~
~~"Applicant"~~	~~R9-30-101~~
~~"Chronic disease"~~	~~R9-30-102~~
~~"Chronically ill" member"~~	~~R9-30-102~~
~~"Clean claim"~~	~~A.R.S. § 36-2904~~
~~"Contract year"~~	~~R9-30-101~~
~~"Contractor"~~	~~A.R.S. § 36-2901~~
~~"Copayment"~~	~~R9-30-107~~
~~"Covered services"~~	~~R9-30-102~~
~~"Date of application"~~	~~R9-30-103~~
~~"Date of notice"~~	~~R9-22-108~~
~~"Day"~~	~~R9-22-101~~
~~"Eligible for AHCCCS benefits"~~	~~R9-30-103~~
~~"Eligible household member"~~	~~R9-30-101~~
~~"Emergency medical services"~~	~~R9-22-102~~
~~"Enrollment"~~	~~R9-30-103~~
~~"FPL"~~	~~R9-30-103~~
~~"Fund"~~	~~A.R.S. § 36-2923~~
~~"Grievance"~~	~~R9-22-108~~
~~"Head-of-household"~~	~~R9-30-103~~
~~"Health History Questionnaire"~~	~~R9-30-101~~
~~"Hearing"~~	~~R9-22-108~~
~~"Hospital"~~	~~R9-22-101~~
~~"Household income"~~	~~R9-30-103~~
~~"Household unit"~~	~~R9-30-103~~
~~"Inpatient hospital services"~~	~~R9-30-101~~
~~"Life threatening"~~	~~R9-27-102~~
~~"Medical record"~~	~~R9-22-101~~
~~"Medical services"~~	~~A.R.S. § 36-401~~
~~"Medically necessary"~~	~~R9-22-101~~
~~"Member"~~	~~A.R.S. § 36-2901~~
~~"Month of application"~~	~~R9-30-103~~
~~"Noncontracting provider"~~	~~A.R.S. § 36-2901~~
~~"Offeror"~~	~~R9-22-106~~
~~"Other health care practitioner"~~	~~R9-27-101~~
~~"Outpatient hospital services"~~	~~R9-22-107~~
~~"Pharmaceutical services"~~	~~R9-22-102~~
~~"Practitioner"~~	~~R9-22-102~~
~~"Premium"~~	~~R9-30-107~~
~~"Premium Share"~~	~~R9-30-107~~
~~"Pre-payment"~~	~~R9-30-107~~
~~"Prescription"~~	~~R9-22-102~~
~~"Primary care provider"~~	~~R9-22-102~~
~~"Prior authorization"~~	~~R9-22-102~~
~~"Providers"~~	~~A.R.S. § 36-2901~~
~~"PSP"~~	~~R9-30-101~~
~~"Quality management"~~	~~R9-22-105~~
~~"Redetermination"~~	~~R9-30-103~~
~~"Referral"~~	~~R9-22-101~~
~~"Respondent"~~	~~R9-22-108~~
~~"RFP"~~	~~R9-22-106~~
~~"Service area"~~	~~R9-30-103~~
~~"Scope of services"~~	~~R9-22-101~~
~~"Subcontract"~~	~~R9-22-101~~
~~"System"~~	~~A.R.S. § 36-2901~~
~~"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.~~

~~"Abuse" means the inappropriate chronic, habitual, or compulsive use of any chemical matter that, when introduced into the body, in any way, is capable of causing altered human behavior or altered mental functioning and which, if used over an extended period of time, may cause psychological or physiologic dependence or impairment.~~

~~"Applicant" means a person who submits, or on whose behalf is submitted, a signed and dated application for enrollment in the PSP.~~

~~"Contract year" means October 1 through September 30.~~

~~"Eligible household member" means a person in a household unit that is eligible for PSP coverage under this Chapter.~~

~~"Health History Questionnaire" means a form that is required to be completed by each person in the household, prior to enrollment that is submitted with the initial premium payment, that indicates any previously treated condition, or disease, or medication received by the person.~~

~~"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 primary care provider or other health care practitioner upon referral from a member's primary care provider.~~

~~"PSP" means Premium Sharing Program.~~

R9-30-102. ~~Scope of Services Related Definitions~~ Repealed

~~Definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.~~

~~"Chronic disease" means a non-acute condition that is not caused by alcohol, drug, or chemical abuse, and if not treated has a reasonable medical probability of causing a life-threatening situation or death. For the purposes of the PSP, chronic disease includes only the following diagnoses as defined under Laws 2001, Ch. 385, § 14:~~

~~Alpha-1-Antitrypsin Deficiency,~~
~~Amyotrophic lateral sclerosis (Lou Gehrig's Disease),~~
~~Cardiomyopathy,~~
~~Chronic liver disease,~~
~~Chronic pancreatitis,~~
~~Chronic rheumatoid arthritis,~~
~~Congenital heart disease,~~
~~Cystic fibrosis,~~
~~Growth hormone deficiency,~~
~~Hematologic cancer,~~
~~Hemophilia,~~
~~History of any solid organ transplant~~
~~Acquired immunodeficiency syndrome, Human immunodeficiency virus,~~
~~Hodgkin's disease,~~
~~Metastatic cancer,~~
~~Multiple sclerosis,~~
~~Muscular dystrophy,~~
~~Pulmonary hypertension, and~~
~~Sickle cell disease.~~

~~"Chronically ill member" means a person enrolled with PSP, who has been diagnosed with a chronic disease as defined in this Section and who has an annual gross household income at or below 400 percent of the FPL under A.R.S. § 36-2923.01.~~

~~"Covered services" means the health and medical services specified in Article 2 of this Chapter.~~

R9-30-103. ~~Eligibility and Enrollment Related Definitions~~ Repealed

~~Definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.~~

~~"Date of application" means the date a signed and dated PSP application is received in the Administration office.~~

~~"Eligible for AHCCCS benefits" means enrolled as a member of the Arizona Health Care Cost Containment System, beginning the first day of the month following the date a person has been determined eligible under A.R.S. 36-2901(6).~~

~~"Enrollment" means the process by which a person applies for coverage, is determined eligible, selects a PSP contractor, and begins making full premium payments to the Administration.~~

~~"FPL" means the federal poverty level, the federal poverty guidelines published annually by the United States Department of Health and Human Services.~~

~~"Head-of-household" means the household member who assumes the responsibility for providing PSP eligibility information for the household unit in accordance with Article 3 of this Chapter. The head-of-household may designate a non-household member as the household's representative.~~

~~"Household income" means the total gross amount of all money received by all eligible or ineligible household members~~

~~such as cash, a check, a cashier's check, a money order, or as a deposit into the household member's solely or jointly owned financial account.~~

~~"Household unit" means one or more persons who reside together in a household and are considered in determining eligibility.~~

~~"Month of application" means the calendar month during which a signed and dated PSP application is postmarked if mailed or, if hand-delivered, the date of actual delivery.~~

~~"Redetermination" means the periodic submission of a PSP redetermination form by a current member requesting continuation of PSP coverage, and the review of that application and determination of ongoing eligibility and premium by the Administration.~~

~~"Service area" means the area for which a contractor has contracted with the Administration to provide services to members.~~

R9-30-106. ~~Grievance and Request for Hearing Related Definitions~~ Repealed

~~Definitions. The words and phrases in this Chapter have the same meaning as specified in 9 A.A.C. 22, Article 1 unless the context of the Chapter explicitly requires another meaning.~~

R9-30-107. ~~Payment Responsibilities Related Definitions~~ Repealed

~~Definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.~~

~~"Copayment" means a monetary amount a member pays directly to a provider at the time covered service is rendered.~~

~~"Premium" means the total amount due monthly for the provision of covered services to members.~~

~~"Premium share" means the portion of the premium, not to exceed 6 percent of the member's gross annual household income, a member whose household income is equal to or less than 200 percent of FPL must pay monthly under A.R.S. § 36-2923.01 for the provision of covered services.~~

~~"Pre-payment" means submission of the household's share of the premium. The prepayment is due 30 days before the month of coverage.~~

ARTICLE 2. ~~SCOPE OF SERVICES~~ REPEALED

R9-30-201. ~~General Requirements~~ Repealed

~~A.~~ ~~In addition to the requirements and limitations specified in this Chapter, the following general requirements apply:~~

~~1.~~ ~~Covered services provided to a 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 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 under Laws 2001, Ch. 385, § 13.~~

~~3.~~ ~~Services shall be rendered in accordance with state laws and regulations, the Arizona Administrative Code, and the Administration's contractual requirements.~~

~~4.~~ ~~Experimental services as determined by the Director or services provided primarily for the purpose of research shall not be covered.~~

~~5.~~ ~~PSP services shall be limited to those services that are not covered for a member who is covered by another funding source as specified in A.R.S. § 36-2923.01.~~

~~6.~~ ~~Services or items, if furnished gratuitously, are not covered.~~

~~7.~~ ~~Personal care items are not covered.~~

~~8.~~ ~~Medical or behavioral health services shall not be covered if provided to:~~

~~a.~~ ~~An inmate of a public institution;~~

~~b.~~ ~~A person who is in 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 Administration shall require that providers be AHCCCS registered. Services shall 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 do not require prior authorization; however, the member shall notify the contractor as required in R9-30-210.~~

~~1.~~ ~~The contractor shall prior authorize services for a member based on the diagnosis, complexity of procedures, and prognosis, and be commensurate with the diagnostic and treatment procedures requested by the member's primary care provider or dentist.~~

2. ~~Services for unrelated conditions requiring additional diagnostic and treatment procedures require additional prior authorization.~~
3. ~~The Administration or 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. Documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.~~

D. ~~A covered service rendered to a member shall be provided within the service area of the member's contractor except when:~~
1. ~~A primary care provider refers a member out of the contractor's area for medical specialty care;~~
2. ~~A covered service that is medically necessary for a 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 member or the member's household;~~
4. ~~A member is placed in a nursing facility located out of the contractor's service area with contractor 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 member is traveling or temporarily outside of the service area of the 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 member may receive services, other than emergency services as specified in subsection (E), from service providers outside the contractor's service area 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 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 contractor for the member during that time.~~

I. ~~The restrictions, limitations, and exclusions in this Article shall not apply to the costs associated with providing any non-covered service to a 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 members.~~

K. ~~A contractor may withhold nonemergency medical services to a member who does not pay a copayment in full at time the service is rendered under A.R.S. § 36-2923.01.~~

R9-30-204. ~~Inpatient General Hospital Services~~ Repealed

A. ~~The contractor shall provide inpatient general hospital accommodations and appropriate staffing, supplies, equipment, and services for:~~
1. ~~Maternity care;~~
2. ~~Neonatal intensive care (NICU);~~
3. ~~Intensive care (ICU);~~
4. ~~Surgery;~~
5. ~~Nursery;~~
6. ~~Routine care; and~~
7. ~~Behavioral health (psychiatric) care:~~
   a. ~~A member is eligible for a maximum of 30 days of inpatient behavioral health services per contract year under Laws 2001, Ch. 385, § 13.~~
   b. ~~For the purpose of this Section, the PSP contract year shall be October 1 through September 30.~~

B. ~~The contractor shall provide ancillary services as specified by the Director and included in contract:~~
1. ~~Labor, delivery, recovery rooms, and birthing centers;~~
2. ~~Surgery and recovery rooms;~~
3. ~~Laboratory services;~~
4. ~~Radiological and medical imaging services;~~
5. ~~Anesthesiology services;~~
6. ~~Rehabilitation services;~~
7. ~~Pharmaceutical services and prescribed drugs;~~
8. ~~Respiratory therapy;~~
9. ~~Blood and blood derivatives;~~
10. ~~Central supply items, appliances, and equipment not ordinarily furnished to all patients and which are customarily reimbursed as ancillary services;~~
11. ~~Maternity services; and~~
12. ~~Nursery and related services.~~

R9-30-205. ~~Primary Care Provider Services~~ Repealed

~~**A.** Primary care provider services shall be furnished by a physician or practitioner and shall be covered for a 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 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 one or more of the objectives listed in subsection (A), it shall be covered by the 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 third-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 member who is less than 18 years of age; and~~
~~4. The following services shall be excluded from PSP coverage:~~
~~a. Infertility services, reversal of surgically induced infertility (sterilization), and sex change operations;~~
~~b. Pregnancy termination counseling services;~~
~~c. Pregnancy termination, unless authorized under state law, as specified in A.R.S. § 35-196.02;~~
~~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. Except for breast reconstruction performed by a contracted contractor 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~~ Repealed

~~A. A member is eligible for the following organ transplantation services under A.R.S. § 36-2923.01 if prior authorized and coordinated with the 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.~~

~~**B.** In addition to a transplantation service in subsection (A), a member who has a chronic illness under A.R.S. § 36-2923.01 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 member's contractor:~~

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

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

R9-30-207. ~~Dental Services~~ Repealed

~~**A.** A contractor shall cover the following emergency dental care services:~~
- ~~1. Emergency oral diagnostic examination including laboratory and radiographs when necessary to determine an emergent condition;~~
- ~~2. Immediate palliative treatment, including extractions when professionally indicated, for relief of severe pain associated with an oral or maxillofacial condition;~~
- ~~3. Initial treatment for acute infection;~~
- ~~4. Immediate and palliative procedures for acute craniomandibular problems and for traumatic injuries to teeth, bone, or soft tissue;~~
- ~~5. Preoperative procedures; and~~
- ~~6. Anesthesia appropriate for optimal patient management.~~

~~**B.** Covered denture services include medically necessary dental services and procedures associated with, and including, the provision of dentures.~~

R9-30-208. ~~Laboratory, Radiology, and Medical Imaging Services~~ Repealed

~~Laboratory, radiology, and medical imaging services shall be covered services if:~~
- ~~1. Prescribed for a member by the primary care provider or the dentist, unless referral is waived by the contractor;~~
- ~~2. Provided in a hospital, clinic, physician office or other health care facility by a licensed health care provider; and~~
- ~~3. Provided by a provider that meets all applicable state license and certification requirements and provides only services that are within the scope of practice stated in the provider's license or certification.~~

R9-30-209. ~~Pharmaceutical Services~~ Repealed

~~**A.** Pharmaceutical services may be provided by an inpatient or outpatient provider including hospitals, clinics, or appropriately licensed health care facilities and pharmacies.~~

~~**B.** The contractor shall make pharmaceutical services available during customary business hours and shall be located within reasonable travel distance of a member's residence.~~

~~**C.** Pharmaceutical services shall be covered upon authorization by the contractor or its designee's formulary if prescribed for a member by:~~
- ~~1. The member's primary care provider or dentist;~~
- ~~2. A specialist, upon referral from the member's primary care provider or dentist; or~~
- ~~3. A specialist without a referral by the member's primary care provider or dentist if the contractor has waived the referral requirement.~~

~~**D.** The following limitations shall apply to pharmaceutical services:~~
- ~~1. A medication personally dispensed by a primary care provider or dentist is not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.~~
- ~~2. A prescription in excess of a 30-day supply or a 100-unit dose is not covered unless:~~
  - ~~a. The medication is prescribed for a chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is more.~~
  - ~~b. The member will be out of the contractor's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 days or 100-unit dose, whichever is more.~~
- ~~3. A nonprescription medication is not covered unless the nonprescription medication is an appropriate alternative medication and less costly than a prescription medication.~~
- ~~4. A prescription is not covered if filled or refilled in excess of the number specified, or if an initial prescription or refill is dispensed after one year from the original prescribed order.~~
- ~~5. Approval by the authorized prescriber is required for all changes in or additions to an original prescription. The date of a prescription change is to be clearly indicated and initialed by the dispensing pharmacist.~~

~~**E.** A contractor shall monitor and take necessary actions to ensure that a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being, is provided sufficient services to eliminate any gap in the required pharmaceutical regimen.~~

R9-30-210. ~~Emergency Medical Services and Emergency Behavioral Health Services~~ Repealed

~~**A.** Emergency medical services and emergency behavioral health services shall be provided to a member by licensed providers.~~

~~**B.** Emergency medical services and emergency behavioral health services shall be available 24 hours per day, seven days per week in each contractor's service area.~~

~~**C.** The member shall notify the contractor within 48 hours after the initiation of treatment. If a member is incapacitated, the provider is responsible for notifying the contractor within 48 hours after the initiation of treatment. Failure of the member or provider to notify the contractor as required may result in denial of payment.~~

~~**D.** Consultation provided by a psychiatrist or psychologist shall be covered as an emergency service if required to evaluate or stabilize an acute episode of mental illness or substance abuse.~~

~~**E.** Emergency services do not require prior authorization.~~

~~1. Providers, nonproviders, and noncontracting providers furnishing emergency services to a member shall notify the member's contractor within 12 hours following the time the member presents for services;~~
~~2. If a member's medical condition is determined not to be an emergency medical condition as defined in A.A.C. R9-22-101, the provider shall notify the member's contractor before initiation of treatment and follow the prior authorization requirements and protocol of the contractor regarding treatment of the member's nonemergency condition. Failure by the provider to provide timely notice or to comply with prior authorization requirements of the contractor constitutes cause for denial of payment.~~

R9-30-211. ~~Transportation Services~~ Repealed

~~**A.** Emergency ambulance services.~~
~~1. Emergency ambulance transportation shall be a covered service for a member. Payment shall be limited to the cost of transporting the member 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. When no other means of transportation is both appropriate and available.~~
~~2. A ground or air ambulance transport that originates in response to a 911 call or other emergency response system shall be reimbursed according to the terms and conditions that the Administration specified in the contractor's contract, if the medical condition at the time of transport justified a medically necessary or emergency ambulance transport. No prior authorization is required for reimbursement of these transports.~~
~~3. Determination of whether transport is medically necessary shall be based upon the medical condition of the member at the time of transport.~~
~~4. A ground or air ambulance provider furnishing transportation 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 to notify the contractor may constitute cause for denial of claims.~~
~~**B.** Medically necessary nonemergency transportation. A member is responsible for the full cost of any nonemergency transportation under Laws 2001, Ch. 385, § 13.~~

R9-30-212. ~~Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices~~ Repealed

~~**A.** Medical supplies, durable equipment, and orthotic and prosthetic devices shall be covered services if:~~
~~1. Prescribed for a member by the member's primary care provider, unless referral is waived by the contractor; or~~
~~2. Provided in compliance with requirements of this Chapter; and~~
~~3. Provided in compliance with the contractor's requirements.~~
~~**B.** Medical supplies include consumable items covered under Medicare that are provided to a member and that are not reusable.~~
~~**C.** Medical equipment includes any durable item, appliance, or piece of equipment that is designed for a medical purpose, is generally reusable by others, and is purchased or rented for a member.~~
~~**D.** Prosthetic and orthotic devices include only those items that are essential for the habilitation or rehabilitation of a member.~~
~~**E.** Prescriptive lenses are covered if they are the sole prosthetic device after a cataract extraction.~~
~~**F.** The following limitations apply:~~
~~1. If medical equipment cannot be reasonably obtained from alternative resources at no cost, the medical equipment shall be furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the equipment shall not exceed the cost of the equipment if purchased.~~
~~2. Reasonable repair or adjustment of purchased medical equipment shall be covered if necessary to make the equipment serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.~~
~~3. Changes in, or additions to, an original order for medical equipment shall be approved by the member's primary care provider or authorized prescriber and shall be indicated clearly and initialed by the vendor. No change or addition to the original order for medical equipment may be made after a claim for services has been submitted to the member's contractor, without prior written notification of the change or addition.~~
~~4. Rental fees shall terminate:~~
~~a. No later than the end of the month in which the primary care provider or authorized prescriber certifies that the member no longer needs the medical equipment;~~
~~b. When the member is no longer eligible for PSP services; or~~
~~c. When the member is no longer enrolled with a contractor, with the exception of transition of care as specified by the Director.~~
~~5. Personal incidentals, including items for personal cleanliness, body hygiene, and grooming, shall not be covered unless needed to treat a medical condition and provided in accordance with a prescription.~~
~~6. First aid supplies shall not be covered unless they are provided in accordance with a prescription.~~
~~7. Hearing aids and prescriptive lenses shall not be covered for a member who is 18 years of age and older, unless authorized under subsection (E).~~
~~**G.** Liability and ownership.~~

1. ~~Purchased durable medical equipment provided by a contractor for a member, but which is no longer needed, may be disposed of in accordance with each contractor's policy.~~
2. ~~The contractor shall retain title to purchased durable medical equipment supplied to a member who becomes ineligible or no longer requires its use.~~
3. ~~If customized durable medical equipment is purchased by the contractor for a member, the equipment will remain with the person during times of transition or if the person becomes ineligible.~~
   a. ~~For purposes of this Section, customized durable medical equipment refers to equipment that has been altered or built to specifications unique to a member's medical needs and which, most likely, cannot be used or reused to meet the needs of another person.~~
   b. ~~Customized equipment obtained fraudulently by a member shall be returned for disposal to the member's contractor if the customized equipment was purchased for a member.~~

R9-30-213. ~~Health Risk Assessment and Screening Services~~ Repealed

~~A.~~ ~~The following services shall be covered for a member less than 18 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; and~~
   c. ~~Provision of prescriptive lenses;~~
3. ~~Hearing services, including:~~
   a. ~~Diagnosis and treatment for defects in hearing;~~
   b. ~~Testing to determine hearing impairment; and~~
   c. ~~Provision of hearing aids;~~
4. ~~Dental services including:~~
   a. ~~Emergency dental services as specified in R9-30-207;~~
   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; and~~
6. ~~Behavioral health services specified in this Chapter;~~

~~B.~~ ~~All providers of services shall meet the following standards:~~
1. ~~Provide services by, or under the direction of, the member's primary care provider or dentist;~~
2. ~~Perform tests and examinations in accordance with the Administration Periodicity Schedule:~~
   a. ~~Refer a member as necessary for dental diagnosis and treatment, and necessary specialty care; or~~
   b. ~~Refer a member as necessary for behavioral health evaluation and treatment services.~~

R9-30-215. ~~Other Medical Professional Services~~ Repealed

~~A.~~ ~~The following medical professional services provided to a 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 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;~~
~~13. A member is eligible for a maximum 30 days of inpatient and of 30 outpatient behavioral health visits per contract year under Laws 2001, Ch. 385, § 13; and~~
~~14. Medically necessary breast reconstruction performed by a contracted contractor following a mastectomy under A.R.S. § 36-2923.01.~~

~~**B.** The following shall be excluded as PSP covered services:~~
~~1. Occupational and speech therapies provided on an outpatient basis for a 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.~~

R9-30-216. ~~Nursing Facility Services~~ Repealed

~~**A.** Nursing facility services including room and board shall be covered for a maximum of 90 days per contract year if the medical condition of a member would require hospitalization if nursing facility services were not provided.~~
~~**B.** Except as otherwise provided in 9 A.A.C. 28, the following services shall be excluded for purpose of separate billing if provided in a nursing facility:~~
~~1. Nursing services including but not limited to:~~
~~a. Administration of medication;~~
~~b. Tube feedings;~~
~~c. Personal care services (assistance with bathing and grooming);~~
~~d. Routine testing of vital signs; and~~
~~e. Maintenance of catheters;~~
~~2. Basic patient care equipment and sickroom supplies, including, but not limited to:~~
~~a. First aid supplies such as:~~
~~i. Bandages,~~
~~ii. Tape,~~
~~iii. Ointments,~~
~~iv. Peroxide,~~
~~v. Alcohol, and~~
~~vi. Over-the-counter remedies;~~
~~b. Bathing and grooming supplies;~~
~~c. Identification devices;~~
~~d. Skin lotions;~~
~~e. Medication cups;~~
~~f. Alcohol wipes, cotton balls, and cotton rolls;~~
~~g. Rubber gloves (non sterile);~~
~~h. Laxatives;~~
~~i. Beds and accessories;~~
~~j. Thermometers;~~
~~k. Ice bags;~~
~~l. Rubber sheeting;~~
~~m. Passive restraints;~~
~~n. Glycerin swabs;~~
~~o. Facial tissue;~~
~~p. Enemas;~~
~~q. Heating pads;~~
~~r. Diapers; and~~
~~s. Alcoholic beverages;~~
~~3. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating;~~
~~4. Any services that are included in a nursing facility's room and board charge or services that are required of the nursing facility to meet federal mandates, state licensure standards, or county certification requirements;~~
~~5. Administrative 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 durable medical equipment.~~
~~**C.** Each admission shall be prior authorized by the contractor for a member.~~

R9-30-217. ~~Behavioral Health Services~~ Repealed

~~**A.** General requirements. A member with a behavioral or substance abuse disorder shall be eligible for behavioral health services with the limitations of 30 days of inpatient and 30 outpatient visits per contract year under Laws 2001, Ch. 385, § 13.~~

~~**B.** Service delivery system and referral. A contractor shall be responsible for the provision of medically necessary behavioral health services to a member.~~

~~**C.** Covered behavioral health services for a member:~~

~~1. The following requirements apply with respect to behavioral health services provided under this Article, subject to all applicable exclusions and limitations.~~

~~a. The service shall be medically necessary, cost effective, and PSP reimbursable;~~

~~b. The service shall be provided by qualified service providers as specified in contract;~~

~~c. A service provider, as applicable, shall contract with a contractor;~~

~~d. A service shall be authorized, as applicable, by the contractor; and~~

~~e. A service shall be provided in appropriate residential settings which meet state licensing standards;~~

~~2. The following behavioral health services shall be covered, subject to the limitations and exclusions in the contract:~~

~~a. Inpatient services,~~

~~b. Professional services,~~

~~c. Rehabilitation services,~~

~~d. Evaluation and case management services,~~

~~e. Behavioral health-related services,~~

~~f. Emergency transportation services,~~

~~g. Qualifications and standards of participation for service providers, and~~

~~h. Utilization control.~~

ARTICLE 3. ~~ELIGIBILITY AND ENROLLMENT~~ REPEALED

R9-30-301. ~~General Requirements~~ Repealed

~~**A.** Expenditure limit. Enrollment is limited to funding under A.R.S. § 36-2923.01. The Administration will accept applications subject to the availability of funds. If the Administration determines that enrollment must be suspended due to the limitation of funding, the Administration shall use the waiting list process under subsection (E).~~

~~**B.** Participation. Subject to the expenditure limitation specified in subsection (A) and the cap and waiting list requirements in 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 paid in full and within the member's payment responsibility under R9-30-701. Failure of the member to make payments under this subsection is cause for termination of PSP coverage.~~

~~**C.** Health history questionnaire. Each eligible household member shall complete and return a health history questionnaire with the initial payment of two monthly premiums.~~

~~**D.** Chronically ill cap.~~

~~1. The chronically ill cap applies to each chronically ill applicant whose gross income is less than or equal to 400 percent FPL.~~

~~2. The total number of chronically ill members in the PSP shall not exceed 200 persons under A.R.S. § 36-2923.01 and is subject to the expenditure limit under subsection (A).~~

~~3. If the Administration determines that enrollment must be suspended due to the limitation of funding, the Administration shall use a waiting list as described in subsection (E).~~

~~**E.** Waiting list requirements.~~

~~1. General requirements.~~

~~a. The Administration 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 (3) the Administration shall place an applicant on a waiting list in the order the application is received, by the calendar date as evidenced by the Administration's date stamp on the application with the following exception. The Administration shall give first priority on the wait list to a parent who:~~

~~i. Was enrolled in PSP immediately prior to eligibility under A.R.S. § 36-2981.01; and~~

~~ii. Would retain eligibility under A.R.S. § 36-2981.01 except for the child's loss of eligibility, unless the reason for ineligibility is non-payment of the child's or parent's monthly premium.~~

~~d. The Administration shall enroll an eligible person in a household when sufficient spaces are available to enroll all eligible household members.~~

~~e. When space and funding is available, the Administration shall notify applicants, in writing, of the availability of spaces.~~

f. ~~The Administration shall request that the applicant submit updated information or a new application as appropriate.~~

g. ~~The Administration shall notify each applicant regarding the outcome of the eligibility determination. If the applicant is determined eligible, the Administration shall mail a written notice that instructs the eligible person to submit an initial premium payment, in full, for the first two months of coverage prior to the initial enrollment.~~

h. ~~If the Administration receives the full premium payment on or before the 15th day of the month following the date of the notice, enrollment will begin on the first day of the next month. If the Administration receives the full premium payment after the 15th day of the month following the date of the notice, coverage begins on the first day of the second month. No retroactive coverage is available.~~

2. ~~Waiting list for a household with an eligible chronically ill person. If a member of an enrolled household with no eligible chronically ill persons is determined chronically ill, the member shall:~~

a. ~~Take priority over a new application for a household with an eligible chronically ill person, or~~

b. ~~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 percent 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. The Administration shall terminate an applicant from the wait list for any of the following reasons:~~

a. ~~The person does not meet the eligibility requirements of this Article;~~

b. ~~Verification of the death of a person;~~

c. ~~Voluntary withdrawal of the application for the PSP;~~

d. ~~The person cannot be located and mail sent to the person is returned as undeliverable;~~

e. ~~The household fails to pay the first two months' of premiums and complete the health history questionnaire; or~~

f. ~~Verification of other insurance coverage.~~

R9-30-302. ~~Time frames for Determining Eligibility~~ Repealed

~~A.~~ ~~The Administration shall review the application in date order and contact the applicant if additional information and verification is needed to complete the eligibility determination.~~

~~B.~~ ~~Provisions of verification:~~

1. ~~An applicant shall provide the Administration with information and corresponding verification requested in subsection (A) within 15 days following the date the information and verification was first requested by the Administration.~~

2. ~~The Administration 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.~~ ~~Unless the Administration has suspended applications under Section R9-30-301(A), the Administration shall determine eligibility in the order that all information necessary to determine eligibility is received by the Administration, by the calendar date that the Administration receives and date stamps the application.~~

R9-30-303. ~~Conditions of Eligibility~~ Repealed

~~A.~~ ~~General eligibility requirements.~~

1. ~~Citizenship/alien status. An applicant shall meet one of the following requirements:~~

a. ~~Be a United States citizen as specified in A.R.S. § 36-2903.01 and A.R.S. § 36-2923.01; 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 under A.R.S. § 36-2923.01.~~

3. ~~Income.~~

a. ~~The Administration shall determine the annualized gross household income from documentation submitted by the applicant that identifies income received by all household members during the full calendar month immediately prior to the month of application.~~

b. ~~The Administration shall count the annualized gross income from employment, self-employment, rental, public assistance benefits, and other earned and unearned income.~~

c. ~~The Administration shall deduct the following amounts from the gross household income:~~

i. ~~Payments paid to cover the costs of doing business,~~

ii. ~~Payments paid to cover the costs of producing income from rental property as specified in the PSP 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 Administration shall disregard the following income:~~

i. ~~Food stamps,~~

ii. ~~Earned income tax credits, and~~

iii. ~~Any portion of lump-sum income intended to cover a period of time prior to the 1-month income period in R9-30-303.~~

c. The Administration shall average income if income is received irregularly or regularly but from sources or in amounts that 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. The Administration 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. The Administration 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 Administration shall divide the amount of the contract payment by the number of months in the contract.
h. The Administration shall use the actual amount of income received in a month if the applicant:
   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 percent of the FPL for a nonchronically ill member and 400 percent FPL for a chronically ill person under A.R.S. § 36-2923.01.
5. Income verification.
   a. The applicant shall provide verification for all sources of income received by all household members during the full calendar month immediately prior to the month of application.
   b. If the applicant fails to provide verification of income, the Administration shall deny the application.
6. Household composition. The Administration determines eligibility by household unit. All members of the household shall be included on the application. In computing the household size and income limit, a pregnant woman is counted as a minimum of two persons. The following persons, when living together, are members of the same household:
   a. Head-of-household;
   b. A spouse as defined in A.A.C. R9-22-101. This includes a spouse who is temporarily away from home for employment or to seek employment;
   c. 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
   d. A dependent child means a child who is unmarried, has not reached age 19, and
      i. Is a biological child, adopted child, a step-child of the head-of-household or spouse or both, or
      ii. The biological child of another dependent child who is a household member, or
      iii. 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 under A.R.S. § 36-2923.01 is not eligible to participate in the Premium Sharing Program.
9. Other health care coverage.
   a. An applicant who has health care coverage or who voluntarily terminated health care coverage in the 30 days prior to application for the PSP, including but not limited to any of the following applicants, is not eligible for coverage under the PSP under A.R.S. § 36-2923.01:
      i. An applicant who voluntarily terminated federal or state-funded health care coverage, except voluntary PSP terminations, which must wait 12 months under R9-30-305;
      ii. An applicant who had COBRA and who terminated COBRA before exhausting COBRA coverage;
      iii. An applicant who had COBRA 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 30 days bare requirement. An applicant who involuntarily terminated health care coverage in the 30 days prior to application for the PSP, including but not limited to any of the following applicants, is excluded from the 30 days 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 coverage limited to the applicant's service related injuries under the VA is eligible for PSP limited to those medical conditions not covered under the VA.
b. Medicare benefits. An applicant who is eligible for Medicare Part A, Medicare Part B, or both, is not eligible for coverage under the PSP.
c. AHCCCS benefits. An applicant who is eligible for AHCCCS medical benefits or KidsCare under A.R.S. Title 36, Chapter 29, Article 2 or 4, is not eligible for the PSP. The Administration 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 PSP.
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 PSP under A.R.S. § 36-2923.01.
e. Payor of last resort. The Administration is the payor of last resort under A.R.S. § 36-2923.01. The contractor shall not be the primary payor for any claim involving worker's compensation, automobile insurance, or homeowner's insurance.

B. Additional requirements for a chronically ill member or applicant.
1. Limited enrollment. There is a 200-space limit for the chronically ill. The Administration shall place an applicant or member on a waiting list once the spaces are filled or expenditure limits are reached under A.R.S. § 36-2923.01.
2. Other health care coverage. The requirements in subsection (A)(9) do not apply to a chronically ill member or applicant who has an annual gross household income greater than 200 percent but equal to or less than 400 percent 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. Medical verification. A member or applicant who is chronically ill shall submit a written statement from a physician indicating that the illness meets the definition of chronic disease as specified in R9-30-102.
b. Premium. A chronically ill member or applicant and each household member whose gross household income is equal to or less than 400 percent FPL but greater than 200 percent FPL shall pay the full premium under A.R.S. § 36-2923.01.
c. Failure to claim chronic disease. A chronically ill member who fails to state that the member has one of the chronic diseases under Laws 2001, Ch. 385, § 14 and R9-30-102 at the time of application may be denied, referred to the Administration for potential fraud, or both.

R9-30-304. ~~Enrollment~~ Repealed

A household shall pay the premiums for eligible household members under A.R.S. § 36-2923.01 for continued enrollment in the PSP.
1. Contractor choice.
a. Each eligible household shall select a contractor at the time of application.
b. The Administration shall enroll all eligible household members with the same contractor.
c. Each eligible household shall have freedom of choice of a PSP contractor when there are one or more contractors in the service area.
2. Open enrollment. The eligible household may change contractors during the annual enrollment choice period.
3. Effective date of enrollment. The Administration shall enroll all eligible household members with the contractor under R9-30-701. Members shall be ineligible for retroactive coverage.

R9-30-305. ~~Disenrollment~~ Repealed

A. A member shall be disenrolled from the PSP under A.R.S. § 36-2923.01 for the following reasons:
1. Nonpayment of premiums for the household;
2. Untimely payments;
3. Providing false or fraudulent information on the Premium Sharing application;

4. ~~Violence, or threatening or other substantially abusive behavior toward the Administration or the PSP employees or agents, or contracting or noncontracting providers or their employees or agents;~~
5. ~~The person no longer meets the eligibility requirements identified in R9-30-303 and A.R.S. § 36-2923.01; or~~
6. ~~Failure or refusal to cooperate in the eligibility process or provide requested information.~~

~~**B.** A 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 member is discharged from the hospital.~~

~~**C.** Grievance and request for hearing process. A member has a right to file a grievance or request for hearing as specified in Article 6.~~

~~**D.** PSP participation. A member who voluntarily terminates PSP eligibility shall not re-enroll for a period of 12 consecutive months under A.R.S. § 36-2923.01. The 12-month period begins with the date of disenrollment and continues for 12 full calendar months.~~

1. ~~Disenrollment from the PSP or nonpayment of a premium is a voluntary termination and subject to the 12-month period.~~
2. ~~Voluntary termination from PSP does not include a disenrollment from the PSP because of a change in employment status that causes the member's gross household income to exceed the income limit.~~

~~**E.** Health Insurance Portability and Accountability Act of 1996. A member who has been disenrolled shall be allowed to use enrollment in the PSP as creditable coverage as defined in P.L. 104-191 under A.R.S. § 36-2923.01.~~

R9-30-306. ~~Redetermination~~ Repealed

~~**A.** Except as provided in subsection (C), the Administration shall conduct a redetermination of eligibility on each Premium Sharing household unit no less often than every 12 months under A.R.S. 36-2923.01 unless the household unit becomes ineligible prior to this time.~~

~~**B.** The 12-month period shall begin with the first day of the month following the eligibility determination date as determined under R9-30-301 or the most recent redetermination date.~~

~~**C.** The Administration shall conduct a redetermination on a household unit when the Administration has reason to believe that a member's situation has changed and the change may affect eligibility or the premium amount paid by the member or household.~~

ARTICLE 5. ~~GENERAL PROVISIONS AND STANDARDS~~ REPEALED

R9-30-501. ~~General Authority~~ Repealed

~~The Director shall administer the PSP and has full operational authority to carry out administrative functions under A.R.S. § 36-2923.01.~~

R9-30-502. ~~Availability and Accessibility of Services~~ Repealed

~~**A.** A contractor shall provide adequate numbers of available and accessible:~~

1. ~~Institutional facilities;~~
2. ~~Service locations;~~
3. ~~Service sites; and~~
4. ~~Professional, allied, and paramedical personnel for the provision of covered services, including all emergency medical services for 24 hours a day, seven days a week.~~

~~**B.** A contractor shall minimally provide the following:~~

1. ~~A ratio of the number of primary care providers to the number of adults and children, as specified in contract;~~
2. ~~A designated emergency services facility, providing care 24 hours a day, seven days a week, accessible to a member in each contracted service area. One or more physicians and one or more nurses shall be on call or on duty at the facility at all times;~~
3. ~~An emergency services system employing at least one physician, registered nurse, physician's assistant, or nurse practitioner, accessible by telephone 24 hours a day, seven days a week, to a member who needs information in an emergency, and to a provider who needs verification of patient membership and treatment authorization;~~
4. ~~An emergency services call log or database to track the following information:~~
   a. ~~Member's name;~~
   b. ~~Address and telephone number;~~
   c. ~~Date and time of call;~~
   d. ~~Nature of complaint or problem; and~~
   e. ~~Instructions given to a member; and~~
5. ~~A written procedure for communicating emergency services information to a member's primary care provider, and other appropriate organizational units.~~

~~**C.** A contractor shall have an affiliation with or subcontract with an organization or person to provide primary care services. The contractor shall agree to provide services under the primary care provider's guidance and direction as specified in contract.~~

R9-30-504. ~~Marketing~~ Repealed

~~The PSA shall require a contractor to develop a marketing plan under A.R.S. § 36-2923.01.~~

R9-30-507. ~~Member Record~~ Repealed

~~A contractor shall maintain a member service record that contains at least the following for each member:~~

1. ~~Encounter data, if required by the Administration;~~
2. ~~Grievances and request for hearings;~~
3. ~~Any informal complaints; and~~
4. ~~Service information.~~

R9-30-509. ~~Transition and Coordination of Member Care~~ Repealed

~~The Administration shall coordinate and implement disenrollment and re-enrollment procedures when a member's change of residence requires a change in contractor as specified in contract.~~

R9-30-510. ~~Transfer of a Member~~ Repealed

~~A contractor shall implement procedures to allow a member to transfer from the primary care provider of record to another primary care provider within the same contracting organization. Criteria for a transfer include, but are not be limited to:~~

1. ~~Change in the member's health, requiring a different medical focus;~~
2. ~~Change in the member's residence resulting in difficulty in obtaining services from the assigned primary care provider; or~~
3. ~~Identification of any problem between the member and the primary care provider, resulting in deterioration of the primary care provider member relationship.~~

R9-30-511. ~~Fraud and Abuse~~ Repealed

~~A contractor, provider, or noncontracting provider shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse under this Chapter.~~

R9-30-512. ~~Release of Safeguarded Information by the PSA and a Contractor~~ Repealed

~~A.~~ ~~The Administration, a contractor, a provider, and a noncontracting provider shall safeguard information concerning an applicant, or a member, which includes 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 services, including diagnosis and history of disease or disability;~~
6. ~~Information from the Arizona Department of Economic Security or the Administration, if required;~~

~~B.~~ ~~The restriction upon disclosure of information does not apply to:~~

1. ~~Summary data,~~
2. ~~Statistics,~~
3. ~~Utilization data, and~~
4. ~~Other information that does not identify a member.~~

~~C.~~ ~~The Administration, a contractor, a provider, and a noncontracting provider shall use or disclose information concerning a member only under the conditions specified in subsection (D), (E), and (F) and only to:~~

1. ~~The person concerned,~~
2. ~~A person authorized by the person concerned, and~~
3. ~~A person or agency for official purposes.~~

~~D.~~ ~~Safeguarded information shall be viewed by or released to only:~~

1. ~~An applicant;~~
2. ~~A member; or~~
3. ~~A dependent child, with written permission of a parent, custodial relative, or designated representative, if:~~
   a. ~~An Administration employee or authorized representative, or responsible caseworker is present during the examination of the eligibility record; or~~
   b. ~~As outlined in subsection (E) after written notification to the provider, and at a reasonable time and place.~~

~~E.~~ ~~An eligibility case record, medical record, and any other related confidential and safeguarded information regarding a member or applicant, shall be released to a person authorized by the member or applicant, only under the following conditions:~~

1. ~~Authorization for release of information is obtained from the member, applicant, or designated representative;~~
2. ~~Authorization used for release is a written document, separate from any other document that specifies the following information:~~
   a. ~~Information or records, in whole or in part, which are authorized for release;~~
   b. ~~To whom release is authorized;~~
   c. ~~The period of time for which the authorization is valid, if limited; and~~

d. ~~A dated signature of the adult and mentally competent member, applicant, or designated representative. If a member, or applicant is a minor, the signature of a parent, custodial relative, or designated representative shall be required unless the minor is sufficiently mature to understand the consequences of granting or denying authorization. If a member or applicant is mentally incompetent, authorization shall be under A.R.S. § 36-509; or~~

3. ~~If a request for hearing or grievance is filed, the member, applicant, or designated representative shall be permitted to review and obtain or copy any nonprivileged record necessary for the proper presentation of the case.~~

~~**F.** Release of safeguarded information to individuals or agencies for official purposes:~~

1. ~~Official purposes directly related to the administration of the PSP are:~~
   a. ~~Establishing eligibility and post-eligibility treatment of income, as applicable;~~
   b. ~~Providing services for a member;~~
   c. ~~Conducting or assisting an investigation, prosecution, or civil or criminal proceeding; and~~
   d. ~~Performing evaluations and analyses of PSP operations;~~
2. ~~For official purposes related to the administration of the PSP and only to the extent required in performance of duties, safeguarded information, including case records and medical records, may be disclosed to the following persons without the consent of the applicant, or member:~~
   a. ~~Employees of the AHCCCS Administration;~~
   b. ~~Employees of the U.S. Social Security Administration;~~
   c. ~~Employees of the Arizona Department of Economic Security;~~
   d. ~~Employees of the Arizona Department of Health Services;~~
   e. ~~Employees of the U.S. Department of Health and Human Services;~~
   f. ~~Employees of contractors, program contractors, providers, and subcontractors; and~~
   g. ~~Employees of the Arizona Attorney General's Office, and the County Attorney, if applicable.~~
3. ~~Law enforcement officials:~~
   a. ~~Information may be released to law enforcement officials without the applicant's or member's written or verbal consent, for the purpose of an investigation, prosecution, or criminal or civil proceeding relating to the administration of the PSP.~~
   b. ~~The Administration and contractors shall release safeguarded information contained in an applicant's or member's medical record to law enforcement officials without the member's consent only if the applicant or member is suspected of fraud or abuse against the PSP.~~
4. ~~The Administration may release safeguarded information including case records and medical records to a review committee in accordance with the provisions of A.R.S. § 36-2917, without the consent of the applicant or member.~~
5. ~~Providers shall furnish requested records to the Administration and its contractors at no charge.~~

~~**G.** The holder of a medical record of a former applicant or member shall obtain written consent from the former applicant, or member before transmitting the medical record to a primary care provider.~~

~~**H.** Subcontractors are not required to obtain written consent from a member before transmitting the member's medical records to a physician who:~~

1. ~~Provides a service to the member under subcontract with the contractor;~~
2. ~~Is retained by the subcontractor to provide services that are infrequently used or are of an unusual nature; and~~
3. ~~Provides a service under the contract.~~

R9-30-513. ~~Discrimination Prohibition~~ Repealed

~~A contractor, provider, and noncontracting provider shall not discriminate against a member as specified in federal and state law.~~

R9-30-514. ~~Equal Opportunity~~ Repealed

~~The contractor shall comply with equal opportunity requirements under A.A.C. R9-22-514.~~

R9-30-518. ~~Information to an Enrolled Member~~ Repealed

~~**A.** Each contractor shall produce and distribute a printed member handbook to each household unit within 10 days of the effective date of coverage. The member handbook shall include the following:~~

1. ~~A description of all available services and an explanation of any service limitation, and exclusions from coverage or charges for services, when applicable;~~
2. ~~An explanation of the procedure for obtaining covered services, including a notice stating the contractor shall only be liable for services authorized by a member's primary care provider or the contractor;~~
3. ~~A list of the names, telephone numbers, and business addresses of primary care providers available for selection by the member, and a description of the selection process, including a statement that informs the member they may request another primary care provider, if they are dissatisfied with their selection;~~
4. ~~Locations, telephone numbers, and procedures for obtaining emergency health services;~~
5. ~~Explanation of the procedure for obtaining emergency health services outside the contractor's service area;~~
6. ~~The causes for which a member may lose coverage;~~
7. ~~A description of the grievance procedures;~~
8. ~~Copayment schedules;~~

9. ~~Information on the appropriate use of health services and on the maintenance of personal and family health;~~
10. ~~Information regarding emergency and medically necessary transportation offered by the contractor; and~~
11. ~~Other information necessary to use the program.~~

~~B.~~ ~~Notification of changes in services. Each contractor shall prepare and distribute to a member, a printed member handbook insert describing any changes that the contractor proposes to make in services provided within the contractor's service area. The insert shall be distributed to all household units at least 14 days before a planned change. Notification shall be provided as soon as possible when unforeseen circumstances require an immediate change in services or service locations.~~

R9-30-520. ~~Financial Statements, Periodic Reports, and Information~~ Repealed

~~Upon request by the Administration, a contractor shall furnish to the Administration financial statements, periodic reports, and information from its records relating to contract performance as specified in contract.~~

R9-30-521. ~~Program Compliance Audits~~ Repealed

~~The Administration may conduct a program compliance audit of each contractor on a periodic basis as specified in contract.~~

R9-30-522. ~~Quality Management/Utilization Management (QM/UM) Requirements~~ Repealed

~~A contractor shall comply with the quality management and utilization review requirements as specified in contract.~~

R9-30-523. ~~Financial Resources~~ Repealed

~~A.~~ ~~A contractor or offeror shall demonstrate upon request by the Administration that it has:~~
1. ~~Adequate financial reserves;~~
2. ~~Administrative abilities; and~~
3. ~~Soundness of program design to carry out its contractual obligations.~~

~~B.~~ ~~As specified in A.R.S. § 36-2912, the Director requires that contract provisions include, but not be limited to:~~
1. ~~Maintenance of deposits;~~
2. ~~Performance bonds unless waived as specified in A.R.S. § 36-2912;~~
3. ~~Financial reserves; or~~
4. ~~Other financial security, unless waived as specified in A.R.S § 36-2912.~~

R9-30-524. ~~Continuity of Care~~ Repealed

~~A contractor shall establish and maintain a system to ensure continuity of care which shall, at a minimum, include:~~
1. ~~Referring a member who needs specialty health care services;~~
2. ~~Monitoring a member with chronic medical conditions;~~
3. ~~Providing hospital discharge planning and coordination including post-discharge care; and~~
4. ~~Monitoring operation of the system through professional review activities.~~

ARTICLE 6. ~~GRIEVANCE AND REQUEST FOR HEARING~~ REPEALED

R9-30-601. ~~General Provisions for a Grievance and a Request for Hearing~~ Repealed

~~A grievance and a request for hearing under this Chapter shall comply with R9-22-801. The grievance and request for hearing process is illustrated in Exhibit A.~~

R9-30-602. ~~Grievance~~ Repealed

~~General requirements. A grievance under this Chapter shall be filed and processed under R9-22-802.~~

R9-30-603. ~~Eligibility Hearing for an Applicant and a Member~~ Repealed

~~A.~~ ~~Except as provided in this Section, an eligibility hearing for an applicant or a member shall comply with R9-22-803.~~

~~B.~~ ~~Adverse eligibility action. An applicant and a member may request a hearing concerning any of the following adverse eligibility actions:~~
1. ~~Denial of eligibility. A denial of eligibility is an adverse decision that determines an applicant ineligible for PSP;~~
2. ~~Discontinuance of eligibility. A discontinuance of eligibility is a termination of a member's eligibility for PSP;~~
3. ~~Determination of premium amount; or~~
4. ~~Determination of chronic illness.~~

~~C.~~ ~~Coverage during the hearing process. A member who requests a hearing regarding a discontinuance shall receive continued Premium Sharing coverage until a final administrative decision is rendered only if the member pays for a minimum of three full months of premiums under R9-30-701, which shall be received no later than 15 days after the date of notice. In the event the final administrative decision is not rendered within three months, the member shall continue to pay monthly premiums. Failure to timely pay monthly premiums in full shall result in the termination of coverage.~~

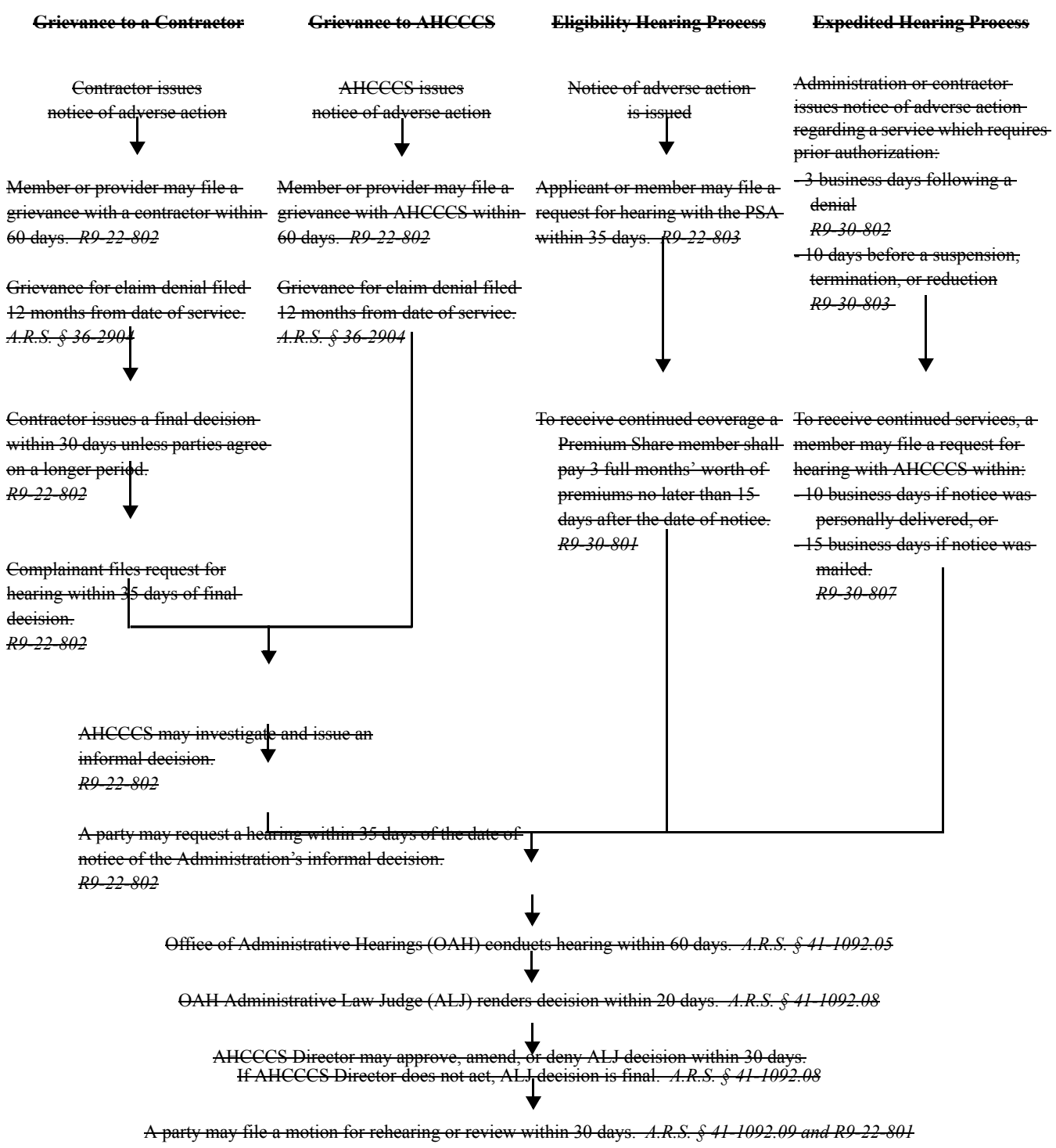
~~D.~~ ~~Non-refundable premium. The Administration shall not refund any portion of the advance three month premium.~~
1. ~~If a member's discontinuance is upheld, any remaining advance premium paid shall be applied toward the cost to the system.~~
2. ~~If a member's discontinuance is overturned, any remaining advance premium paid shall be applied to the next month's premium charge.~~

~~E.~~ ~~Refundable premium. The Administration may refund a monthly premium if:~~

~~1. The member pays premiums beyond the non-refundable three month advance premium, and~~

~~2. Prior to the month of coverage of the services, the member's discontinuance is upheld. Once a premium is refunded the PSP coverage will terminate at the end of the previous month.~~

Exhibit A. ~~**Grievance and Request for Hearing Process**~~ **Repealed**



ARTICLE 7. ~~PAYMENT RESPONSIBILITIES~~ REPEALED

R9-30-701. ~~A Member's Payment Responsibilities~~ Repealed

~~**A.** Premium payment requirement. A member shall pay in full the required premium payment established by the Administration under A.R.S. § 36-2923.01.~~

~~**B.** Monthly premium payment. The monthly premium payment is based on annual household income equal to or less than 200 percent FPL, determined by the one-month income period. A member whose gross household income is equal to or less than 200 percent FPL shall pay the full monthly premium amount to the Administration under subsection (E). The member shall pay the share of the premium depending on the number of eligible household members and the gross household income.~~

~~1. For one eligible household member, the premium share will be equal to three percent of the gross household income;~~
~~2. For two eligible household members, the premium share will be equal to four percent of the gross household income;~~
~~3. For three eligible household members, the premium share will be equal to five percent of the gross household income;~~
~~4. For four or more household members, the premium share will be equal to six percent of the gross household income.~~

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

~~**D.** Premium payment schedule for initial enrollment. The Administration requires that upon conditional approval of the application, the member shall pay the full premium for the first two months of coverage prior to initial enrollment. If the Administration receives the premium payment on or before the 15th day of the month, enrollment will begin on the first day of the next month. If the Administration receives the premium payment after the 15th day of the month, following the date of the notice, coverage begins on the first day of the second month.~~

~~**E.** When and how to submit monthly premium payments. The member shall submit the full monthly premium payment to the Administration by the first day of the month prior to the month of coverage. The monthly premium payment is delinquent if received or postmarked after the 25th day of the month prior to the month of coverage. Monthly premium payments that are untimely shall result in the termination of coverage.~~

~~1. All premiums paid in advance by the member are nonrefundable, unless the member is disenrolled at least 15 days prior to the month of coverage. Premiums paid during a grievance under R9-30-603 are nonrefundable.~~
~~2. A member shall pay the full monthly premium with sufficient funds in the form of a:~~
~~a. Cashier's check,~~
~~b. Personal check,~~
~~c. Money order, or~~
~~d. Other means approved by the Administration.~~
~~3. A member whose payment is returned for nonsufficient funds shall pay the full monthly premium in the form of a:~~
~~a. Cashier's check,~~
~~b. Money order, or~~
~~c. Other means approved by the Administration.~~

~~**F.** Newborns. All newborns shall be enrolled 30 days following the birth to be eligible for coverage. Upon enrollment, the newborn's premium is due to the Administration 30 days following the birth for coverage retroactive to the first day of the month in which the birth occurred.~~

~~**G.** Copayment requirements. A member shall pay the following under A.R.S. § 36-2923.01~~

~~1. $10 for each physician visit,~~
~~2. $50 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. Prescriptions:~~
~~a. $5 for generic,~~
~~b. $20 for formulary brand name prescriptions; the generic copayment applies to branded prescription medications for which there is no FDA rated A-B generic equivalent.~~
~~5. $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;~~
~~6. $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;~~
~~7. $50 for each behavioral health admission to an inpatient behavioral facility. Members are eligible for a maximum of 30 days of inpatient behavioral health services annually;~~
~~8. $10 for individual outpatient behavioral health services. Members are eligible for a maximum of 30 outpatient behavioral health visits annually;~~
~~9. $5 for outpatient behavioral health group services; and~~
~~10. The full cost of any nonemergency transportation.~~

~~**H.** A contractor may withhold nonemergency medical services to a member who does not pay copayments in full at the time service is rendered under A.R.S. § 36-2923.01.~~

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

~~**A.** Liability for covered services. The Administration shall have no liability for the provision of covered services or for the completion of a plan of treatment to a member beyond the date of disenrollment except when the member is confined to a hospital as specified in R9-30-305. The Administration 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 Administration 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 Administration 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 Administration in litigation involving the contractor's subcontracts.~~

~~**D.** Capitation rates. The Administration shall establish actuarially sound capitation rates under A.R.S. § 36-2923.01. The Administration may adjust the capitation rates. The oversight committee reviews changes to capitation rates, premiums and copayments under A.R.S. § 36-2923.02.~~

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

~~**F.** Medical financial risk. The Administration will limit the medical financial risk to contractors associated with the PSP through a risk sharing reconciliation arrangement as specified in contract.~~

~~**G.** Payments made on behalf of a contractor; recovery of indebtedness. The Administration 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 Administration may at any time negotiate or contract for specialty contracts on behalf of providers, and noncontracting providers. The Administration and a contractor shall meet the requirements in A.A.C. R9-22-716.~~

~~**I.** Charges against a 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 member or person acting on behalf of a 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, 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 member without first receiving verification from the Administration that the person was ineligible for PSP on the date of service or that the services provided were not covered by PSP.~~

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

~~**L.** First- and third-party collections and coordination of benefits. The Administration shall recover all first- and third-party collections and coordinate benefits under 9 A.A.C. 22, Article 10 and A.R.S. § 36-2923.01. The Administration is entitled to all rights for liens and claims under A.R.S. §§ 36-2915 and 36-2916.~~

R9-30-703. ~~Contractor's and Provider's Claims and Payment Responsibilities~~ Repealed

~~**A.** General responsibilities. A provider shall submit to a contractor all claims for services rendered to a member enrolled with the contractor. A contractor shall pay for all admissions and covered services provided to a member when the admissions or covered services have been arranged and necessary authorization has been obtained by:~~

~~1. A contractor's agent or employee;~~

~~2. A subcontracting provider; or~~

~~3. Other person acting on the subcontractor's behalf.~~

~~**B.** Claims.~~

~~1. Time-frame to pay a claim. A contractor shall reimburse subcontracting and noncontracting providers for the provision of covered services to a member either:~~

~~a. Within the time period specified by contract between a contractor and a subcontracting entity; or~~

~~b. Within 60 days of receipt of a clean claim, if a time period is not specified in contract; or~~

~~c. For a hospital claim, a contractor shall pay a noncontracting provider for inpatient hospital and outpatient hospital services according to the quick pay discount and slow pay penalties as specified in A.R.S. § 36-2903.01.~~

2. When a contractor is not required to pay a claim. A contractor is not required to pay a claim for covered services that is submitted more than 6 months after the date of the service, or that is submitted as a clean claim more than 12 months after the date of service.
3. Inpatient or outpatient hospital claim. A contractor shall pay the hospitals in accordance with:
   a. How a hospital claim is processed under A.A.C. R9-22-705;
   b. What personal care items are covered under A.A.C. R9-22-717; and
   c. What hospital supplies and equipment are covered under A.A.C. R9-22-717.
4. Review of hospital claims. If a contractor and a hospital do not agree on reimbursement levels, terms and conditions, the requirements specified in A.A.C. R9-22-705 shall apply.
5. Denial and rights of a claimant. A contractor shall provide written notice to a provider whose claim is denied or reduced by the contractor within 60 days of receipt of a claim. This notice shall include a statement describing the provider's right to:
   a. Grieve the contractor's rejection or reduction of the claim; and
   b. Submit a grievance in accordance with A.A.C. R9-22-804.

C. Reimbursement.

1. In-state inpatient hospital reimbursement. A contractor shall reimburse an in-state subcontractor and noncontracting provider for the provision of inpatient hospital services. The contractor may choose among the following reimbursement methodologies depending on the county in which the services are provided.
   a. Maricopa and Pima counties.
      i. A rate specified by subcontract. Subcontract rates, terms and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and A.A.C. R9-22-715; or
      ii. Reimbursement based on the pilot program described in A.A.C. R9-22-718.
   b. For the remaining counties in Arizona.
      i. A rate specified by subcontract. Subcontract rates, terms and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and A.A.C. R9-22-715; or
      ii. The prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and A.A.C. R9-22-712.
2. Payment for emergency services and subsequent care. A contractor shall pay for all emergency care services provided to a member by subcontracting and noncontracting providers when a service:
   a. Conforms to the notification requirements in 9 A.A.C. 30, Article 2;
   b. Conforms to the definition of emergency medical services defined in 9 A.A.C. 22, Article 1;
   c. Meets the requirements in A.A.C. R9-22-709 - Contractor's Liability for Hospital for the Provision of Emergency and Subsequent Care; and
   d. Is provided in the most appropriate, cost-effective, and least restrictive setting.
3. Observation days. A contractor may reimburse subcontracting and noncontracting providers for the provision of observation days that do not result in an admission at:
   a. A rate specified by subcontract; or
   b. In the absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered billed charges.
4. Outpatient hospital reimbursement. A contractor shall reimburse subcontracting and noncontracting providers for the provision of outpatient hospital services rendered at either:
   a. A rate specified by subcontract. Subcontract rates, terms, and conditions are subject to review, and approval or disapproval under A.R.S. § 36-2904 and A.A.C. R9-22-715; or
   b. In the absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered billed charges.
5. Out-of-state hospital reimbursement. A contractor shall reimburse an out-of-state hospital for the provision of inpatient and outpatient hospital services at:
   a. The lower of the negotiated discounted rates; or
   b. 80 percent of billed charges.

D. Transfer of payments. The Administration or a contractor shall meet the requirements in A.A.C. R9-22-704.

ARTICLE 8. ~~MEMBERS' RIGHTS AND RESPONSIBILITIES FOR EXPEDITED HEARINGS~~ REPEALED

R9-30-801. ~~General Intent and Definitions~~ Repealed

A. This Article defines the notice and expedited hearing process when a contractor denies, reduces, suspends, or terminates a service that requires prior authorization. This Article provides an expedited hearing process and opportunity for continued services as an alternative to the provisions of 9 A.A.C. 30, Article 6. The expedited hearing process is illustrated in 9 A.A.C. 30, Article 6, Exhibit A.

B. 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:
"Action" means a denial, termination, suspension, or reduction of a service.
"Contractor" means a health plan, Arizona Department of Health Services Division of Behavioral Health Services, or a

~~Tribal or Regional Behavioral Health Authority.~~
~~"Notice" means a written statement that meets the requirements specified in R9-30-804.~~
~~"Party" means a member or contractor.~~

R9-30-802. ~~Denial of a Request for a Service~~ Repealed
~~A contractor shall provide a member with written notice no later than three business days after the date the Administration or a contractor denies authorization for a requested service that the member does not currently receive.~~

R9-30-803. ~~Reduction, Suspension, or Termination of a Service~~ Repealed
~~Except as permitted under R9-30-805 and R9-30-806, if the contractor reduces, suspends, or terminates a service currently provided by the contractor, the contractor shall provide the member written notice at least 10 days before the effective date of the intended action.~~

R9-30-804. ~~Content of Notice~~ Repealed
~~A notice required under R9-30-802 or R9-30-803 shall contain the following:~~
1. ~~A statement of the action the contractor has taken or intends to take;~~
2. ~~The specific reason for the action, including the specific facts, personal to the member, that support the action;~~
3. ~~The specific law, rule, or other written policy, standards, or criteria that supports the action, or the specific change in federal or state law that authorizes the action;~~
4. ~~An explanation of:~~
   a. ~~A member's right to request an evidentiary hearing; and~~
   b. ~~The circumstances under which the contractor shall grant a hearing for an action based on a change in the law; and~~
5. ~~An explanation of the circumstance under which the contractor shall continue a covered service if a member requests a hearing regarding a service that is:~~
   a. ~~Reduced,~~
   b. ~~Suspended, or~~
   c. ~~Terminated.~~

R9-30-805. ~~Exceptions from an Advance Notice~~ Repealed
~~A contractor may mail a notice for a reduction, suspension, or termination of a service no later than the date of action if the contractor:~~
1. ~~Has factual information confirming the death of a member;~~
2. ~~Receives a written statement signed by the member that:~~
   a. ~~States services are no longer wanted; or~~
   b. ~~Provides information that requires a reduction or a termination of a service and indicates that the member understands that a reduction or termination of a service shall be the result of that information;~~
3. ~~Learns that a member has been admitted to an institution that makes the member ineligible for services;~~
4. ~~Does not know the member's whereabouts and mail directed to the member is returned by the post office and no forwarding address is provided;~~
5. ~~Has established the fact that a member has been approved for Medicaid;~~
6. ~~Knows that the member's primary care provider has prescribed a change in the level of medical care.~~

R9-30-806. ~~Notice in a Case of Probable Fraud~~ Repealed
~~A contractor may shorten the advance notice period to five days before the date of action if:~~
1. ~~The circumstances indicate that action should be taken because of probable fraud by a member; and~~
2. ~~The facts have been verified through collateral resources, if possible.~~

R9-30-807. ~~Expedited Hearing Process~~ Repealed
~~A.~~ ~~Request for expedited hearing.~~
1. ~~If a contractor denies, reduces, suspends, or terminates a service that requires authorization, a member is entitled to an expedited hearing if a member files a request for hearing under the time-frames in subsection (B).~~
2. ~~A member shall file a request for expedited hearing or a request for expedited hearing and continued services in the same manner as provided in R9-22-803.~~

~~B.~~ ~~Time-frames. A member shall file a request for hearing with the Administration or the contractor:~~
1. ~~No later than 10 business days after the date of personal delivery of the notice to the member; or~~
2. ~~No later than 15 business days after the postmark date, if mailed, of the notice.~~

~~C.~~ ~~Expedited hearing. A hearing under this Section shall be held no sooner than 20 days, and not later than 40 days, after the Administration's receipt of the request for hearing. The hearing may be held sooner than 20 days after the Administration's receipt of the request for hearing upon the agreement of all of the parties or upon written motion of one of the parties establishing:~~
1. ~~Extraordinary circumstances, or~~
2. ~~The possibility of irreparable harm if the hearing is not held sooner.~~

~~**D.** Notice of hearing. The Administration or its designee shall provide notice of the hearing to the member or the authorized representative and to all other parties to the hearing.~~

~~**E.** Continued services. If a request for expedited hearing and a request for continued services is filed in a timely manner under this Section, the contractor shall not terminate, reduce, or suspend the service during the expedited hearing process.~~

~~**F.** Previously authorized service.~~

~~1. In addition to services which are continued under subsection (E), the contractor shall continue services pending a hearing decision if:~~

~~a. The contractor denies an authorization for a previously authorized service for the member because the contractor considers the service new and independent of any previous authorization;~~

~~b. The member's primary care physician asserts that the requested service is a necessary continuation of the previous authorization; and~~

~~c. The member challenges the denial on this basis and timely requests continued services.~~

~~2. Services shall not be continued if:~~

~~a. The parties reach some other agreement, or~~

~~b. The contractor believes the primary care provider's request endangers the member.~~

~~**G.** Financial liability of a member. A member whose service is continued during the expedited hearing process is financially liable for the service received if the Director upholds the decision to reduce, suspend, or terminate the service.~~

~~**H.** General provisions. If an expedited hearing is requested, a hearing shall be conducted under A.R.S. § 41-1092.~~

~~**I.** Alternative hearing process. A request for expedited hearing shall be considered a grievance under 9 A.A.C. 30, Article 6, and the Administration shall forward the request to the contractor within 10 business days after the day the Administration receives the request if:~~

~~1. The Administration determines that a request for hearing filed under this Section is not timely, as determined by the Office of Legal Assistance's date stamp on the document; or~~

~~2. The request for hearing does not involve the denial, reduction, suspension, or termination of a service.~~

R9-30-808. ~~Maintenance of Records~~ Repealed

~~The contractor providing notice of denial, reduction, suspension, or termination of a service shall maintain records of the written notification and the date of the notice given to the member.~~

R9-30-809. ~~Member Handbook~~ Repealed

~~A contractor shall furnish each member with a handbook, as specified in contract, that explains a member's right to file a grievance or request a hearing concerning an action that affects a member's receipt of medical services.~~

ARTICLE 9. ~~CONTRACT PROCESS~~ REPEALED

R9-30-901. ~~General Provisions~~ Repealed

~~**A.** Authority. The Administration has full operational authority to award contracts under A.R.S. § 36-2923.01.~~

~~**B.** Requirements. The Administration and qualified providers of health care who have contracts to provide services under the Administration shall conform to the requirements in this Article and A.R.S. § 36-2923.01. A contractor that has contracts and subcontracts entered into under this Article shall have records on file.~~

~~**C.** Insufficient Coverage. If the Director determines there is insufficient coverage in a county, the Director shall attempt to contract with a prepaid capitated provider as defined in A.R.S. § 36-2901, to provide services under the PSP under A.R.S. § 36-2923.01.~~

~~**D.** Contract. If the Administration determines that it is in the best interest of the state, The Administration may cancel or reject a contract in whole or in part, as specified in contract. The Administration shall include the reasons for cancellation or rejection in the contract file.~~

~~**E.** Damages or claims. Offerors shall have no right to damages or basis for any claims against the state, its employees, or agents, as a result of any action by the Administration under the provisions of subsection (B).~~

R9-30-902. ~~Contract Compliance Sanction~~ Repealed

~~The Director may impose a sanction upon a contractor that violates any provision of the rules as specified in contract and under A.A.C. R9-22-606.~~

R9-30-903. ~~Contract Protest; Grievance and Request for Hearing~~ Repealed

~~The contractor shall file a grievance under 9 A.A.C. 22, Article 8.~~

NOTICE OF FINAL SUMMARY RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 32. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PRESCRIPTION MEDICATION COVERAGE PILOT PROGRAM

PREAMBLE

1. Sections Affected — **Rulemaking Action**

Chapter 32	Repeal
Article 1	Repeal
R9-32-101	Repeal
Article 2	Repeal
R9-32-201	Repeal
R9-32-202	Repeal
R9-32-203	Repeal
R9-32-204	Repeal
Article 3	Repeal
R9-32-301	Repeal
Article 4	Repeal
R9-32-401	Repeal
R9-32-402	Repeal
Article 5	Repeal
R9-32-501	Repeal
R9-32-502	Repeal
R9-32-503	Repeal
R9-32-504	Repeal

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

Authorizing statute: A.R.S. § 36-2903.01

Implementing statute: None

3. The permanent effective date of the summary rules:

October 10, 2003, effective April 4, 2004

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

Name: Barbara Ledder

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

Telephone: (602) 417-4580

Fax: (602) 253-9115

E-mail: proposedrules@ahcccs.state.az.

5. The concise explanatory statement, including an explanation of the rules and the agency's reasons for initiating the rules:

Laws 2001, Ch. 347 repealed the Prescription Medication Coverage Pilot Program effective October 1, 2003, thus repealing AHCCCS statutory authority for this program. AHCCCS received no comment from the public regarding this rule amendment.

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

Not applicable

7. The economic, small business, and consumer impact:

An economic, small business, and consumer impact statement is not required pursuant to A.R.S. § 41-1055(D)(2).

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

Not applicable

9. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rules:

AHCCCS held a public hearing on November 12, 2003. There were no attendees from the public.

10. An explanation of why summary proceedings are justified:

Laws 2001, Ch. 347, repealed the Prescription Medication Coverage Pilot Program effective October 1, 2003, thus repealing AHCCCS statutory authority for this program.

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

Not applicable

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

There are no incorporations by reference.

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 32. ~~ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PRESCRIPTION MEDICATION COVERAGE PILOT PROGRAM~~ REPEALED

ARTICLE 1. ~~DEFINITIONS~~ REPEALED

Section

R9-32-101. ~~General Definitions~~ Repealed

ARTICLE 2. ~~GENERAL PROVISIONS AND STANDARDS~~ REPEALED

Section

R9-32-201. ~~General Requirements~~ Repealed

R9-32-202. ~~Funding and Expenditures~~ Repealed

R9-32-203. ~~Pilot Program Termination~~ Repealed

R9-32-204. ~~Termination Notification~~ Repealed

ARTICLE 3. ~~SCOPE OF SERVICES~~ REPEALED

Section

R9-32-301. ~~Pharmaceutical Services~~ Repealed

ARTICLE 4. ~~PILOT PROGRAM DEDUCTIBLES AND BENEFITS~~ REPEALED

Section

R9-32-401. ~~Deductibles~~ Repealed

R9-32-402. ~~Benefits~~ Repealed

ARTICLE 5. ~~ELIGIBILITY AND ENROLLMENT~~ REPEALED

Section

R9-32-501. ~~Conditions of Eligibility~~ Repealed

R9-32-502. ~~Applications~~ Repealed

R9-32-503. ~~Enrollment~~ Repealed

R9-32-504. ~~Reenrollment~~ Repealed

ARTICLE 1. ~~DEFINITIONS~~ REPEALED

R9-32-101. ~~Location of Definitions~~ Repealed

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

~~Definition~~	~~Section or Citation~~
~~"Administration"~~	~~R9-32-101~~
~~"Applicant"~~	~~R9-32-101~~
~~"Application"~~	~~R9-32-101~~
~~"Completed application"~~	~~R9-32-101~~
~~"Day"~~	~~R9-32-101~~
~~"Director"~~	~~R9-32-101~~
~~"Enrollment fee"~~	~~R9-32-101~~
~~"Fiscal Year"~~	~~R9-32-101~~
~~"FPL"~~	~~R9-32-101~~
~~"Member"~~	~~R9-32-101~~
~~"PBM"~~	~~R9-32-101~~
~~"Participating pharmacy"~~	~~R9-32-101~~
~~"Pilot program"~~	~~R9-32-101~~
~~"Prescription quantities"~~	~~R9-32-101~~

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

~~"Administration" means the Arizona Health Care Cost Containment System (AHCCCS) Administration under A.R.S. § 36-2901.~~

~~"Applicant" means a person who submits or whose representative submits a written, signed, and dated application for AHCCCS benefits under this Chapter that has not been approved or denied.~~

~~"Application" means an official request for prescription medication coverage under this Chapter.~~

~~"Completed Application" means the applicant or representative:~~

~~Submits a legible application with appropriate responses for all information requested,~~

~~Signs and dates the application, and~~

~~Encloses the enrollment fee.~~

~~"Day" means a calendar day.~~

~~"Director" means the Director of the AHCCCS Administration.~~

~~"Enrollment Fee" means the fee established by the Administration under Laws 2001, Ch. 347.~~

~~"Fiscal Year" means the time-frame from July 1 through June 30.~~

~~"FPL" means the federal poverty guidelines updated annually in the Federal Register by the United States Department of Health and Human Services.~~

~~"Member" means a person who enrolls in the Pilot Program.~~

~~"PBM" means pharmaceutical benefit management company or pharmacy administrator designated by the Administration to manage the pharmacy administrative services under the Pilot Program.~~

~~"Participating Pharmacy" means a pharmacy that contracts with the PBM to dispense medications as part of the Pilot Program.~~

~~"Pilot Program" means Prescription Medication Coverage Pilot Program established under Laws 2001, Ch. 347.~~

~~"Prescription Quantities" means a prescription, which is written for a therapeutic supply of medications up to a maximum of a 30-day supply or 100-unit dose.~~

ARTICLE 2. ~~GENERAL PROVISIONS AND STANDARDS~~ REPEALED

R9-32-201. ~~General Requirements~~ Repealed

~~Under Laws 2001, Ch. 347, the Administration has full operational authority to adopt rules to establish a Pilot Program. The Administration shall administer the Pilot Program under Laws 2001, Ch. 347. The Administration shall provide pharmacy services subject to expenditure limits under Laws 2001, Ch. 347 and this Chapter.~~

R9-32-202. ~~Funding and Expenditures~~ Repealed

~~**A.** Funding. Enrollment in the Pilot Program is limited to funding and time-frames under Laws 2001, Ch. 347 and this Chapter.~~

~~**B.** Time-frames.~~

~~1. The Pilot Program begins November 1, 2001.~~

~~2. The Administration or PBM shall not accept applications on or after December 1, 2002.~~

~~3. The Administration or PBM shall not issue an enrollment or reenrollment card to an applicant or member after December 30, 2002.~~

~~4. An enrollment card, issued by the Administration or PBM on or after July 1, 2002, shall expire no later than July 1, 2003.~~

~~5. All enrollment cards shall expire July 1, 2003 and the Administration or PBM shall not provide benefits on or after that date.~~

~~6. The Pilot Program is repealed October 1, 2003 under Laws 2001, Ch. 347.~~

~~**C.** Administration's Expenditure.~~

~~1. The Administration shall disperse funds for fiscal years 2002 and 2003 under Laws 2001, Ch. 347.~~

~~2. The Administration shall cover 50 percent of the cost of a member's prescription medication that exceeds the deductible amounts for the duration of the enrollment period under Article 4.~~

~~3. If less than 75 percent of the appropriation for fiscal year 2002 is expended, the Administration may reduce the deductible amounts up to $300 for the next fiscal year.~~

~~4. The Administration or PBM shall terminate paying claims when:~~

~~a. Funds are exhausted for fiscal year 2002. The Administration or PBM shall resume the Pilot Program in the new fiscal year beginning July 1, 2002 utilizing the fiscal year 2003 allocation.~~

~~b. Funds are exhausted for fiscal year 2003 prior to July 1, 2003.~~

~~c. The Pilot Program ends under Laws 2001, Ch. 347.~~

R9-32-203. ~~Pilot Program Termination~~ Repealed

~~**A.** The Administration or PBM shall not provide coverage for prescriptions purchased on or after July 1, 2003.~~

~~**B.** The Pilot Program is terminated on either October 1, 2003, or the date on which a federal law takes effect that provides coverage equal to or greater than the coverage provided by this Chapter whichever date occurs first. If the Pilot Program is terminated because of the federal law the Administration or PBM shall:~~

~~1. Immediately stop processing all applications, and~~

~~2. Provide reimbursement to all members until the member's current eligibility expires.~~

R9-32-204. ~~Termination Notification~~ Repealed

~~The Administration or PBM shall provide a 30-day notice to a member regarding the Pilot Program termination or if funds are exhausted for the fiscal year.~~

ARTICLE 3. ~~SCOPE OF SERVICES~~ REPEALED

R9-32-301. ~~Pharmaceutical Services~~ Repealed

~~**A.** The Administration or PBM shall reimburse the participating pharmacies for prescription medication as defined by this Chapter, which is approved by the federal food and drug administration and purchased within the United States.~~

~~**B.** The Administration or PBM shall ensure that pharmaceutical services provided by the participating pharmacies are available during customary business hours. The Administration or PBM shall provide the member with the list of participating pharmacies.~~

~~**C.** The following limitations shall apply to prescription quantities. A prescription in excess of a 30-day supply or a 100-unit dose is not covered unless:~~

~~1. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is greater.~~

~~2. 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 100 days or 100-unit dose, whichever is greater.~~

~~3. The medication is prescribed for birth control and the prescription is limited to no more than a 100-day supply.~~

ARTICLE 4. ~~PILOT PROGRAM DEDUCTIBLES AND BENEFITS~~ REPEALED

R9-32-401. ~~Deductibles~~ Repealed

~~**A.** Deductibles for an enrollment period are calculated prospectively.~~

~~1. The member shall use the enrollment card to activate the deductible process. The PBM shall track purchases made with the card to calculate when the member has met the deductible amount specified in subsection (B).~~

~~2. For purchases which occur without the use of the enrollment card, the PBM shall not apply any prescription medication cost towards the deductible.~~

~~**B.** A member who meets all conditions of eligibility in Article 5 shall pay 50 percent of the prescription drug costs after meeting the deductible for the enrollment period.~~

1. ~~A member with income above 100 percent but not more than 150 percent of the FPL shall have a deductible of $500 per year.~~
2. ~~A member with income above 150 percent but not more than 200 percent of the FPL shall have a deductible of $1000 per year.~~

R9-32-402. ~~Benefits~~ Repealed

~~Benefits are prospective.~~

1. ~~A member shall present the enrollment card at the time of each purchase.~~
2. ~~The member shall use the enrollment card to:~~
   a. ~~Activate the benefit process, and~~
   b. ~~Receive benefits.~~
3. ~~The 50 percent benefit begins immediately after the deductible is met.~~
4. ~~For purchases which occur without the use of the enrollment card, a participating pharmacy shall not give the member the 50 percent benefit.~~

ARTICLE 5. ~~ELIGIBILITY AND ENROLLMENT~~ REPEALED

R9-32-501. ~~Conditions of Eligibility~~ Repealed

~~To be eligible for the Pilot Program, an applicant shall:~~

1. ~~Qualify for Medicare;~~
2. ~~Be an Arizona resident and reside in a county that either:~~
   a. ~~Does not have a Medicare Health Maintenance Organization (HMO), or~~
   b. ~~Has a Medicare HMO that does not provide prescription drug benefits;~~
3. ~~Have an income above 100 percent but not more than 200 percent of the FPL;~~
4. ~~Submit a completed application; and~~
5. ~~Not be currently eligible for prescription drug coverage through another program administered by AHCCCS.~~

R9-32-502. ~~Applications~~ Repealed

~~A.~~ ~~Availability. The Administration or PBM shall not accept applications after December 1, 2002. The application form will contain questions specific to the Pilot Program.~~

~~B.~~ ~~Submission of Application.~~

1. ~~The applicant shall submit the enrollment fee and the completed application by mail.~~
2. ~~The applicant shall pay the enrollment fee in the form of:~~
   a. ~~Cashier's check,~~
   b. ~~Personal check,~~
   c. ~~Money order, or~~
   d. ~~Credit or debit card.~~

~~C.~~ ~~Date of Application. The Administration or PBM shall consider the date of application as the date the completed application is received and date stamped.~~

~~D.~~ ~~Time-frames for Determining Eligibility.~~

1. ~~The Administration or PBM shall review the application and contact the applicant by telephone or by mail if the application is incomplete. The applicant must respond within 20 days of contact by the Administration or PBM with the additional information and or enrollment fee.~~
2. ~~The Administration or PBM shall determine eligibility and issue a notice within 30 days from the date a completed application is received.~~

~~E.~~ ~~Notice of Approval. The Administration or PBM shall notify the applicant in writing of the approval of the application under subsection (D)(2) and R9-32-503.~~

~~F.~~ ~~Notice of Adverse Action.~~

1. ~~The Administration or PBM shall notify the applicant in writing of the denial of the application within 30 days from the date a completed application is received. The Administration or PBM may deny the application if the applicant fails to:~~
   a. ~~Provide the requested information,~~
   b. ~~Meet the conditions of eligibility under R9-32-501, or~~
   c. ~~Submit the application timely under subsection (D)(1).~~
2. ~~The Administration or PBM shall return the enrollment fee in a timely manner.~~
3. ~~The applicant may file a grievance and request a hearing under 9 A.A.C. 22, Article 8 concerning the denial of the application or the calculation of the deductible amount.~~

R9-32-503. ~~Enrollment~~ Repealed

~~A.~~ ~~The Administration or PBM shall notify the applicant in writing of the approval of the application within 30 days from the date a completed application is received and include, at a minimum:~~

1. ~~An approval letter which contains:~~
   a. ~~The required annual deductible,~~
   b. ~~Information regarding the enrollment card and its use as a tracking mechanism for purchases,~~
   c. ~~Period of enrollment, and~~
   d. ~~A member's responsibility for reporting income or county of residence changes;~~
2. ~~An enrollment card; and~~
3. ~~A list of participating pharmacies.~~

B. ~~The Administration or PBM shall issue an enrollment card for a 12 month period with the following exceptions:~~
1. ~~The Administration or PBM shall not issue an enrollment or reenrollment card to an applicant or member after December 30, 2002.~~
2. ~~An enrollment card, issued by the Administration or PBM on or after July 1, 2002, shall expire no later than July 1, 2003.~~
3. ~~All enrollment cards shall expire July 1, 2003, and the Administration or PBM shall not provide benefits on or after that date.~~

C. ~~Discontinuance of approved benefits.~~
1. ~~Enrollment shall discontinue prior to the period specified in subsection (B) if:~~
   a. ~~The member's income increases above 200 percent of the FPL, or~~
   b. ~~The member qualifies for and receives prescription coverage from another AHCCCS program, or~~
   c. ~~The member moves to a county that has a HMO offering prescription drug coverage, or~~
   d. ~~The member moves out of state.~~
2. ~~The Administration or PBM shall issue a Notice of Adverse Action if benefits are discontinued.~~
3. ~~The applicant may file a grievance and request a hearing under 9 A.A.C. 22, Article 8.~~

R9-32-504. ~~Reenrollment~~ Repealed

A. ~~The Administration or PBM shall notify the member 60 days prior to the expiration of the enrollment card of the need to submit a renewal application and reenrollment fee.~~

B. ~~The Administration or PBM shall notify the member regarding reenrollment status under R9-32-503.~~