

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ARIZONA LONG-TERM CARE SYSTEM

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

Editor's Note: This Chapter contains rules which were adopted under an exemption from the rulemaking provisions of the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6, §§ 1001 et seq.) as specified in Laws 1992, Ch. 301, § 61 and Ch. 302, § 13, and Laws 1994, Ch. 322, § 21. Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; AHCCCS did not submit these rules to the Governor's Regulatory Review Council; AHCCCS was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is printed on blue paper. The rules affected by this exemption appear throughout this Chapter.

ARTICLE 1. DEFINITIONS

Former Section R9-28-101 repealed; new Sections R9-28-101 thru R9-28-111 adopted effective December 8, 1997 (Supp. 97-4).

Section

- R9-28-101. General Definitions
- R9-28-102. Covered Services Related Definitions
- R9-28-103. Preadmission Screening Related Definitions
- R9-28-104. Repealed
- R9-28-105. Repealed
- R9-28-106. Request for Proposals and Contract Process Related Definitions
- R9-28-107. Repealed
- R9-28-108. Repealed
- R9-28-109. Repealed
- R9-28-110. Reserved
- R9-28-111. Behavioral Health Services Related Definitions

ARTICLE 2. COVERED SERVICES

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- R9-28-201. General Requirements
- R9-28-202. Medical Services
- R9-28-203. Coverage for CRS Services
- R9-28-204. Institutional Services
- R9-28-205. Home and Community Based Services (HCBS)
- R9-28-206. ALTCS Services that may be Provided to a Member Residing in either an Institutional or HCBS Setting

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- R9-28-301. Definitions
- R9-28-302. General Provisions
- R9-28-303. Preadmission Screening (PAS) Process
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- R9-28-408. Income Criteria for Eligibility
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- R9-28-411. Changes, Redeterminations, and Notices
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- R9-28-413. Enrollment with an EPD Program Contractor
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Section

- R9-28-501. Program Contractor and Provider Standards – Related Definitions
- R9-28-501.01. Pre-Existing Conditions
- R9-28-502. Long-term Care Provider Requirements
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- R9-28-504. Standards of Participation, Licensure, and Certification for HCBS Providers
- R9-28-505. Standards, Licensure, and Certification for Providers of Hospital and Medical Services
- R9-28-506. Requirements for Spouse as Paid Caregiver
- R9-28-507. Program Contractor General Requirements
- R9-28-508. Self-directed Attendant Care (SDAC)
- R9-28-509. Agency with Choice
- R9-28-510. Case Management
- R9-28-511. Quality Management/Utilization Management (QM/UM) Requirements
- R9-28-512. Expired
- R9-28-513. Program Compliance Audits
- R9-28-514. Release of Safeguarded Information by the Administration and Contractors
- R9-28-515. Repealed

ARTICLE 6. RFP AND CONTRACT PROCESS

Article 6, consisting of Sections R9-28-601 through R9-28-610, repealed; new Article 6, consisting of Sections R9-28-601 through R9-28-608, adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

Section

- R9-28-601. General Provisions
- R9-28-602. RFP
- R9-28-603. Contract Award
- R9-28-604. Contract or Proposal Protests; Appeals
- R9-28-605. Waiver of Contractor's Subcontract with Hospitals
- R9-28-606. Contract Compliance Sanction
- R9-28-607. Repealed
- R9-28-608. Repealed
- R9-28-609. Repealed

R9-28-610. Repealed

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

- R9-28-701. Standards for Payment Related Definitions
- R9-28-701.10. General Requirements
- R9-28-702. Nursing Facility Assessment
- R9-28-703. Nursing Facility Supplemental Payments
- R9-28-704. Repealed
- R9-28-705. Repealed
- R9-28-706. Repealed
- R9-28-707. Repealed
- R9-28-708. Repealed
- R9-28-709. Repealed
- R9-28-710. Repealed
- R9-28-711. Repealed
- R9-28-712. County of Fiscal Responsibility
- R9-28-713. Repealed
- R9-28-714. Repealed
- R9-28-715. Repealed

ARTICLE 8. TEFRA LIENS AND RECOVERIES

Article 8, consisting of Sections R9-28-801 through R9-28-807, made by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

Article 8, consisting of Sections R9-28-801 through R9-28-803, repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).

Section

- R9-28-801. Definitions Related to TEFRA Liens
- R9-28-801.01. TEFRA Liens – General
- R9-28-802. TEFRA Liens – Affected Members
- R9-28-803. TEFRA Liens – Prohibitions
- R9-28-804. TEFRA Liens – AHCCCS Notice of Intent
- R9-28-805. TEFRA Liens and Estate Recovery – Member’s Request for a State Fair Hearing
- R9-28-806. TEFRA Liens – Recovery
- R9-28-807. TEFRA Liens – Release

ARTICLE 9. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES

Section

- R9-28-901. Definitions
- R9-28-902. General Provisions
- R9-28-903. Cost Avoidance
- R9-28-904. Member Participation
- R9-28-905. Collections
- R9-28-906. AHCCCS Monitoring Responsibilities
- R9-28-907. Notification for Perfection, Recording, and Assignment of AHCCCS Liens
- R9-28-908. Notification Information for Liens
- R9-28-909. Notification of Health Insurance Information
- R9-28-910. Recoveries
- R9-28-911. Estate Recovery and Undue Hardship
- R9-28-912. Partial Recovery
- R9-28-913. Repealed
- R9-28-914. Repealed
- R9-28-915. Repealed
- R9-28-916. Repealed
- R9-28-917. Repealed
- R9-28-918. Repealed
- R9-28-919. Repealed

ARTICLE 10. CIVIL MONETARY PENALTIES AND ASSESSMENTS

Section

- R9-28-1001. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims
- R9-28-1002. Repealed
- R9-28-1003. Repealed
- R9-28-1004. Repealed

ARTICLE 11. BEHAVIORAL HEALTH SERVICES

Article 11, consisting of Sections R9-28-1101 through R9-28-1106, repealed; new Article 11, consisting of Sections R9-28-1101 through R9-28-1108, adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4).

Section

- R9-28-1101. General Requirements
- R9-28-1102. Program or Tribal Contractor Responsibilities
- R9-28-1103. Eligibility for Covered Services
- R9-28-1104. General Service Requirements
- R9-28-1105. Scope of Behavioral Health Services
- R9-28-1106. General Provisions and Standards for Service Providers
- R9-28-1107. General Provisions for Payment
- R9-28-1108. Repealed

ARTICLE 12. REPEALED

Article 12, consisting of Section R9-28-1201, repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004. The subject matter of Article 12 is now in 9 A.A.C. 34 (Supp. 04-1).

Article 12, consisting of Section R9-28-1201, adopted effective September 9, 1998 (Supp. 98-3).

Section

- R9-28-1201. Repealed

ARTICLE 13. FREEDOM TO WORK

Article 13, consisting of Sections R9-28-1301 through R9-28-1324, made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

Section

- R9-28-1301. General Freedom to Work Requirements
- R9-28-1302. General Administration Requirements
- R9-28-1303. Application for Coverage
- R9-28-1304. Notice of Approval or Denial
- R9-28-1305. Reporting and Verifying Changes
- R9-28-1306. Actions that Result from a Redetermination or Change
- R9-28-1307. Notice of Adverse Action
- R9-28-1308. Request for Hearing
- R9-28-1309. Conditions of Eligibility
- R9-28-1310. Repealed
- R9-28-1311. Repealed
- R9-28-1312. Repealed
- R9-28-1313. Premium Requirements
- R9-28-1314. Repealed
- R9-28-1315. Repealed
- R9-28-1316. Institutionalized Person
- R9-28-1317. Repealed
- R9-28-1318. Repealed
- R9-28-1319. Repealed
- R9-28-1320. Additional Eligibility Criteria for the Basic Coverage Group
- R9-28-1321. Share of Cost
- R9-28-1322. Repealed
- R9-28-1323. Enrollment

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R9-28-1324. Redetermination of Eligibility

ARTICLE 1. DEFINITIONS**R9-28-101. General Definitions**

A. Location of definitions. Definitions applicable to Chapter 28 are found in the following:

Definition	Section or Citation		
"210"	42 CFR 435.211	"CSRD"	R9-28-401
"217"	42 CFR 435.217	"Current"	R9-28-301
"236"	42 CFR 435.236	"Day"	R9-22-101 or R9-22-1101
"Acute"	R9-28-301	"De novo hearing"	42 CFR 431.201
"ADHS"	R9-22-101	"Department"	A.R.S. § 36-2901
"ADL"	R9-28-101	"Developmental disability" or "DD"	A.R.S. § 36-551
"Administration"	A.R.S. § 36-2931	"Diagnostic services"	R9-22-101
"Advance notice"	R9-28-411	"Director"	R9-22-101
"Aged"	R9-28-402	"Disabled"	R9-28-402
"Aggregate"	R9-22-701	"Disenrollment"	R9-22-1701
"Aggression"	R9-28-301	"Disruptive behavior"	R9-28-301
"AHCCCS"	R9-22-101	"DME"	R9-22-101
"AHCCCS registered provider"	R9-22-101	"Dressing"	R9-28-301
"ALTCS"	R9-28-101	"Eating"	R9-28-301
"ALTCS acute care services"	R9-28-401	"Eating or drinking"	R9-28-301
"Alternative HCBS setting"	R9-28-101	"Emergency medical services for the non-FES member"	R9-22-201
"Ambulance"	A.R.S. § 36-2201	"Emotional and cognitive functioning"	R9-28-301
"Ambulation"	R9-28-301	"Employed"	R9-28-1320
"Applicant"	R9-22-101	"Encounter"	R9-22-701
"Assessor"	R9-28-301	"Enrollment"	R9-22-1701
"Auto-assignment algorithm" or "Algorithm"	R9-22-1701	"EPD"	R9-28-301
"Bathing"	R9-28-301	"E.P.S.D.T. services"	42 CFR 440.40(b)
"Bathing or showering"	R9-28-301	"Estate"	A.R.S. § 14-1201
"Bed hold"	R9-28-102	"Experimental services"	R9-22-203
"Behavior intervention"	R9-28-102	"Expressive verbal communication"	R9-28-301
"Behavior management services"	R9-22-1201	"Facility"	R9-22-101
"Behavioral health evaluation"	R9-22-1201	"Factor"	42 CFR 447.10
"Behavioral health medical practitioner"	R9-22-1201	"Fair consideration"	R9-28-401
"Behavioral health professional"	R9-20-101	"FBR"	R9-22-101
"Behavioral health service"	R9-20-101	"Federal financial participation" or "FFP"	42 CFR 400.203
"Behavioral health technician"	R9-20-101	"Fee-For-Service" or "FFS"	R9-22-101
"Billed charges"	R9-22-701	"File"	R9-28-801
"Blind"	42 U.S.C. 1382c(a)(2)	"First continuous period of institutionalization"	R9-28-401
"Capped fee-for-service"	R9-22-101	"Food preparation"	R9-28-301
"Case management plan"	R9-28-101	"Frequency"	R9-28-301
"Case management"	R9-28-1101	"Functional assessment"	R9-28-301
"Case manager"	R9-28-101	"Grievance"	R9-34-202
"Case record"	R9-22-101	"Grooming"	R9-28-301
"Categorically-eligible"	R9-22-101	"GSA"	R9-22-101
"Certification"	R9-28-501	"Guardian"	A.R.S. § 14-5311
"Certified psychiatric nurse practitioner"	R9-22-1201	"Hand use"	R9-28-301
"CFR"	R9-28-101	"HCBS" or "Home and community based services"	A.R.S. § 36-2931
"Child"	R9-22-1503	"Health care practitioner"	R9-22-1201
"Clarity of communication"	R9-28-301	"History"	R9-28-301
"Clean claim"	A.R.S. § 36-2904	"Home"	R9-28-101 and R9-28-801
"Clinical supervision"	R9-22-201	"Home health services"	R9-22-201
"CMS"	R9-22-101	"Hospice"	A.R.S. § 36-401
"Community mobility"	R9-28-301	"Hospital"	R9-22-101
"Community spouse"	R9-28-401	"ICF-MR" or "Intermediate care facility for the mentally retarded"	42 U.S.C. 1396d(d)
"Consecutive days"	R9-28-801	"IADL"	R9-28-101
"Continence"	R9-28-301	"IHS"	R9-22-101
"Contract"	R9-22-101	"IMD" or "Institution for mental diseases"	42 CFR 435.1010
"Contract year"	R9-22-101	"Immediate risk of institutionalization"	R9-28-301
"Contractor"	A.R.S. § 36-2901	"Individual Representative"	R9-28-509
"Cost avoid"	R9-22-1201 or R9-22-1001	"Institutionalized"	R9-28-401
"County of fiscal responsibility"	R9-28-701	"Institutionalized spouse"	R9-28-101
"Covered services"	R9-28-101	"Interested Party"	R9-28-106
"CPT"	R9-22-701	"Intergovernmental agreement" or "IGA"	R9-28-1101
"Crawling and standing"	R9-28-301	"Intervention"	R9-28-301
		"JCAHO"	R9-28-101
		"License" or "licensure"	R9-22-101
		"Medical assessment"	R9-28-301

“Medical or nursing services and treatments”	
or “services and treatments”	R9-28-301
“Medical record”	R9-22-101
“Medical services”	A.R.S. § 36-401
“Medically eligible”	R9-28-401
“Medically necessary”	R9-22-101
“Member”	A.R.S. § 36-2931 and R9-28-901
“Mental disorder”	A.R.S. § 36-501
“MMMNA”	R9-28-401
“Mobility”	R9-28-301
“Natural Support Services”	R9-28-101
“Noncontracting provider”	A.R.S. § 36-2931
“Nursing facility” or “NF”	42 U.S.C. 1396r(a)
“Occupational therapy”	R9-22-201
“Orientation”	R9-28-301
“Partial care”	R9-22-1201
“PAS”	R9-28-103
“Personal hygiene”	R9-28-301
“Pharmaceutical service”	R9-22-201
“Physical therapy”	R9-22-201
“Physically disabled”	R9-28-301
“Physician”	R9-22-101
“Physician consultant”	R9-28-301
“Post-stabilization care services”	42 CFR 438.114
“Practitioner”	R9-22-101
“Primary care provider” or “(PCP)”	R9-22-101
“Primary care provider services”	R9-22-201
“Prior authorization”	R9-22-101
“Prior period coverage” or “PPC”	R9-22-101
“Program contractor”	A.R.S. § 36-2931
“Provider”	A.R.S. § 36-2931
“Psychiatrist”	R9-22-1201
“Psychologist”	R9-22-1201
“Psychosocial rehabilitation services”	R9-22-201
“Qualified behavioral health service provider”	R9-28-1101
“Quality management”	R9-22-501
“Radiology”	R9-22-101
“Reassessment”	R9-28-103
“Recover”	R9-28-901
“Redetermination”	R9-28-401
“Referral”	R9-22-101
“Regional behavioral health authority”	
or “RBHA”	A.R.S. § 36-3401
“Reinsurance”	R9-22-701
“Representative”	R9-28-401
“Resistiveness”	R9-28-301
“Respiratory therapy”	R9-22-201
“Respite care”	R9-28-102
“RFP”	R9-22-101
“Room and board”	R9-28-102
“Rolling and sitting”	R9-28-301
“Running or wandering away”	R9-28-301
“Scope of services”	R9-28-102
“Section 1115 Waiver”	A.R.S. § 36-2901
“Self-injurious behavior”	R9-28-301
“Sensory”	R9-28-301
“Seriously mentally ill” or “SMI”	A.R.S. § 36-550
“Social worker”	R9-28-301
“Special diet”	R9-28-301
“Speech therapy”	R9-22-201
“Spouse”	R9-28-401
“SSA”	42 CFR 1000.10
“SSI”	42 CFR 435.4
“Subcontract”	R9-22-101
“TEFRA lien”	R9-28-801
“Therapeutic leave”	R9-28-501

“Toileting”	R9-28-301
“Transferring”	R9-28-301
“TRBHA”	R9-22-1201
“Tribal contractor”	R9-28-1101
“Tribal facility”	A.R.S. § 36-2981
“Utilization management/review”	R9-22-501
“Ventilator dependent”	R9-28-102
“Verbal or physical threatening”	R9-28-301
“Vision”	R9-28-301
“Wandering”	R9-28-301
“Wheelchair mobility”	R9-28-301

B. General definitions. In addition to definitions contained in A.R.S. §§ 36-551, 36-2901, 36-2931, and 9 A.A.C. 22, Article 1, the following words and phrases have the following meanings unless the context of the Chapter explicitly requires another meaning:

“ADL” or “Activities of Daily Living” mean activities a member must perform daily for the member’s regular day-to-day necessities, including but not limited to mobility, transferring, bathing, dressing, grooming, eating, and toileting.

“ALTCS” means the Arizona Long-term Care System as authorized by A.R.S. § 36-2932.

“Alternative HCBS setting” means a living arrangement approved by the Director and licensed or certified by a regulatory agency of the state, where a member may reside and receive HCBS, including:

For a person with a developmental disability specified in A.R.S. § 36-551:

Community residential setting defined in A.R.S. § 36-551;

Group home defined in A.R.S. § 36-551;

State-operated group home under A.R.S. § 36-591;

Group foster home under R6-5-5903;

Licensed residential facility for a person with traumatic brain injury under A.R.S. § 36-2939;

Behavioral health adult therapeutic home under 9 A.A.C 20, Articles 1 and 15;

Level 2 and Level 3 behavioral health residential agencies under 9 A.A.C. 20, Articles 1, 4, 5, and 6; and

Rural substance abuse transitional centers under 9 A.A.C. 20, Articles 1 and 14; and

For a person who is Elderly and Physically Disabled (EPD) under R9-28-301, and the facility, setting, or institution is registered with AHCCCS:

Adult foster care defined in A.R.S. § 36-401 and as authorized in A.R.S. § 36-2939;

Assisted living home or assisted living center, units only, under A.R.S. § 36-401, and as authorized in A.R.S. § 36-2939;

Licensed residential facility for a person with a traumatic brain injury specified in A.R.S. § 36-2939;

Behavioral health adult therapeutic home under 9 A.A.C. 20, Articles 1 and 15;

Level 2 and Level 3 behavioral health residential agencies under 9 A.A.C. 20, Articles 1, 4, 5, and 6; and

Rural substance abuse transitional centers under 9 A.A.C. 20, Articles 1 and 14.

“Case management plan” means a service plan developed by a case manager that involves the overall management of a member’s care, and the continued monitoring and reassessment of the member’s need for services.

“Case manager” means a person who is either a degreed social worker, a licensed registered nurse, or has a minimum of two years of experience in providing case management services to a person who is EPD.

“CFR” means Code of Federal Regulations, unless otherwise specified in this Chapter.

“Covered services” means the health and medical services described in Articles 2 and 11 of this Chapter as being eligible for reimbursement by AHCCCS.

“Home” means a residential dwelling that is owned, rented, leased, or occupied by a member, at no cost to the member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a:

- Health care institution under A.R.S. § 36-401;
- Residential care institution under A.R.S. § 36-401;
- Community residential setting under A.R.S. § 36-551; or
- Behavioral health facility under 9 A.A.C. 20, Articles 1, 4, 5, and 6.

“IADL” or “Instrumental Activities of Daily Living” mean activities related to independent living that a member must perform, including but not limited to:

- Preparing meals,
- Managing money,
- Shopping for groceries or personal items,
- Performing light or heavy housework, and
- Use of the telephone.

“IHS” means the Indian Health Service.

“Institutionalized spouse” means the same as defined in 42 U.S.C. 1396r-5.

“JCAHO” means the Joint Commission on Accreditation of Healthcare Organizations.

“Natural Support Services” are services provided voluntarily by a person not legally obligated to provide those services. The services are specified in the service plan as described under R9-28-510 and cannot supplant other covered services.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1). Subsection (A)(69) amended to correct a printing error, filed in the Office of the Secretary of State August 13, 1999 (Supp. 99-3). Amended by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 2461, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 6 A.A.R.

3365, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 2356, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 9 A.A.R. 3810, effective October 4, 2003 (Supp. 03-3). Amended by final rulemaking at 10 A.A.R. 1312, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 11 A.A.R. 3165, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 1090, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2). Amended by final rulemaking at 18 A.A.R. 3380, effective January 1, 2013 (Supp. 12-4).

R9-28-102. Covered Services Related Definitions

Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

“Bed hold” means a 24 hour per day unit of service that is authorized by an ALTCS case manager or designee during a period of short-term hospitalization or therapeutic leave that meets the requirement specified in 42 CFR 483.12.

“Behavior intervention” means the planned interruption of a member’s inappropriate behavior using techniques such as reinforcement, training, behavior modification, and other systematic procedures intended to result in more acceptable behavior.

“Respite care” means a short-term service provided in a NF or a home and community based service setting to an individual if necessary to relieve a family member or other person caring for the individual.

“Room and board” means lodging and meals.

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

“Ventilator dependent,” for purposes of ALTCS eligibility, means an individual is medically dependent on a ventilator for life support at least six hours per day and has been dependent on ventilator support as an inpatient in a hospital, NF, or ICF-MR for at least 30 consecutive days.

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2461, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 9 A.A.R. 3810, effective October 4, 2003 (Supp. 03-3).

R9-28-103. Preadmission Screening Related Definitions

Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

“Developmental disability” is defined in A.R.S. § 36-551.

“PAS” means preadmission screening, which is the process of determining an individual’s risk of institutionalization at a NF or ICF-MR level of care, as specified in Article 3 of this Chapter.

“Reassessment” means the process of redetermining PAS eligibility for ALTCS services as appropriate, for all members.

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2461, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 9 A.A.R. 3810, effective October 4, 2003 (Supp. 03-3). Amended by final rulemaking at 10 A.A.R. 1312, effective May 1, 2004 (Supp. 04-1).

R9-28-104. Repealed

Adopted effective December 8, 1997 (Supp. 97-4). Amended effective November 4, 1998 (Supp. 98-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 6 A.A.R. 2461, effective June 9, 2000 (Supp. 00-2). Repealed by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2).

R9-28-105. Repealed

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4).

R9-28-106. Request for Proposals and Contract Process Related Definitions

Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22 Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning: “Interested Party” means an actual or prospective offeror whose economic interest may be affected substantially and directly by the issuance of a request for proposals, the award of a contract, or the failure to award a contract.

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-107. Repealed

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4). Amended effective November 4, 1998 (Supp. 98-4). Amended by final rulemaking at 6 A.A.R. 2461, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 9 A.A.R. 3810, effective October 4, 2003 (Supp. 03-3). Section repealed by final rulemaking at 11 A.A.R. 3165, effective October 1, 2005 (Supp. 05-3).

R9-28-108. Repealed

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004 (Supp. 04-1).

R9-28-109. Repealed

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-110. Reserved

R9-28-111. Behavioral Health Services Related Definitions

Definitions. The words and phrases in this Chapter, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, have the same meaning as specified in 9 A.A.C. 22, Article 1.

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4).

ARTICLE 2. COVERED SERVICES

R9-28-201. General Requirements

In addition to the exclusions and limitations specified in this Article, services provided to a member are covered services if:

1. Medically necessary, cost effective, and federally reimbursable;
2. Coordinated by a case manager in accordance with requirements specified in R9-28-510;
3. The provider obtains prior authorization as required by a member’s program contractor or by the Administration:
 - a. Failure of the provider to obtain prior authorization is cause for denial.
 - b. Services provided during prior period coverage are exempt from prior authorization requirements;
4. Provided in facilities or areas of facilities that are licensed or certified under Article 5 of this Chapter, or meet other requirements described in Article 5 of this Chapter;
5. Rendered by AHCCCS registered providers as permitted under this Chapter and within their scope of practice; and
6. Provided at an appropriate level of care, as determined by the case manager or the primary care provider.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Section repealed; new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2356, effective May 9, 2002 (Supp. 02-2).

R9-28-202. Medical Services

The Administration or a contractor shall cover medical services specified in 9 A.A.C. 22, Article 2 for a member, subject to the limitations and exclusions specified in Article 2, unless otherwise specified in this Chapter.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2356, effective May 9, 2002 (Supp. 02-2).

R9-28-203. Coverage for CRS Services

- A. Beginning October 1, 2013, ALTCS DD members who need active treatment for one or more of the qualifying medical condition(s) in A.A.C. R9-22-1303 shall receive CRS services

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through the CRS contractor as described under Chapter 22, Article 13.

- B.** Beginning October 1, 2013, AHCCCS ALTCS EPD members who need active treatment for one or more of the qualifying medical conditions in A.A.C. R9-22-1303 shall not receive CRS services through the CRS contractor as described under Chapter 22, Article 13. These members shall receive treatment for those conditions through their assigned ALTCS EPD contractor. However, an American Indian member with a CRS condition(s) who is enrolled with a tribal contractor or Native American Community Health (NACH) shall obtain CRS services through the CRS contractor.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Repealed effective September 22, 1997 (Supp. 97-3). New Section R9-28-203 made by final rulemaking at 19 A.A.R. 2963, effective November 10, 2013 (Supp. 13-3).

R9-28-204. Institutional Services

- A.** Institutional services are provided in:
1. A NF;
 2. An ICF-MR; or
 3. A facility identified in R9-28-1105(A)(1)(b), (B), or (C).
- B.** The Administration and a contractor shall include the following services in the per diem rate for a facility listed in subsection (A):
1. Nursing care services;
 2. Rehabilitative services prescribed as a maintenance regimen;
 3. Restorative services, such as range of motion;
 4. Social services;
 5. Nutritional and dietary services;
 6. Recreational therapies and activities;
 7. Medical supplies and non-customized durable medical equipment under 9 A.A.C. 22, Article 2;
 8. Overall management and evaluation of a member's care plan;
 9. Observation and assessment of a member's changing condition;
 10. Room and board services, including supporting services such as food and food preparation, personal laundry, and housekeeping;
 11. Non-prescription and stock pharmaceuticals; and
 12. Respite care services not to exceed 600 hours per benefit year.
- C.** Each facility listed in subsection (A) is responsible for coordinating the delivery of at least the following auxiliary services:
1. Under 9 A.A.C. 22, Article 2:
 - a. Attending physician, practitioner, and primary care provider services;
 - b. Pharmaceutical services;
 - c. Diagnostic services under A.A.C. R9-22-208;
 - d. Emergency medical services; and
 - e. Emergency and medically necessary transportation services.
 2. Therapy services under R9-28-206.
- D.** Limitations. The following limitations apply:
1. A private room in a NF, ICF-MR, or facility identified in R9-28-1105(A)(1)(b), (B), or (C) is covered only if:

- a. The member or has a medical condition that requires isolation, and
 - b. The member's primary care provider or attending physician provides written authorization;
2. Each ICF-MR shall meet the standards in A.R.S. § 36-2939(B)(1), and in 42 CFR 483, Subpart I, February 28, 1992, incorporated by reference and on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation contains no future editions or amendments;
 3. Bed hold days as authorized by the Administration or its designee for a fee-for-service provider shall meet the following criteria:
 - a. Short-term hospitalization leave for a member age 21 and over is limited to 12 days per AHCCCS benefit year, and is available if a member is admitted to a hospital for a short stay. After the short-term hospitalization, the member is returned to the institutional facility from which leave is taken, and to the same bed if the level of care required can be provided in that bed; and
 - b. Therapeutic leave for a member age 21 and older is limited to nine days per AHCCCS benefit year. A physician order is required for therapeutic leave from the facility for one or more overnight stays to enhance psycho-social interaction, or as a trial basis for discharge planning. After the therapeutic leave, the member is returned to the same bed within the institutional facility;
 - c. Therapeutic leave and short-term hospitalization leave are limited to any combination of 21 days per benefit year for a member under age 21;
 4. The Administration or a contractor shall cover services that are not part of a per diem rate but are ALTCS covered services included in this Article, and deemed necessary by a member's case manager or the case manager's designee if:
 - a. The services are ordered by the member's primary care provider; and
 - b. The services are specified in a case management plan under R9-28-510;
 5. A member age 21 through 64 is eligible for behavioral health services provided in a facility under subsection (A)(3) that has more than 16 beds, for up to 30 days per admission and no more than 60 days per benefit year as allowed under the Administration's Section 1115 Waiver with CMS and except as specified by 42 CFR 441.151, May 22, 2001, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation contains no future editions or amendments; and
 6. The limitations in subsection (D)(5) do not apply to a member:
 - a. Under age 21 or age 65 or over, or
 - b. In a facility with 16 beds or less.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsections (A) and (D) effective June 6, 1989 (Supp. 89-2). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2356, effective May 9, 2002

(Supp. 02-2). Amended by exempt rulemaking at 17 A.A.R. 1876, effective October 1, 2011 (Supp. 11-3). Exemption to amend rules to expire December 31, 2013 under Laws 2012, Chapter 299, Section 8 therefore this Section was amended by final rulemaking at 19 A.A.R. 2758, effective October 8, 2013 (Supp. 13-3).

R9-28-205. Home and Community Based Services (HCBS)

- A.** Subject to the availability of federal funds, HCBS are covered services if provided to a member residing in the member's own home or an alternative residential setting. Room and board services are not covered in a HCBS setting.
- B.** The case manager shall authorize and specify in a case management plan any additions, deletions, or changes in home and community based services provided to a member or in accordance with R9-28-510.
- C.** Home and community based services include the following:
1. Home health services provided on a part-time or intermittent basis. These services include:
 - a. Nursing care;
 - b. Home health aide;
 - c. Medical supplies, equipment, and appliances;
 - d. Physical therapy;
 - e. Occupational therapy;
 - f. Respiratory therapy; and
 - g. Speech and audiology services;
 2. Private duty nursing services;
 3. Medical supplies and durable medical equipment, including customized DME, as described in 9 A.A.C. 22, Article 2;
 4. Transportation services to obtain covered medically necessary services;
 5. Adult day health services provided to a member in an adult day health care facility licensed under 9 A.A.C. 10, Article 5, including:
 - a. Supervision of activities specified in the member's care plan;
 - b. Personal care;
 - c. Personal living skills training;
 - d. Meals and health monitoring;
 - e. Preventive, therapeutic, and restorative health related services; and
 - f. Behavioral health services, provided either directly or through referral, if medically necessary;
 6. Personal care services;
 7. Homemaker services;
 8. Home delivered meals, that provide at least one-third of the recommended dietary allowance, for a member who does not have a developmental disability under A.R.S. § 36-551;
 9. Respite care services for no more than 600 hours per benefit year;
 10. Habilitation services including:
 - a. Physical therapy;
 - b. Occupational therapy;
 - c. Speech and audiology services;
 - d. Training in independent living;
 - e. Special development skills that are unique to the member;
 - f. Sensory-motor development;
 - g. Behavior intervention; and
 - h. Orientation and mobility training;
 11. Developmentally disabled day care provided in a group setting during a portion of a 24-hour period, including:
 - a. Supervision of activities specified in the member's care plan;
 - b. Personal care;

- c. Activities of daily living skills training; and
 - d. Habilitation services;
12. Supported employment services provided to a member in the ALTCS transitional program under R9-28-306 who is developmentally disabled under A.R.S. § 36-551.

Historical Note

Adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2356, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 17 A.A.R. 1876, effective October 1, 2011 (Supp. 11-3). Exemption to amend rules to expire December 31, 2013 under Laws 2012, Chapter 299, Section 8 therefore this Section was amended by final rulemaking at 19 A.A.R. 2758, effective October 8, 2013 (Supp. 13-3).

R9-28-206. ALTCS Services that may be Provided to a Member Residing in either an Institutional or HCBS Setting

The Administration shall cover the following services if the services are provided to a member within the limitations listed:

1. Occupational and physical therapies, speech and audiology services, and respiratory therapy:
 - a. The duration, scope, and frequency of each therapeutic modality or service is prescribed by the member's primary care provider or attending physician;
 - b. The therapy or service is authorized by the member's contractor or the Administration; and
 - c. The therapy or service is included in the members case management plan;
 - d. AHCCCS will not cover more than 15 outpatient physical therapy visits for the contract year with the exception of the required Medicare coinsurance and deductible payment as described in 9 A.A.C. 29, Article 3.
2. Medical supplies, durable medical equipment, and customized durable medical equipment, which conform with the requirements and limitations of 9 A.A.C. 22, Article 2;
3. Ventilator dependent services:
 - a. Inpatient or institutional services are limited to services provided in a general hospital, special hospital, NF, or ICF-MR. Services provided in a general or special hospital are included in the hospital's unit tier rate under 9 A.A.C. 22, Article 7;
 - b. A ventilator dependent member may receive the array of home and community based services under R9-28-205 as appropriate.
4. Hospice services:
 - a. Hospice services are covered only for a member who is in the final stages of a terminal illness and has a prognosis of death within six months;
 - b. Covered hospice services for a member are those allowable under 42 CFR 418.202, December 20, 1994, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments; and
 - c. Covered hospice services do not include:
 - i. Medical services provided that are not related to the terminal illness, or
 - ii. Home delivered meals.
 - d. Medicare is the primary payor of hospice services for a member if applicable.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp.

92-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2356, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 16 A.A.R. 1664, effective October 1, 2010 (Supp. 10-3).

ARTICLE 3. PREADMISSION SCREENING (PAS)

R9-28-301. Definitions

A. Common definitions. In addition to definitions contained in A.R.S. Title 36, Chapter 29, and 9 A.A.C. 28, Article 1, the words and phrases in this Article have the following meanings for an individual who is elderly or physically disabled (EPD) or developmentally disabled (DD) unless the context explicitly requires another meaning:

“Applicant” is defined in A.A.C. R9-22-101.

“Assessor” means a social worker as defined in this subsection or a licensed registered nurse (RN) who:

Is employed by the Administration to conduct PAS assessments,

Completes a minimum of 30 hours of classroom training in both EPD and DD PAS for a total of 60 hours, and

Receives intensive oversight and monitoring by the Administration during the first 30 days of employment and ongoing oversight by the Administration during all periods of employment.

“Current” means belonging to the present time.

“Disruptive behavior” means inappropriate behavior by the applicant or member including urinating or defecating in inappropriate places, sexual behavior inappropriate to time, place, or person or excessive whining, crying, or screaming that interferes with an applicant’s or member’s normal activities or the activities of others and requires intervention to stop or interrupt the behavior.

“Frequency” means the number of times a specific behavior occurs within a specified interval.

“Functional assessment” means an evaluation of information about an applicant’s or member’s ability to perform activities related to:

Developmental milestones,
Activities of daily living,
Communication, and
Behavior.

“Immediate risk of institutionalization” means the status of an applicant or member under A.R.S. § 36-2934(A)(5) and as specified in A.R.S. § 36-2936 and in the Administration’s Section 1115 Waiver with Centers for Medicare and Medicaid Services (CMS).

“Intervention” means therapeutic treatment, including the use of medication, behavior modification, and physical restraints to control behavior. Intervention may be formal or informal and includes actions taken by friends or family to control the behavior.

“Medical assessment” means an evaluation of an applicant’s or member’s medical condition and the applicant’s or member’s need for medical services.

“Medical or nursing services and treatments” or “services and treatments” means specific, ongoing medical, psychiatric, or nursing intervention used actively to resolve or prevent deterioration of a medical condition. Durable medical equipment and activities of daily living assistive

devices are not treatment unless the equipment or device is used specifically and actively to resolve the existing medical condition.

“Physician consultant” means a physician who contracts with the Administration.

“Social worker” means an individual with two years of case management-related experience or a baccalaureate or master’s degree in:

Social work,
Rehabilitation,
Counseling,
Education,
Sociology,
Psychology, or
Other closely related field.

“Special diet” means a diet planned by a dietitian, nutritionist, or nurse that includes high fiber, low sodium, or pureed food.

“Toileting” means the process involved in an applicant’s or member’s managing of the elimination of urine and feces in an appropriate place.

“Vision” means the ability to perceive objects with the eyes.

B. EPD. In addition to definitions contained in subsection (A), the following also apply to an applicant or member who is EPD:

“Aggression” means physically attacking another, including:

Throwing an object,
Punching,
Biting,
Pushing,
Pinching,
Pulling hair,
Scratching, and
Physically threatening behavior.

“Bathing” means the process of washing, rinsing, and drying all parts of the body, including an applicant’s or member’s ability to transfer to a tub or shower and to obtain bath water and equipment.

“Continence” means the applicant’s or member’s ability to control the discharge of body waste from bladder and bowel.

“Dressing” means the physical process of choosing, putting on, securing fasteners, and removing clothing and footwear. Dressing includes choosing a weather-appropriate article of clothing but excludes aesthetic concerns. Dressing includes the applicant’s or member’s ability to put on artificial limbs, braces, and other appliances that are needed daily.

“Eating” means the process of putting food and fluids by any means into the digestive system.

“Emotional and cognitive functioning” means an applicant’s or member’s orientation and mental state, as evidenced by aggressive, self-injurious, wandering, disruptive, and resistive behaviors.

“EPD” means an applicant or member who is elderly and physically disabled.

“Grooming” means an applicant’s or member’s process of tending to appearance. Grooming includes: combing or brushing hair; washing face and hands; shaving; oral hygiene (including denture care); and menstrual care. Grooming does not include aesthetics such as styling hair, skin care, nail care, and applying cosmetics.

“Mobility” means the extent of an applicant’s or member’s purposeful movement within a residential environment.

“Orientation” means an applicant’s or member’s awareness of self in relation to person, place, and time.

“Physically disabled” means an applicant or member who is determined to be physically impaired by the Administration through the PAS assessment as allowed under the Administration’s Section 1115 Waiver with CMS.

“Resistiveness” means inappropriately obstinate and uncooperative behaviors, including passive or active obstinate behaviors, or refusing to participate in self-care or to take necessary medications. Resistiveness does not include difficulties with auditory processing or reasonable expressions of self-advocacy.

“Self-injurious behavior” means repeated self-induced, abusive behavior that is directed toward infliction of immediate physical harm to the body.

“Sensory” means of or relating to the senses.

“Transferring” means an applicant’s or member’s ability to move horizontally or vertically between two surfaces within a residential environment, excluding transfer for toileting or bathing.

“Wandering” means an applicant’s or member’s moving about with no rational purpose and with a tendency to go beyond the physical parameter of the residential environment.

C. DD. In addition to definitions contained in subsection (A), the following also apply to an applicant or member who is DD:

“Acute” means an active medical condition having a sudden onset, lasting a short time, and requiring immediate medical intervention.

“Aggression” means physically attacking another, including:

- Throwing objects,
- Punching,
- Biting,
- Pushing,
- Pinching,
- Pulling hair, and
- Scratching.

“Ambulation” means the ability to walk and includes quality of the walking and the degree of independence in walking.

“Bathing or showering” means an applicant’s or member’s ability to complete the bathing process including drawing the bath water, washing, rinsing, and drying all parts of the body, and washing the hair.

“Clarity of communication” means an ability to speak in recognizable language or use a formal symbolic substitution, such as American-Sign Language.

“Community mobility” means the applicant’s or member’s ability to move about a neighborhood or community independently, by any mode of transportation.

“Crawling and standing” means an applicant’s or member’s ability to crawl and stand with or without support.

“DD” means developmentally disabled.

“Developmental milestone” means a measure of an applicant’s or member’s functional abilities, including:

- Fine motor skills,
- Gross motor skills,
- Communication,
- Socialization,
- Daily living skills, and
- Behaviors.

“Dressing” means the ability to put on and remove an article of clothing. Dressing does not include the ability to put on or remove braces nor does it reflect an applicant’s or member’s ability to match colors or choose clothing appropriate for the weather.

“Eating or drinking” means the process of putting food and fluid by any means into the digestive system.

“Expressive verbal communication” means an applicant’s or member’s ability to communicate thoughts with words or sounds.

“Food preparation” means the ability to prepare a simple meal including a sandwich, cereal, or a frozen meal.

“Hand use” means the applicant’s or member’s ability to use both hands, or one hand if an applicant or member has only one hand or has the use of only one hand.

“History” means a medical condition that occurred in the past, regardless of whether the medical condition required treatment in the past, and is not now active.

“Personal hygiene” means the process of tending to one’s appearance. Personal hygiene may include: combing or brushing hair, washing face and hands, shaving, performing routine nail care, oral hygiene including denture care, and menstrual care. This does not include aesthetics such as styling hair, skin care, and applying cosmetics.

“Rolling and sitting” means an applicant’s or member’s ability to roll and sit independently or with the physical support of another person or with a device such as a pillow or specially-designed chair.

“Running or wandering away” means an applicant or member leaving a physical environment without notifying or receiving permission from the appropriate individuals.

“Self-injurious behavior” means an applicant’s or member’s repeated behavior that causes injury to the applicant or member.

“Verbal or physical threatening” means any behavior in which an applicant or member uses words, sounds, or action to threaten harm to self, others, or an object.

“Wheelchair mobility” means an applicant’s or member’s mobility using a wheelchair and does not include the ability to transfer to the wheelchair.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsection (C) effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed by emergency action, new Section adopted by emergency action, subsection (A) effective June 30, 1995, subsection (B) effective Septem-

ber 1, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days; entire Section filed in the Secretary of State's Office June 30, 1995 (Supp. 95-2). Section repealed by emergency action, new Section adopted again by emergency action with changes effective January 2, 1996, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 96-1). Emergency expired June 1, 1996. Section in effect before emergency action restored. Section repealed; new Section adopted effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 12 A.A.R. 4007, effective October 5, 2006 (Supp. 06-4). Amended by final rulemaking at 17 A.A.R. 167, effective March 12, 2011 (Supp. 11-1).

R9-28-302. General Provisions

To qualify for services described in A.R.S. § 36-2939:

1. An applicant shall meet the financial criteria described in Article 4, and
2. AHCCCS shall determine that the applicant is at immediate risk of institutionalization under the PAS assessment as specified in this Article.

Historical Note

New Section adopted by emergency action, subsection (A) effective June 30, 1995, subsection (B) effective September 1, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days; entire Section filed in the Office of the Secretary of State June 30, 1995 (Supp. 95-2). New Section adopted again by emergency action with changes effective January 2, 1996, pursuant to A.R.S. § 41-1026 (Supp. 96-1). Emergency expired June 1, 1996. New Section adopted effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4).

R9-28-303. Preadmission Screening (PAS) Process

- A. The assessor shall use the PAS instrument to determine whether the following applicants or members are at immediate risk of institutionalization:
 1. The assessor shall use the PAS instrument prescribed in R9-28-304 to assess an applicant or member who is EPD except as specified in subsection (A)(2) for an applicant or member who is physically disabled and who is less than 6 years old. After assessing a child who is physically disabled and age 6 years to less than 12 years, the assessor shall refer the child for physician consultant review under subsections (G) through (J).
 2. The assessor shall use the age-specific PAS instrument prescribed in R9-28-305 to assess an applicant or member who is physically disabled and less than 6 years old. After assessing the child, the assessor shall refer the child for physician consultant review under subsections (G) through (J).
 3. The assessor shall use the PAS instrument prescribed in R9-28-305 to assess an applicant or member who is DD, except as specified in subsection (A)(4) for an applicant or member who is DD and residing in a NF. After assessing a child who is DD and less than 6 months of age, the assessor shall refer the child for physician consultant review under subsections (G) through (J).
 4. The assessor shall use the PAS instrument prescribed in R9-28-304 for an applicant or a member who is DD and residing in a NF.
 5. The assessor shall use the PAS instrument prescribed in R9-28-304 or R9-28-305, whichever is applicable, to assess an applicant or member who is classified as venti-

lator-dependent, under Section 1902(e)(9) of the Social Security Act.

- B. For an initial assessment of an applicant who is in a hospital or other acute care setting:
 1. A registered nurse assessor shall complete the PAS assessment; or
 2. In the event that a registered nurse assessor is not available, a social worker assessor shall complete the PAS assessment; and
 3. The assessor shall conduct the PAS assessment and determine medical eligibility when discharge is scheduled within seven days.
- C. An assessor shall conduct a face-to-face PAS assessment with an applicant or member, except as provided in subsection (F). The assessor shall make reasonable efforts to obtain the applicant's or member's available medical records. The assessor may also obtain information for the PAS assessment from face-to-face interviews with the:
 1. Applicant or member,
 2. Parent,
 3. Guardian,
 4. Caregiver, or
 5. Any person familiar with the applicant's or member's functional or medical condition.
- D. Using the information described in subsection (C), an assessor shall complete the PAS assessment based on the assessor's education, experience, professional judgment, and training.
- E. After the assessor completes the PAS assessment, the assessor shall calculate a PAS score. The assessor shall compare the PAS score to an established threshold score. The scoring methodology and threshold scores are specified in R9-28-304 and R9-28-305. Except as determined by physician consultant review as provided in subsections (G) through (J), the threshold score is the point at which an applicant or member is determined to be at immediate risk of institutionalization.
- F. Upon request from a person acting on behalf of the applicant, the Administration shall conduct a PAS assessment to determine whether a deceased applicant who was residing in a NF or who received services in an ICF-MR any time during the time period covered by the application would have been eligible to receive ALTCS benefits for those months.
- G. In the following circumstances, the Administration shall request that a physician consultant review the PAS assessment, the available medical records, and use professional judgment to make the determination that an applicant or member has a developmental disability or has a nonpsychiatric medical condition that, by itself or in combination with other medical conditions, places an applicant or member at immediate risk of institutionalization:
 1. The PAS score of an applicant or member who is EPD is less than the threshold specified in R9-28-304, but is at least 56;
 2. The PAS score of an applicant or member who is DD is less than the threshold specified in R9-28-305, but is at least 38;
 3. An applicant or member scores below the threshold specified in R9-28-304, but the Administration has reasonable cause to believe that the applicant's or member's unique functional abilities or medical condition may place the applicant or member at immediate risk of institutionalization;
 4. An applicant or member scores below the threshold specified in R9-28-304 and has a documented diagnosis of autism, autistic-like behavior, or pervasive developmental disorder;

5. An applicant or member who is seriously mentally ill as defined in A.R.S. § 36-550 who scores at or above the threshold specified in R9-28-304, but may not meet the requirements of A.R.S. § 36-2936. When an applicant or member who is seriously mentally ill scores at or above the threshold, the physician consultant shall exercise professional judgment to determine whether the applicant or member meets the requirements of A.R.S. § 36-2936.
 6. An applicant is an AHCCCS acute care member and scores at or above the threshold specified in R9-28-304 but the Administration has reasonable cause to believe that the applicant's condition is convalescent and requires less than 90 days of institutional care;
 7. An applicant or member is a child who is physically disabled and is at least 6 but less than 12 years of age;
 8. An applicant or member is a child who is physically disabled and is under 6 years of age; and
 9. An applicant is under 6 months of age.
- H.** The physician consultant shall consider the following:
1. Activities of daily living dependence;
 2. Delay in development;
 3. Continence;
 4. Orientation;
 5. Behavior;
 6. Any medical condition, including stability and prognosis of the condition;
 7. Any medical nursing treatment provided to the applicant or member including skilled monitoring, medication, and therapeutic regimens;
 8. The degree to which the applicant or member must be supervised;
 9. The skill and training required of the applicant or member's caregiver; and
 10. Any other factor of significance to the individual case.
- I.** If the physician consultant is unable to make the determination from the PAS assessment and the available medical records, the physician consultant may conduct a face-to-face review with the applicant or member or contact others familiar with the applicant's or member's needs, including a primary care physician or other caregiver, to make the determination.
- J.** The physician consultant shall state the reasons for the determination in the physician review comment section of the PAS instrument.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective July 13, 1992 (Supp. 92-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed by emergency action, new Section adopted by emergency action effective June 30, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 95-2). Section repealed by emergency action, new Section adopted again by emergency action effective January 2, 1996, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 96-1). Emergency expired June 1, 1996. Section in effect before emergency action restored. Section repealed; new Section adopted effective January 14, 1997 (Supp. 97-1). Former Section R9-28-303 renumbered to R9-28-304; new Section R9-28-303 made by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 12 A.A.R. 4007, effective October 5, 2006 (Supp. 06-4). Amended by final rulemaking at 17 A.A.R. 167, effective March 12, 2011 (Supp. 11-1).

R9-28-304. Preadmission Screening Criteria for an Applicant or Member who is Elderly and Physically Disabled (EPD)

- A.** The PAS instrument for an applicant or member who is EPD includes the following categories:
1. Intake information category. The assessor solicits intake information category information on an applicant's or member's demographic background. The components of the intake information category are not included in the calculated PAS score.
 2. Functional assessment category. The assessor solicits functional assessment category information on an applicant's or member's:
 - a. Need for assistance with activities of daily living, including:
 - i. Bathing,
 - ii. Dressing,
 - iii. Grooming,
 - iv. Eating,
 - v. Mobility,
 - vi. Transferring, and
 - vii. Toileting in the residential environment or other routine setting;
 - b. Communication and sensory skills, including hearing, expressive communication, and vision; and
 - c. Continence, including bowel and bladder functioning.
 3. Emotional and cognitive functioning category. The assessor solicits emotional and cognitive functioning category information on an applicant's or member's:
 - a. Orientation to person, place, and time. In soliciting this information, the assessor shall also take into account the caregiver's judgment; and
 - b. Behavior, including:
 - i. Wandering,
 - ii. Self-injurious behavior,
 - iii. Aggression,
 - iv. Resistiveness, and
 - v. Disruptive behavior.
 4. Medical assessment category. The assessor solicits medical assessment category information on an applicant's or member's:
 - a. Medical conditions that have an impact on the applicant's or member's functional ability in relation to activities of daily living, continence, and vision;
 - b. Medical condition that requires medical or nursing service and treatment;
 - c. Medication, treatment, and allergies;
 - d. Specific services and treatments that the applicant or member is currently receiving; and
 - e. Physical measurements, hospitalization history, and ventilator dependency.
- B.** The assessor shall use the PAS instrument to assess an applicant or member who is EPD as specified in this Section. A copy of the PAS instrument is available from the Administration. The Administration uses the assessor's PAS assessment to calculate three scores: a functional score, a medical score, and a total score.
1. Functional score.
 - a. The Administration calculates the functional score from responses to scored items in the functional assessment and emotional and cognitive functioning categories. For each response to a scored item, a number of points is assigned, which is multiplied by a weighted numerical value. The result is a weighted score for each response.

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- b. In the functional assessment matrix, all items in the following categories are scored according to subsection (C):
 - i. Activities of daily living,
 - ii. Continence,
 - iii. Sensory,
 - iv. Orientation, and
 - v. Behavior.
 - c. The sum of the weighted scores equals the functional score. The weighted score per item can range from 0 to 15. The maximum functional score attainable by an applicant or member is 166.
2. Medical score.
- a. In the medical assessment matrix, all items in the following categories are scored according to:
 - i. Medical conditions as specified in subsection (C), and
 - ii. Medical or nursing services and treatments in subsection (C).
 - b. The Administration calculates the medical score based on the applicant's or member's:
 - i. Diagnosis of Alzheimer's, dementia, or organic brain syndrome (OBS);
 - ii. Diagnosis of paralysis; and
 - iii. Current use of oxygen.
 - c. The maximum medical score attainable by an applicant or member is 31.5.
3. Total score.
- a. The sum of an applicant's or member's functional and medical scores equals the total score.
 - b. The total score is compared to the established threshold score as calculated under this Section. The threshold score is 60.
 - c. As defined in R9-28-303, an applicant or member is determined at immediate risk of institutionalization if the total score is equal to or greater than 60.
- C. The following matrices represent the number of points available and the respective weight for each scored item.
- 1. Functional assessment points. The lowest value in the range of points available per item in the functional assessment category, zero, indicates minimal to no impairment. Conversely, the highest value indicates severe impairment.
 - 2. Medical assessment points. The lowest value in the range of points available per item in the medical assessment category, zero, indicates that the applicant or member:
 - a. Does not have the scored medical condition,
 - b. Does not need the scored medical or nursing services, or
 - c. Does not receive the scored medical or nursing services.

FUNCTIONAL ASSESSMENT	# of Points Available Per Item (P)	Weight (W)	Range of Possible Weighted Score per Item (P)x(W)
Activities of Daily Living Section			
Mobility	0-3	5	0-15
Transfer	0-3	5	0-15
Bathing	0-3	5	0-15
Dressing	0-3	5	0-15
Grooming	0-3	5	0-15
Eating	0-3	5	0-15
Toileting	0-3	5	0-15
Continence Section			
Bowel	0-3	1	0-3
Bladder	0-3	1	0-3
Sensory Section			
Vision	0-3	2	0-6
Orientation Section			
Place	0-4	.5	0-2
Time	0-4	.5	0-2
Emotional or Cognitive Behavior Section			
Aggression-Frequency	0-3	1.5	0-4.5
Aggression-Intervention	0-3	1.5	0-4.5
Self-injurious-Frequency	0-3	1.5	0-4.5
Self-injurious-Intervention	0-3	1.5	0-4.5
Wandering-Frequency	0-3	1.5	0-4.5
Wandering-Intervention	0-3	1.5	0-4.5
Resistiveness-Frequency	0-3	1.5	0-4.5
Resistiveness-Intervention	0-3	1.5	0-4.5
Disruptive-Frequency	0-3	1.5	0-4.5
Disruptive-Intervention	0-3	1.5	0-4.5

MEDICAL ASSESSMENT	# of Points Available Per Item (P)	Weight (W)	Range of Possible Weighted Score Per Item (P)x(W)
Medical Conditions Section			
Paralysis	0-1	6.5	0 or 6.5
Alzheimer's, or OBS, or Dementia	0-1	20	0 or 20
Services and Treatments Section			
Oxygen	0-1	5	0 or 5

Historical Note

New Section adopted by emergency action, subsection (A) effective June 30, 1995, subsection (B) effective September 1, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days; entire Section filed as an emergency rule with the Secretary of State's Office June 30, 1995 (Supp. 95-2). New Section adopted again by emergency action with changes effective January 2, 1996, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 96-1). Emergency expired. New Section adopted effective January 14, 1997 (Supp. 97-1). Former Section R9-28-304 renumbered to R9-28-305; new Section R9-28-304 renumbered from R9-28-303 and amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 12 A.A.R. 4007, effective October 5, 2006 (Supp. 06-4).

R9-28-305. Preadmission Screening Criteria for an Applicant or Member who is Developmentally Disabled (DD)

- A. The Administration shall conduct a PAS assessment of an applicant or member who is DD using one of three PAS instruments specifically designed to assess an applicant or member in the following age groups:
 - 1. Twelve years of age and older,
 - 2. Six through 11 years of age, and
 - 3. Birth through 5 years of age.
- B. The PAS instruments for an applicant or member who is DD include three major categories:
 - 1. Intake information category. The assessor solicits intake information category information on an applicant's or member's demographic background. The components of this category are not included in the calculated PAS score.
 - 2. Functional assessment category. The functional assessment category differs by age group as indicated in subsections (B)(2)(a) through (e):
 - a. For an applicant or member 12 years of age and older, the assessor solicits the functional assessment category information on an applicant's or member's:
 - i. Need for assistance with independent living skills, including hand use, ambulation, wheelchair mobility, transfer, eating or drinking, dressing, personal hygiene, bathing or showering, food preparation, community mobility, and toileting;
 - ii. Communication skills and cognitive abilities, including expressive verbal communication, clarity of communication, associating time with an event and action, and remembering an instruction and a demonstration; and
 - iii. Behavior, including aggression, verbal or physical threatening, self-injurious behavior, and resistive or rebellious behavior.
 - b. For an applicant or member 6 through 11 years of age, the assessor solicits the functional assessment category information on an applicant's or member's:
 - i. Need for assistance with independent living skills, including rolling and sitting, crawling and standing, ambulation, climbing stairs or ramps, wheelchair mobility, dressing, personal hygiene, bathing or showering, toileting, level of bladder control, and orientation to familiar settings;
- ii. Communication, including expressive verbal communication and clarity of communication; and
- iii. Behavior, including aggression, verbal or physical threatening, self-injurious behavior, running or wandering away, and disruptive behavior.
- c. For an applicant or member 6 months through 5 years of age, the assessor solicits the functional assessment category information on an applicant's or member's performance with respect to a series of developmental milestones that measure an applicant's or member's degree of functional growth.
- d. For an applicant or member less than 6 months of age, the assessor shall not complete a functional assessment. The assessor shall include a description of the applicant's or member's development in the PAS instrument narrative summary.
- 3. Medical assessment category. The assessor solicits medical assessment category information on an applicant's or member's:
 - a. Medical condition;
 - b. Specific services and treatments the applicant or member receives or needs and the frequency of those services and treatments;
 - c. Current medication;
 - d. Medical stability;
 - e. Sensory functioning;
 - f. Physical measurements; and
 - g. Current living arrangement, ventilator dependency and eligibility for DES Division of Developmental Disabilities program services.
- C. The assessor shall use the PAS instrument to assess an applicant or member who is DD. A copy of the PAS instrument is available from the Administration. The Administration uses the assessor's PAS instrument responses to calculate three scores: a functional score, a medical score, and a total score.
 - 1. Functional score.
 - a. The Administration calculates the functional score from responses to scored items in the functional assessment category. Each response is assigned a number of points which is multiplied by a weighted numerical value, resulting in a weighted score for each response.

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- b. The following items are scored as indicated in subsection (D), under the Functional Assessment matrix:
 - i. For an applicant or member 12 years of age and older, all items in the behavior section are scored. Designated items in the independent living skills, communication skills, and cognitive abilities sections are also scored;
 - ii. For an applicant or member 6 through 11 years of age, all items in the communication section are scored. Designated items in the independent living skills and behavior sections are scored;
 - iii. For an applicant or member 6 months of age through 5 years of age, items in the developmental milestones section are scored based on the age of the applicant.
- c. The sum of the weighted scores equals the functional score. The range of weighted score per item and maximum functional score for each age group is presented below:

AGE GROUP	RANGE FOR WEIGHTED SCORE PER ITEM	MAXIMUM FUNCTIONAL SCORE ATTAINABLE
12+	0 - 11.2	124.1
6-11	0 - 24	112.5
0-5	0 - 5.0	106.02

- d. No minimum functional score is required.
- 2. Medical score.
 - a. Subsections (C)(2)(a)(i) through (iii) are scored as indicated in subsection (D), under the Medical Assessment matrix:
 - i. The assessor shall score designated items in the medical conditions for an applicant or member 12 years of age and older and 6 years of age through 11 years of age.
 - ii. The assessor shall score designated items in the medical conditions and medical stability sections for an applicant or member 6 months of age through 5 years of age.
 - iii. The assessor shall complete only the medical assessment section of the PAS for an applicant or member less than 6 months of age. There is no weighted or calculated score assigned. The assessor shall refer the applicant or member for physician consultant review.

- iv. The assessor shall complete only the medical assessment section of the PAS for an applicant or member less than 6 months of age. There is no weighted or calculated score assigned. The assessor shall refer the applicant or member for physician consultant review.
- b. The Administration calculates the medical score from information obtained in the medical assessment category. Each response to a scored item is assigned a number of points. The sum of the points equals the medical score. The range of points per item and the maximum medical score attainable by an applicant or member is presented below:

AGE GROUP	RANGE OF POINTS PER ITEM	MAXIMUM MEDICAL SCORE ATTAINABLE
12+	0 - 20.6	21.4
6-11	0 - 2.5	5
0-5	0 - 10	60

- c. No minimum medical score is required.
- 3. Total score.
 - a. The sum of an applicant's or member's functional and medical scores equals the total score.
 - b. The total score is compared to an established threshold score in R9-28-304. For an applicant or member who is DD, the threshold score is 40. Based upon the PAS instrument an applicant or member with a total score equal to or greater than 40 is at immediate risk of institutionalization.
- D. The following matrices represent the number of points available and the weight for each scored item.
 - 1. Functional assessment points. An applicant or member age group 0 to 5: The value is received for each negative response. An applicant or member age groups 6 to 11 and 12+: the lowest value in the range of points available per item in the functional assessment category indicates minimal to no impairment. Conversely, the highest value indicates severe impairment.
 - 2. Medical assessment points. The lowest value in the range of points available per item in the medical assessment category, zero, indicates that the applicant or member:
 - a. Does not have a medical condition specified in the following matrices,
 - b. Does not need medical or nursing service as specified in the following matrices, or
 - c. Does not receive any medical or nursing service as specified in the following matrices.

AGE GROUP 12 AND OLDER FUNCTIONAL ASSESSMENT	# of Points Available Per Item (P)	Weight (W)	Range of Possible Weighted Score Per Item (P) x (W)
Independent Living Skills Section			
Hand Use, Food Preparation	0-3	3.5	0-10.5
Ambulation, Toileting, Eating, Dressing, Personal Hygiene	0-4	2.8	0-11.2
Communicative Skills and Cognitive Abilities Section			
Associating Time, Remembering Instructions	0-3	0.5	0 - 1.5
Behavior Section			
Aggression, Threatening, Self Injurious	0-4	2.8	0-11.2
Resistive	0-3	3.5	0-10.5

AGE GROUP 12 AND OLDER MEDICAL ASSESSMENT	# of Points Available Per Item (P)	Weight (W)	Range of Possible Weighted Score Per Item (P) x (W)
Medical Conditions Section			
Cerebral Palsy, Epilepsy	0-1	0.4	0-.4
Moderate, Severe, Profound Mental Retardation	0-1	20.6	0-20.6

AGE GROUP 6-11 FUNCTIONAL ASSESSMENT	# of Points Available Per Item (P)	Weight (W)	Range of Possible Weighted Score Per Item (P) x (W)
Independent Living Skills Section			
Climbing Stairs, Wheelchair Mobility, Bladder Control	0-3	1.875	0-5.625
Ambulation, Dressing, Bathing, Toileting	0-4	1.5	0-6
Crawling or Standing	0-5	1.25	0-6.25
Rolling or Sitting	0-8	0.833	0-6.66
Communication Section			
Clarity	0-4	1.5	0-6
Expressive Communication	0-5	1.25	0-6.25
Behavior Section			
Wandering	0-4	6	0-24
Disruptive	0-3	7.5	0-22.5

AGE GROUP 6 - 11 MEDICAL ASSESSMENT	# of Points Available Per Item (P)	Weight (W)	Range of Possible Weighted Score Per Item (P) x (W)
Medical Conditions Section			
Cerebral Palsy, Epilepsy	0-1	2.50	0-2.5

AGE GROUP 0 – 5 FUNCTIONAL ASSESSMENT	Weight
6 -9 Months	5.0
9-11 Months	4.1
12-17 Months	2.9
18-23 Months	2.125
24-29 Months	1.75
30-35 Months	1.55
36-47 Months	1.34
48-59 Months	1.14
60 Months+	1.03

AGE GROUP 0 - 5 MEDICAL ASSESSMENT	Weight
Cerebral Palsy	5.0
Epilepsy	5.0
Moderate, Severe, or Profound Mental Retardation (36 Months and older only)	15.0
Autism + M-CHAT (18 Months and older only) Fails at least six M-CHAT based questions	7.0
Autism + Behaviors (30-35 Months only) Exhibits at least 3 of 4 specific behaviors	5.0
Autism + Behaviors (36 Months and older only) Exhibits at least 6 of 8 specific behaviors	10.0
Drug Regulation + Administration (6 Months to 35 Months)	1.0
Drug Regulation + Administration (36 Months and older)	1.5
Non-Bowel/Bladder Ostomy Care (6 Months to 35 Months)	7.0
Non-Bowel/Bladder Ostomy Care (36 Months and older)	5.0
Tube Feeding (6 Months to 35 Months)	7.0
Tube Feeding (36 Months and older)	5.0
Physical Therapy or Occupational Therapy (6 Months to 35 Months)	1.0
Physical Therapy or Occupational Therapy (36 Months and older)	1.5

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Acute Hospital Admission (One)	1.0
Acute Hospital Admissions (Two or more)	2.0
Direct Care Staff Trained (6 Months to 11 Months)	0.5
Direct Care Staff Trained (12 Months and older)	1.0
Special Diet	2.0

Historical Note

Section adopted by emergency action effective June 30, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 95-2). Section adopted again by emergency action effective January 2, 1996, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 96-1). Emergency expired. New Section adopted effective January 14, 1997 (Supp. 97-1). Former Section R9-28-305 renumbered to R9-28-306; new Section R9-28-305 renumbered from R9-28-304 and amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 17 A.A.R. 167, effective March 12, 2011 (Supp. 11-1).

R9-28-306. Reassessments

- A.** An assessor shall reassess an ALTCS member to determine continued eligibility:
1. In connection with a routine audit of the PAS assessment by AHCCCS;
 2. In connection with a request by a provider, program contractor, case manager, or other party, if AHCCCS determines that continued eligibility is uncertain due to substantial evidence of a change in the member's circumstances or error in the PAS assessment; or
 3. Annually when part of a population group identified by the Director in a written report as having an increased likelihood of becoming ineligible.
- B.** An assessor shall determine continued eligibility for ALTCS using the same criteria used for the initial PAS assessment as prescribed in R9-28-303.
- C.** An assessor shall refer the reassessment to physician consultant review if the member is:
1. Determined ineligible,
 2. In the ALTCS Transitional Program under R9-28-307 and resides in a NF or ICF-MR, or
 3. Seriously mentally ill and no longer has a non-psychiatric medical condition that impacts the member's ability to function.

Historical Note

Adopted effective September 1, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1994, Ch. 322, § 21; filed with the Office of the Secretary of State June 29, 1995 (Supp. 95-3). Former Section R9-28-306 renumbered to R9-28-307; new Section R9-28-306 renumbered from R9-28-305 and amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 10 A.A.R. 1312, effective May 1, 2004 (Supp. 04-1).

R9-28-307. The ALTCS Transitional Program for a Member who is Elderly and Physically Disabled (EPD) or Developmentally Disabled (DD)

- A.** The ALTCS transitional program serves members enrolled in the ALTCS program who, at the time of reassessment as described in R9-28-306, no longer meet the threshold specified in R9-28-304 for EPD or in R9-28-305 for DD but do meet all other ALTCS eligibility criteria. The Administration shall compare the member's PAS assessment to a scoring methodology for eligibility in the ALTCS transitional program as defined in subsections (B) and (C).
- B.** The Administration shall transfer a member who is DD from the ALTCS program to the ALTCS transitional program if, at the time of a reassessment, the total PAS score is less than the threshold described in R9-28-305 but is at least 30, or the member is diagnosed with moderate, severe, or profound mental retardation.

- C.** The Administration shall transfer a member who is EPD from the ALTCS program to the ALTCS transitional program if, at the time of a reassessment, the PAS score is less than the threshold described in R9-28-304 but is at least 40.
- D.** For a member residing in a NF or ICF-MR, the program contractor or the Administration shall ensure that the member is moved to an approved home- and community-based setting within 90 continuous days from the enrollment date of the member's eligibility for the ALTCS transitional program.
- E.** A member in the ALTCS transitional program shall continue to receive all medically necessary covered services as specified in Article 2.
- F.** A member in the ALTCS transitional program is eligible to receive up to 90 continuous days per NF or ICF-MR admission when the member's condition worsens to the extent that an admission is medically necessary.
- G.** For a member requiring medically necessary NF or ICF-MR services for longer than 90 days, the program contractor shall request the Administration to conduct a reassessment under R9-28-306.

Historical Note

New Section renumbered from R9-28-306 and amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 12 A.A.R. 4007, effective October 5, 2006 (Supp. 06-4).

ARTICLE 4. ELIGIBILITY AND ENROLLMENT**R9-28-401. Eligibility and Enrollment-Related Definitions**

Definitions. For purposes of this Article, the following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

“ALTCS acute care services” means services under 9 A.A.C. 22, Articles 2 and 12, that are provided to a person who meets ALTCS eligibility requirements in 9 A.A.C. 28, Article 4 and who:

Lives in an acute care living arrangement described in R9-28-406; or

Is not eligible for long-term care benefits, described in R9-28-409, due to a transfer under R9-28-409 without receiving fair consideration, or

Has refused institutionalized or HCBS services.

“Community spouse” means the husband or wife of an institutionalized person who has entered into a contract of marriage, recognized as valid by the state of Arizona, and who does not live in a medical institution.

“CSRDR” means Community Spouse Resource Deduction, the amount of a married couple's resources that is

excluded in the eligibility determination to prevent impoverishment of the community spouse as determined under R9-28-410.

“Fair consideration” means income, real or personal property, services, or support and maintenance equal to or exceeding the fair market value of the income or resources that were transferred.

“First continuous period of institutionalization” means the first period beginning on or after September 30, 1989 that the applicant was institutionalized for 30 consecutive days or more. To be considered institutionalized, the applicant must:

- Have resided in a medical institution;
- Have received paid formal Home and Community Based Services (HCBS);
- Have received a combination of medical institutionalization and HCBS, or
- Intend to receive HCBS and either:
 - Requests a Resource Assessment and is determined in need of institutional services by a Resource Assessment Medical Evaluation; or
 - Applies for ALTCS and is determined medically eligible by the Pre-Admission Screening (PAS).

“Institutionalized” means residing in a medical institution or receiving or expecting to receive HCBS that prevent the person from being placed in a medical institution as determined by the PAS.

“Medically eligible” means meeting the ALTCS medical eligibility criteria under Article 3 of this Chapter.

“MMMNA” means Minimum Monthly Maintenance Needs Allowance.

“Redetermination” means a periodic review of all eligibility factors for a recipient.

“Representative” means a person other than a spouse or a parent of a dependent child, who applies for ALTCS on behalf of another person.

“Spouse” means a person legally married under Arizona law, a person eligible for Social Security benefits as the spouse of another person, or a person living with another person of the opposite sex and the couple represents themselves in the community as husband and wife.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5138, effective January 3, 2004 (Supp. 03-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2).

R9-28-401.01. General

A. Application for ALTCS coverage.

1. The Administration shall provide a person the opportunity to apply for ALTCS without delay.
2. A person may be accompanied, assisted, or represented by another in the application process.
3. To apply for ALTCS, a person shall submit an application to an ALTCS eligibility office.

- a. The application shall contain the applicant’s name and address.
- b. Before the application is approved, a person listed in A.A.C. R9-22-1406(D) shall sign the application.
- c. A witness shall also sign the application if an applicant signs the application with a mark.
- d. The date of application is the date the application is received by the Administration or Department as described in R9-22-1406(C).

4. Except as provided in R9-22-1501(D)(5), the Administration shall determine eligibility within 45 days from the date of application.
5. An applicant or representative who files an ALTCS application may withdraw the application for ALTCS coverage either orally or in writing to the ALTCS eligibility office where the application was filed. The Administration shall provide the applicant with a denial notice under subsection (G).
6. If an applicant dies while an application is pending, the Administration shall complete an eligibility determination for the deceased applicant.
7. If a person dies before an application is filed, the Administration shall complete an eligibility determination on an application filed on behalf of the deceased applicant, if the application is filed in the month of the person’s death.

B. Conditions of ALTCS eligibility. Except for persons identified in subsection (C), the Administration shall approve a person for ALTCS if all conditions of eligibility for one of the ALTCS coverage groups listed in R9-28-402(B) are met. The conditions of eligibility are:

1. Categorical requirements under R9-28-402;
2. Citizenship and alien status under R9-28-404;
3. SSN under R9-28-405;
4. Living arrangements under R9-28-406;
5. Resources under R9-28-407;
6. Income under R9-28-408;
7. Transfers under R9-28-409;
8. A legally authorized person shall assign rights to the Administration for medical support and for payment of medical care from any first- and third-parties and shall cooperate by:
 - a. Obtaining medical support and payments and establishing paternity for a child born out of wedlock, except for pregnant women under A.A.C. R9-22-1421, unless the person establishes good cause under 42 CFR 433.147 for not cooperating; and
 - b. Identifying and providing information to assist the Administration in pursuing first- and third-parties who may be liable to pay for care and services unless the person establishes good cause for not cooperating;
9. A person shall take all necessary steps to obtain annuity, pension, retirement, and disability benefits for which a person may be entitled unless the person establishes good cause for not doing so;
10. State residency under R9-28-403;
11. Medical eligibility as specified in Article 3 of this Chapter; and
12. Providing information and verification as specified in subsection (D).

C. Persons eligible for Title IV-E or Title XVI. To be determined eligible for ALTCS, a person eligible for benefits under Title IV-E or Title XVI of the Social Security Act shall provide information to allow the Administration to determine:

1. Medical eligibility as specified in Article 3 of this Chapter,

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2. Post-eligibility treatment of income as specified in R9-28-408,
 3. The existence of trusts in accordance with federal and state law, and
 4. Transfer of property as specified in R9-28-409.
- D.** Verification. If requested by the Administration, a person shall provide information and documentation to verify the following criteria or shall authorize the Administration to verify the following criteria:
1. Conditions of eligibility as specified in subsection (B); and
 2. Other individual circumstances necessary to determine a person's eligibility and post-eligibility treatment of income (share-of-cost).
- E.** Documentation of the eligibility decision. The ALTCS eligibility interviewer shall include facts in a person's case record to support the decision on the person's application.
- F.** Eligibility effective date. Eligibility is effective the first day of the month that all eligibility requirements are met including the period described under R9-22-303.
- G.** Notice. The Administration shall send a person a written notice of the decision regarding the person's application. The notice shall include a statement of the action and an explanation of the person's hearing rights as specified in 9 A.A.C. 34 and:
1. If the applicant's eligibility is approved, the notice shall contain:
 - a. The effective date of eligibility; and
 - b. Post-eligibility treatment of income (share-of-cost) information, which is the amount the person shall pay toward the cost of care.
 2. If the applicant's eligibility is denied, the notice shall contain:
 - a. The effective date of the denial;
 - b. A statement detailing the reason for the person's denial, including specific financial calculations and the financial eligibility standard if applicable; and
 - c. The legal authority supporting the decision.
- H.** Confidentiality. The Administration shall maintain the confidentiality of a person's record and shall not disclose information regarding the person's financial, medical, or other privacy interests except under A.A.C. R9-22-512.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2). Amended by final rulemaking at 19 A.A.R. 3320, effective November 30, 2013 (Supp. 13-4).

R9-28-402. Categorical Requirements and Coverage Groups

- A.** Categorical requirements. As a condition of ALTCS eligibility, a person shall meet one of the following categorical requirements in this Section under 42 CFR 435, Subpart F.
1. Aged.
 - a. "Aged" means a person who is 65 years of age or older.
 - b. A person is considered to be age 65 on the day before the anniversary of birth.
 - c. Age shall be verified under 20 CFR 404.715 and 20 CFR 404.716.
 2. Blind. Blindness shall be determined by the DES Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(2).
 3. Disabled. A person is considered to be disabled for ALTCS if the person is determined medically eligible under Article 3.
 4. Child. A child is a person defined in A.A.C. R9-22-1420.

5. Pregnant.
 - a. Pregnancy shall be medically verified by one of the following licensed health care professionals:
 - i. Licensed physician;
 - ii. Certified physician's assistant;
 - iii. Certified nurse practitioner;
 - iv. Licensed midwife; or
 - v. Licensed registered nurse, under the direction of a licensed physician.
 - b. Written verification of pregnancy shall include the expected date of delivery.
 6. A specified relative who is the caretaker relative of a deprived child under Section 2 of the AFDC State Plan as it existed on July 16, 1996, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
- B.** ALTCS coverage groups. In addition to other requirements in this Article, a person shall meet ALTCS eligibility criteria in one of the following coverage groups:
1. A coverage group under A.R.S. §§ 36-2901(6)(a)(i) or 36-2901(6)(a)(ii).
 2. The 210 coverage group specified in 42 CFR 435.210. A person in the 210 coverage group is medically eligible as specified in Article 3 and would be eligible for SSI cash assistance or meets the criteria for AFDC under Section 2 of the AFDC State Plan as it existed on July 16, 1996.
 3. The 236 coverage group under 42 CFR 435.236. A person in the 236 coverage group is medically eligible as specified in Article 3 and the person resides in a medical institution.
 4. The 217 coverage group under 42 CFR 435.217. A person in the 217 coverage group is medically eligible as specified in Article 3 and the person resides in a home and community-based setting described in R9-28-406(A)(2).

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Repealed effective November 4, 1998 (Supp. 98-4). New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3).

R9-28-403. State Residency

As a condition of eligibility, a person shall be a resident of Arizona as specified in 42 CFR 435.403, December 21, 1990, incorporated by reference and on file with the Administration and Secretary of State. This incorporation contains no future editions or amendments.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Amended effective July 13, 1992 (Supp. 92-3). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-404. Citizenship and Qualified Alien Status

As a condition of eligibility, a person shall be:

1. A citizen of the United States;
2. A qualified alien specified in 8 U.S.C. 1641 and A.R.S. § 36-2903.03, to the extent consistent with federal law; or

3. A nonqualified alien who received ALTCS services on or before August 21, 1996, as specified in Laws 1997, Ch. 300, § 70.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-405. Social Security Enumeration

As a condition of eligibility, a person shall furnish an SSN, as specified in 42 CFR 435.910 and 435.920.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-406. ALTCS Living Arrangements

- A.** Long-term care living arrangements. A person may be eligible for ALTCS services, under Article 2, while living in one of the following settings:

1. Institutional settings:
 - a. A NF defined in 42 U.S.C. 1396r(a),
 - b. An IMD for a person who is either under age 21 or age 65 or older or a person aged 21 through 64 for up to 30 days per admission and no more than 60 days per contract year under the Administration's Section 1115 Waiver with CMS,
 - c. An ICF-MR for a person with developmental disabilities,
 - d. A hospice (free-standing, hospital, or nursing facility subcontracted beds) defined in A.R.S. § 36-401; or
2. Home and community-based services (HCBS) settings:
 - a. A person's home defined in R9-28-101(B), or
 - b. Alternative HCBS settings defined in R9-28-101(B).

- B.** ALTCS acute care living arrangements. A person applying for or receiving ALTCS coverage shall be eligible for only ALTCS acute care coverage in the following living arrangements, settings, or locations:

1. The gross income limit is 300 percent of the FBR for a person meeting the requirements of the 236 coverage group under R9-28-402(B) and who resides in one of the following settings:
 - a. A noncertified medical facility, or
 - b. A medical facility that is registered with AHCCCS but does not have a contract with an ALTCS program contractor, or
 - c. A location outside of Arizona if the person is temporarily absent from Arizona.
2. The net income limit is 100 percent of the FBR for a person who does not meet the requirements of the 217 or 236 coverage groups specified in R9-28-402(B) and who resides in one of the following settings:
 - a. At home or in an alternative HCBS setting if a person refuses HCBS service; or
 - b. A room in an assisted living center, or a licensed assisted living home or center which is not registered with AHCCCS.

- C.** Inmate of a public institution. An inmate of a public institution is not eligible for the ALTCS program if federal financial participation (FFP) is not available.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3).

R9-28-407. Resource Criteria for Eligibility

- A.** The following Medicaid-eligible persons shall be deemed to meet the resource requirements for ALTCS eligibility unless ineligible due to federal and state laws regarding trusts.
1. A person receiving Supplemental Security Income (SSI);
 2. A person receiving Title IV-E Foster Care Maintenance payment; or
 3. A person receiving a Title IV-E Adoption Assistance.
- B.** Except as provided in subsection (C), if a person's ALTCS eligibility is most closely related to SSI and is not included in subsection (A), the Administration shall determine eligibility using resource criteria in 42 U.S.C. 1382(a)(3), 42 U.S.C. 1382b, and 20 CFR 416 Subpart L.
- C.** The Administration permits the following exceptions to the resource criteria for a person identified in subsection (B):
1. Resources of the spouse or parent of a minor child are disregarded beginning the first day in the month the person is institutionalized.
 2. The value of household goods and personal effects is excluded.
 3. The value of oil, timber, and mineral rights is excluded.
 4. The value of all of the following shall be disregarded:
 - a. Term insurance;
 - b. Burial insurance;
 - c. Assets that a person has irrevocably assigned to fund the expense of a burial;
 - d. The cash value of all life insurance if the face value does not exceed \$1,500 total per insured person and the policy has not been assigned to fund a pre-need burial plan or has a legally binding designation as a burial fund;
 - e. The value of any burial space held for the purpose of providing a place for the burial of the person, a spouse, or any other member of the immediate family;
 - f. \$1,500 of the equity value of an asset that has a legally binding designation as a burial fund or a revocable burial arrangement if there is no irrevocable burial arrangement;
 - g. During the time a person remains continuously eligible, all appreciation in the value of the assets in subsection (C)(4)(f) will be disregarded; and
 - h. The amount of a payment refunded by a nursing facility after ALTCS approval is only excluded for six months beginning with the month the refund was received. The Administration shall evaluate the refund in accordance with R9-28-409 if transferred without receiving something of equal value.
- D.** For an institutionalized spouse, a resource disregard is allowed under 42 U.S.C. 1396r-5(c).
- E.** Trusts are evaluated in accordance with federal and state laws to determine eligibility.
- F.** A person is not eligible for long-term care services if countable resources exceed the following limits:

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1. For a SSI-related person identified in subsection (B), the limit is \$2,000 or \$3,000 per couple under 20 CFR 416.1205.
 2. For a person eligible under 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII), there is no resource limit.
- G.** A person shall provide information and verification necessary to determine the countable value of resources.
- Historical Note**
- Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2).
- R9-28-408. Income Criteria for Eligibility**
- A.** The following Medicaid-eligible persons shall be deemed to meet the resource requirements for ALTCS eligibility unless ineligible due to federal and state laws regarding trusts.
1. A person receiving Supplemental Security Income (SSI);
 2. A person receiving Title IV-E Foster Care Maintenance Payments; or
 3. A person receiving Title IV-E Adoption Assistance.
- B.** If a person's ALTCS eligibility is most closely related to SSI and the person is not included in subsection (A), the Administration shall count the income described in 42 U.S.C. 1382a and 20 CFR 416 Subpart K to determine eligibility with the following exceptions:
1. Income types excluded by 42 U.S.C. 1382a(b) for determining net income are also excluded in determining gross income to determine eligibility;
 2. Income of the parent or spouse of a minor child is counted as part of income under 42 CFR 435.602, except that the income of the parent or spouse is disregarded for the month the person is institutionalized;
 3. In-kind support and maintenance, under 42 U.S.C. 1382a(a)(2)(A), are excluded for both net and gross income tests;
 4. The income exceptions under A.A.C. R9-22-1503(B) apply to the net income test; and
 5. Income described in subsection (D) is excluded.
- C.** For a person whose eligibility is determined under 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), or 42 U.S.C. 1396a(a)(10)(A)(i)(VII), the methodology in A.A.C. R9-22-1420 through R9-22-1426 is used to determine eligibility in accordance with 42 CFR 435.602. Income standards are then applied as described in A.A.C. R9-22-1428.
- D.** The following are income exceptions:
1. Disbursements from a trust are considered in accordance with federal and state law; and
 2. For an institutionalized spouse, a person defined in 42 U.S.C. 1396r-5(h)(1), income is calculated in accordance with 42 U.S.C. 1396r-5(b).
- E.** As a condition of eligibility for ALTCS, countable income shall be less than or equal to the following limits:
1. For a person in either the 217 or 236 coverage group specified in R9-28-402(B), 300 percent of the FBR;
 2. For a person or a couple in the SSI-related 210 coverage group specified in R9-28-402(B), 100 percent of the FBR;
3. For a person who is under 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII) and is:
 - a. A child who is at least age six but less than age 19; 100 percent of the FPL, adjusted by household size;
 - b. A child age one through five, 133 percent of the FPL, adjusted by household size;
 - c. A child less than age one, 140 percent of the FPL, adjusted by household size; or
 - d. A pregnant woman, 150 percent of the FPL, adjusted by household size.
- F.** The Director shall determine the amount a person shall pay for the cost of ALTCS services and the post-eligibility treatment of income (share-of-cost) under A.R.S. § 36-2932(L) and 42 CFR 435.725 or 42 CFR 435.726. The Director shall consider the following in determining the share-of-cost:
1. Income types excluded by 42 U.S.C. 1382a(b) for determining net income are excluded in determining share-of-cost.
 2. SSI benefits paid under 42 U.S.C. 1382(e)(1)(E) and (G) to a person who receives care in a hospital or nursing facility are not included in calculating the share-of-cost.
 3. The share-of-cost of a person with a spouse is calculated as follows:
 - a. If an institutionalized person has a community spouse under 42 U.S.C. 1396r-5(h), share-of-cost is calculated under R9-28-410 and 42 U.S.C. 1396r-5(b) and (d); and
 - b. If an institutionalized person does not have a community spouse, share of cost is calculated solely on the income of the institutionalized person.
 4. Income assigned to a trust is considered in accordance with federal and state law.
 5. The following expenses are deducted from the share-of-cost of an eligible person to calculate the person's share-of-cost:
 - a. A personal-needs allowance equal to 15 percent of the FBR for a person residing in a medical institution for a full calendar month. A personal-needs allowance equal to 300 percent of the FBR for a person who receives or intends to receive HCBS or who resides in a medical institution for less than the full calendar month;
 - b. A spousal allowance, equal to the FBR minus the income of the spouse, if a spouse but no children remain at home;
 - c. A family allowance equal to the standard specified in Section 2 of the AFDC State Plan as it existed on July 16, 1996 for the number of family members minus the income of the family members if a spouse and children remain at home;
 - d. Expenses for the medical and remedial care services listed in subsection (6) if the expenses have not been paid or are not subject to payment by a third-party, the person still has the obligation to pay the expense, and one of the following conditions is met:
 - i. The expense represents a payment made and reported to the Administration during the application period or a payment reported to the Administration no later than the end of the month following the month in which the payment occurred and the expense has not previously been allowed a share-of-cost deduction; or
 - ii. The expense represents the unpaid balance of an allowed, noncovered medical or remedial

- expense, and the expense has not been previously a share-of-cost deduction;
- e. An amount determined by the Director for the maintenance of a single person's home for not longer than six months if a physician certifies that the person is likely to return home within that period; or
 - f. An amount for Medicare and other health insurance premiums, deductibles, or coinsurance not subject to third-party reimbursement; and
6. In the post-eligibility calculation of income;
 - a. The Administration recognizes that the following medical and remedial care services are not covered under the Title XIX State Plan, nor covered by a program contractor for a person determined to need institutional services under this Article when the medical or remedial care services are medically necessary for the person:
 - i. Nonemergency dental services for a person who is age 21 or older;
 - ii. Hearing aids and hearing aid batteries for a person who is age 21 or older;
 - iii. Nonemergency eye care and prescriptive lenses for a person who is age 21 or older;
 - iv. Chiropractic services, including treatment for subluxation of the spine, demonstrated by x-ray;
 - v. Orthognathic surgery for a person who is age 21 or older; or
 - b. On a case-by-case basis, other noncovered medically necessary services that a person petitions the Administration for and the Director approves.
- G.** A person shall provide information and verification of income under A.R.S. § 36-2934(G) and 20 CFR 416.203.
- Historical Note**
- New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2).
- R9-28-409. Transfer of Assets**
- A.** The provisions in this Section apply to an institutionalized person who has, or whose spouse has, transferred assets and received less than the fair market value (uncompensated value) specified in A.R.S. § 36-2934(B) and 42 U.S.C. 1396p(c)(1)(A), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
 - B.** A person shall report transfer of assets. The Administration shall evaluate all transfers occurring during or after the look-back period under 42 U.S.C. 1396p(c)(1)(B), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments. The person shall provide verification of any transfer.
 - C.** Certain transfers are permitted under 42 U.S.C. 1396p(c)(2), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
 - D.** If the Administration determines a disqualification period applies due to a transfer, and the person is otherwise eligible, the person may remain eligible for ALTCS acute care services but shall be disqualified for receiving ALTCS coverage under 42 U.S.C. 1396p(c)(1)(C), August 10, 1993, which is incorporated by reference and on file with the Administration and the Secretary of State. This incorporation contains no future editions or amendments.
 - E.** The period of disqualification for transfers shall be computed by dividing the cumulative uncompensated value of the transferred assets by the average cost for a private pay patient for nursing care services at the time of application.
 1. For single or multiple transfers occurring in the same calendar month, the sum of all uncompensated value shall be divided by the monthly private pay rate. Disregarding fractions, the result of this calculation equals the number of months of ineligibility.
 2. For multiple transfers occurring in different calendar months, the total uncompensated value for each transfer of assets shall be determined under subsection (E)(1) but, if the periods of ineligibility overlap, the period of ineligibility shall run consecutively. Fractions are disregarded at the end of the entire period.
 3. For multiple transfers occurring in different months, the total uncompensated value for each transfer shall be determined under subsection (E)(1), but if the periods of ineligibility do not overlap, each period of ineligibility shall be treated under subsection (E)(1).
 - F.** Transfers of assets for less than fair market value are presumed to have been made to establish eligibility for ALTCS services.
 - G.** Rebuttal of disqualification.
 1. A person found ineligible for ALTCS services by reason of a transfer of assets for uncompensated value shall have the right to rebut the disqualification under 42 U.S.C. 1936p(c)(2)(C), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
 2. The person shall have the burden of rebutting the presumption.
 3. If a person rebuts a transfer on the basis of debt repayment, the Administration shall determine the validity of the debt under A.R.S. § 44-101.
 - H.** Undue hardship. A period of disqualification for ALTCS services due to a transfer may be waived by the Director if the person is otherwise eligible and a substantial showing is made by clear and convincing evidence that:
 1. The person is unable to obtain necessary medical care without ALTCS eligibility, and
 2. Is in imminent danger of death.
- Historical Note**
- New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).
- R9-28-410. Community Spouse**
- A.** The methodology in this Section applies to an institutionalized person who has a community spouse.
 - B.** If the institutionalized person's most current period of continuous institutionalization began on or after September 30, 1989, the Administration shall use the methodology for the treatment of resources under 42 U.S.C. 1396r-5(c).
 1. The following resource criteria shall be used in addition to the criteria specified in R9-28-407 to be eligible:
 - a. Resources owned by a couple at the beginning of the first continuous period of institutionalization from and after September 30, 1989, shall be computed from the first day of institutionalization. The total value of resources owned by the institutionalized spouse and the community spouse, and a spousal share equal to one-half of the total value, are computed under 42 U.S.C. 1396r-5(c)(1).

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- b. The Community Spouse Resource Reduction (CSRSD) is calculated under 42 U.S.C. 1396r-5(f)(2).
 - c. The CSRSD is subtracted from the total resources of the couple to determine the amount of the couple's resources considered available to the institutionalized spouse at the time of application under 42 U.S.C. 1396r-5(c)(2).
 - i. Resources in excess of the CSRSD must be equal to or less than the standard for a person specified in R9-28-407.
 - ii. The CSRSD is allowed as a deduction for 12 consecutive months beginning with the first month in which the institutionalized spouse is eligible for ALTCS benefits. Beginning with the 13th month, the separate property of the institutionalized spouse must be within the resource standard for a person specified in R9-28-407.
 - iii. If a person who was previously eligible for ALTCS as an institutionalized person with a community spouse reapplies for ALTCS after a break in institutionalization of more than 30 days, the CSRSD will be allowed as a deduction from resources for a 12-month period in addition to the period in subsection (c)(ii).
 2. Resources are excluded as specified in R9-28-407, except that one vehicle is totally excluded regardless of its value, and any additional vehicles are included using equity value.
 3. The Director may grant eligibility if the Administration determines that a denial of eligibility would create an undue hardship for the institutionalized spouse.
- C.** This Section applies to the income eligibility and post-eligibility treatment of income beginning September 30, 1989, regardless of when the first period of institutionalization began.
1. Income payments are attributed to the institutionalized person and the community spouse under 42 U.S.C. 1396r-5(b)(2).
 2. Income is excluded as specified in R9-28-408.
 3. The institutionalized spouse's income eligibility is determined by combining the income of the institutionalized person and the community spouse and dividing by two. If the institutionalized person is not eligible using this method, the income eligibility shall be based on the income received in the person's name.
 4. The following allowances described in 42 U.S.C. 1396r-5(d)(1) and (2) are allowed as deductions from the institutionalized spouse's income in determining share-of-cost:
 - a. A personal-needs allowance specified in R9-28-408(f)(5)(a);
 - b. A community spouse monthly income allowance, but only to the extent that the institutionalized spouse's income is made available to or for the benefit of the community spouse;
 - c. A family allowance for each family member equal to one-third of the amount remaining after deducting the countable income of the family member from a minimum monthly-needs allowance (MMMNA);
 - d. An amount for medical or remedial services as specified in R9-28-408; and
 - e. An amount for Medicare and other health insurance premiums, deductibles, or coinsurance not subject to third-party reimbursement.
- D.** Transfers.
1. The institutionalized spouse may transfer to any of the following an amount of resources equal to the CSRSD without affecting eligibility under 42 U.S.C. 1396r-5(f). The institutionalized spouse may transfer resources to:
 - a. The community spouse; or
 - b. Someone other than the community spouse if the resources are for the sole benefit of the community spouse.
 2. The institutionalized spouse is allowed a period of 12 consecutive months, beginning with the first month of eligibility, to transfer resources in excess of the resource standard in R9-28-407(E)(2) to the persons listed in subsection (D)(1).
 3. All other transfers by the institutionalized person or transfers by the community spouse are treated under the provisions in R9-28-409.
- E.** Specific hearing rights as described under 9 A.A.C. 34 apply to a person whose eligibility is determined under this Section.
1. The institutionalized spouse or the community spouse is entitled to a fair hearing if dissatisfied with the determination of any of the following:
 - a. The community spouse monthly income allowance,
 - b. The amount of monthly income allocated to the community spouse,
 - c. The computation of the spousal share of resources,
 - d. The attribution of resources, or
 - e. The CSRSD.
 2. The hearing officer may increase the amount of the MMMNA if either the community spouse or institutionalized spouse establishes that the community spouse needs income above the established MMMNA due to exceptional circumstances.
 3. The hearing officer may increase the amount of the CSRSD to allow the community spouse to retain enough resources to generate income to meet the MMMNA. The hearing officer may allow the community spouse to retain an amount of resources necessary to purchase a single premium life annuity that would furnish monthly income sufficient to bring the community spouse's total monthly income up to the MMMNA.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2).

R9-28-411. Changes, Redeterminations, and Notices

- A.** Reporting and verifying changes.
1. A person shall report to the ALTCS eligibility office the following changes for a person, a person's spouse, or a person's dependent children under 42 CFR 435.916:
 - a. A change of address;
 - b. An admission to or discharge from a medical facility, public institution, or private institution;
 - c. A change in the household's composition;
 - d. A change in income;
 - e. A change in resources;
 - f. A determination of eligibility for other benefits;
 - g. A death;
 - h. A change in marital status;
 - i. An improvement in the person's medical condition;
 - j. A change in school attendance;
 - k. A change in Arizona state residency;
 - l. A change in citizenship or alien status;
 - m. Receipt of an SSN under R9-28-405;
 - n. A transfer of assets under R9-28-409;

- o. A change in trust income and disbursements in accordance with state and federal law;
 - p. A change in first- or third-party liability that may be responsible for payment of all or a portion of the person's medical costs;
 - q. A change in first-party medical insurance premiums;
 - r. A change in the household expenses used to calculate the community spouse monthly income allowance described in R9-28-410;
 - s. A change in the amount of the community spouse monthly income allowance that is provided to the community spouse by the institutionalized spouse under R9-28-410; and
 - t. Any other change that may affect the person's eligibility or share-of-cost.
2. A change shall be reported either orally or in writing and shall include:
 - a. The name of the affected person;
 - b. The change;
 - c. The date the change happened;
 - d. The name of the person reporting the change; and
 - e. The person's Social Security or case number, if known, under A.R.S. § 36-2934.
 3. A person shall provide verification of changes upon request, under A.R.S. § 36-2934, if needed to redetermine eligibility or to re-calculate post-eligibility computation of income.
 4. A person shall report anticipated changes in advance, as soon as the future event becomes known.
 5. A person shall report other changes events within 10 days of the date the change occurred.
- B.** Processing of changes and redeterminations. A person's eligibility shall be redetermined at least one time every 12 months and when changes occur, under 42 CFR 435.916. A person's share-of-cost, specified in R9-28-408, shall be redetermined whenever a change occurs that may affect the post-eligibility computation of income.
- C.** Actions that may result from a redetermination or change. Processing a redetermination or change shall result in one of the following findings:
1. No change in eligibility or the post-eligibility computation of income;
 2. Discontinuance of eligibility if a condition of eligibility is no longer met;
 3. Suspension of eligibility if a condition of eligibility is temporarily not met;
 4. A change in the post-eligibility computation of income and the person's share-of-cost; or
 5. A change in service from ALTCS to ALTCS acute care services, or from ALTCS acute care services to ALTCS, caused by changes in a person's living arrangement, specified in R9-28-406, or a transfer of assets specified in R9-28-409.
- D.** Notices.
1. Contents of notice. The Administration shall issue a notice when an action is taken regarding a person's eligibility or computation of share-of-cost. The notice shall contain the following information:
 - a. A statement of the action being taken;
 - b. The effective date of the action;
 - c. The specific reason for the intended action;
 - d. The actual figures used in the eligibility determination and specify the amount by which the person exceeds income standards if eligibility is being discontinued because either a person's resources exceed the resource limit specified in R9-28-407(E), or a person's income exceeds the income limit specified in R9-28-408(E);
 - e. The specific law or regulation that supports the action, or a change in federal or state law that requires an action;
 - f. An explanation of a person's right to request an evidentiary hearing; and
 - g. An explanation of the date by which a request for hearing must be received so that eligibility or the current share-of-cost may be continued.
 2. Advance notice of changes in eligibility or share-of-cost. "Advance notice" means a notice that is issued to a person at least 10 days before the effective date of change, under 42 CFR 435.919. Except as specified in subsection (D)(3), advance notice shall be issued whenever the following adverse action is taken:
 - a. To discontinue or suspend eligibility if an eligible person no longer meets a condition of eligibility, either ongoing or temporarily;
 - b. To affect post-eligibility computation of income and increase a person's share-of-cost; or
 - c. To reduce benefits from ALTCS to ALTCS acute care services due to a change from a long-term care living arrangement to an acute care living arrangement, specified in R9-28-406(B), or due to a transfer with uncompensated value, specified in R9-28-409.
 3. Under 42 CFR 431.213, notice shall be issued to a person to discontinue eligibility or to increase the share-of-cost, no later than the effective date of action if:
 - a. A person provides a clear, written statement, signed by the person, that a person no longer desires services;
 - b. A person provides information that requires termination of eligibility or an increase in the share-of-cost and the person signs a clear written statement waiving advance notice;
 - c. A person cannot be located and mail sent to that person has been returned as undeliverable;
 - d. A person has been admitted to a public institution where the person is ineligible for ALTCS under R9-28-406; or
 - e. A person has been approved for Medicaid in another state;
 - f. The Administration has information that confirms the death of the person;
 - g. The person's primary care provider has prescribed a change in the level of medical care; or
 - h. The notice involves an adverse determination regarding the PAS, specified in A.R.S. § 36-2536.
- E.** Transitional. HCBS services may be provided to a person who is no longer at risk of institutionalization but who continues to require significant long-term care services under A.R.S. § 36-2936(D).

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-412. General Enrollment

- A.** Program contractors. The Administration shall enroll each ALTCS member with:
1. An elderly and physically disabled (EPD) program contractor,
 2. The developmentally disabled (DD) program contractor,
 3. A tribal program contractor, or
 4. The AHCCCS fee-for-service program.

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- B. Enrollment choice. An ALTCS member may choose a program contractor:
 1. At the time of application, or
 2. If the ALTCS member establishes a home outside of the GSA.
- C. Annual enrollment. If an ALTCS member is elderly or physically disabled and lives in a GSA served by more than one program contractor, a member may change to an available program contractor during the annual enrollment choice period.
- D. A program contractor is responsible for the enrolled ALTCS member as described in R9-28-712, County-of-Fiscal Responsibility.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2).

R9-28-413. Enrollment with an EPD Program Contractor

- A. A member's enrollment with one EPD program contractor. The Administration shall enroll an ALTCS elderly or physically disabled member with the one EPD program contractor assigned to that GSA.
- B. New member makes a choice of an EPD program contractor on or after October 1, 2000. The Administration shall provide a new member an opportunity to choose an EPD program contractor, if an ALTCS member is elderly or physically disabled, and lives in a GSA served by more than one EPD program contractor.
- C. New member who makes no choice of an EPD program contractor on or after October 1, 2000. The Administration shall enroll an elderly or physically disabled new member that lives in a GSA with more than one EPD program contractor and who makes no choice of an EPD program contractor under the following:
 1. Criteria. The Administration will prioritize enrollment based on continuity of care and enroll a member with an EPD program contractor chosen under the following criteria, including but not limited to:
 - a. A member's living arrangement, and
 - b. A member's primary care practitioner.
 2. Algorithm. The Administration shall enroll a member through an algorithm as specified in contract, when a member has a choice of more than one EPD program contractor and the criteria in subsection (C)(1) does not apply.
- D. A member enrolled with an EPD program contractor prior to October 1, 2000, and is enrolled in the system after October 1, 2000.
 1. Choice. The Administration shall request an existing member residing in a GSA with more than one EPD program contractor to choose an EPD program contractor.
 2. A member makes no choice. If a member makes no choice, the Administration will continue enrollment with a member's existing EPD program contractor. If that existing EPD program contractor is not awarded a bid, the member will be enrolled with an EPD program contractor as specified in Section (C).

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-414. Enrollment with the DD Program Contractor

- A. A member's DD program contractor. The Administration shall enroll a member with the DES Division of Developmental Disabilities as specified in A.R.S. § 36-2940, if the ALTCS member is eligible for services for the developmentally disabled services.
- B. Indian on and off reservation. The Administration shall enroll an Indian ALTCS member who is developmentally disabled, with the DES Division of Developmental Disabilities. This enrollment shall be made whether the member is considered to be residing on or off reservation.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-415. Enrollment with a Tribal Program Contractor

- A. On-reservation. Notwithstanding R9-28-412, the Administration shall enroll a Native American ALTCS member who is elderly or physically disabled with the ALTCS tribal program contractor as specified in A.R.S. § 36-2932 if the person:
 1. Lives on-reservation of a tribe participating as an ALTCS tribal program contractor, or
 2. Lived on-reservation of a tribe participating as an ALTCS tribal program contractor immediately prior to placement in an off-reservation NF or alternative HCBS setting.
- B. Off-reservation. The Administration shall enroll a Native American ALTCS member who is elderly or physically disabled with an EPD program contractor under R9-28-413, if the member lives off-reservation, and does not have on-reservation status as specified in subsection (A)(2).

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2).

R9-28-416. Enrollment with the FFS Program

- A. No tribal or EPD program contractor in GSA. The Administration shall enroll an ALTCS elderly or physically disabled member who resides in an area with no ALTCS tribal program contractor or EPD program contractor in the AHCCCS FFS program under A.R.S. § 36-2945.
- B. Prior period coverage. The Administration shall enroll a member in AHCCCS fee-for-service program if a member is eligible for ALTCS services only during prior period coverage.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3).

R9-28-417. Notification Requirements

- A. Administration responsibilities. The Administration shall notify a member's program contractor when a member is enrolled or disenrolled from the ALTCS program. The Administration shall include the following in the notification:
 1. The member's name,
 2. The member's identification number,
 3. The member's effective date of enrollment or disenrollment, and
 4. The member's share-of-cost on a monthly enrollment roster.
- B. Program contractor's responsibilities. The program contractor shall notify the Administration if an ALTCS member has any change that may affect eligibility including but not limited to:
 1. A change in residential address,

2. A change in medical or functional condition,
3. A change in living arrangement including:
 - a. Alternative HCBS setting,
 - b. Home,
 - c. Nursing facility, or
 - d. Other living arrangement not specified in this subsection,
4. Change in resource or income, or
5. Death.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28 418. Disenrollment

The Administration shall disenroll an ALTCS member on the last day of the month following receipt of appropriate notification under R9-28-411 except:

1. The Administration shall disenroll an ALTCS member who dies. A member's last day of enrollment shall be the date of death.
2. The Administration may disenroll a member immediately if requested.
3. If ALTCS benefits have been continued pending an eligibility appeal decision and the discontinuance is upheld as specified in 9 A.A.C. 34, the Administration shall disenroll a member effective on the date of the hearing decision.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2).

ARTICLE 5. PROGRAM CONTRACTOR AND PROVIDER STANDARDS**R9-28-501. Program Contractor and Provider Standards – Related Definitions**

Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

“Certification” means a voluntary process by which a federal or state regulatory entity grants recognition to a person, facility, or organization that has met certain qualifications specified by the regulatory entity, allowing the person, facility, or organization to use the word “certified” in a title or designation.

“Therapeutic leave” means that a member leaves an institutional facility for a period that does not exceed nine days per contract year.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

New Section made by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4).

Amended by final rulemaking at 14 A.A.R. 4406, effective January 3, 2009 (Supp. 08-4).

R9-28-501.01. Pre-Existing Conditions

A program contractor shall comply with the pre-existing condition requirements in A.A.C. R9-22-502.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 4406, effective January 3, 2009 (Supp. 08-4).

R9-28-502. Long-term Care Provider Requirements

- A. A provider shall obtain any necessary authorization from the program contractor or the Administration for services provided to a member.
- B. A provider shall maintain and make available to a program contractor and to the Administration, financial, and medical records for not less than five years from the date of final payment, or for records relating to costs and expenses to which the Administration has taken exception, five years after the date of final disposition or resolution of the exception. The provider shall maintain records that meet uniform accounting standards and generally accepted practices for maintenance of medical records, including detailed specification of all patient services delivered, the rationale for delivery, and the service date.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsection (E) effective June 6, 1989 (Supp. 89-2). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4).

R9-28-503. Licensure and Certification for Long-term Care Institutional Facilities

- A. A nursing facility shall not provide services to a member unless the facility is licensed by Arizona Department of Health Services, Medicare- and Medicaid-certified, and meets the requirements in 42 CFR 442, as of October 1, 2004, and 42 CFR 483, as of October 1, 2004, incorporated by reference, on file with the Administration, and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments.
- B. An ICF-MR shall not provide services to a member unless the ICF-MR is Medicaid-certified and meets the requirements in A.R.S. § 36-2939(B)(1) and 42 CFR 442, Subpart C, as of October 1, 2004, and 42 CFR 483, as of October 1, 2004, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments.
- C. A nursing facility or ICF-MR that provides services to a member shall register as a provider with the Administration to receive reimbursement. The Administration shall not register a provider unless the provider meets the licensure and certification requirements of subsection (A) or (B).

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective November 5, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4406, effective January 3, 2009 (Supp. 08-4).

R9-28-504. Standards of Participation, Licensure, and Certification for HCBS Providers

- A. A noninstitutional long-term care provider shall not register with the Administration unless the provider meets the requirements of the Arizona Department of Health Services' rules for licensure, if applicable.
- B. Additional qualifications to provide services to a member:

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1. A community residential setting and a group home for a person with developmental disabilities shall be licensed by the appropriate regulatory agency of the state as described in A.A.C. R9-33-107 and A.A.C. R6-6-714;
2. An adult foster care home shall be certified or licensed under 9 A.A.C. 10;
3. A home health agency shall be Medicare-certified and licensed under 9 A.A.C. 10;
4. A person providing a homemaker service shall meet the requirements specified in the contract between the person and the Administration;
5. A person providing a personal care service shall meet the requirements specified in the contract between the person and the Administration;
6. An adult day health care provider shall be licensed under 9 A.A.C. 10;
7. A therapy provider shall meet the following requirements:
 - a. A physical therapy provider shall meet the requirements in 4 A.A.C. 24;
 - b. A speech therapist provider shall meet the applicable requirements under 9 A.A.C. 16, Article 2.
 - c. An occupational therapy provider shall meet the requirements in 4 A.A.C. 43; and
 - d. A respiratory therapy provider shall meet the requirements in 4 A.A.C. 45;
8. A respite provider shall meet the requirements specified in contract;
9. A hospice provider shall be Medicare-certified and licensed under 9 A.A.C. 10;
10. A provider of home-delivered meal service shall comply with the requirements in 9 A.A.C. 8;
11. A provider of non-emergency transportation shall be licensed by the Arizona Department of Transportation, Motor Vehicle Division;
12. A provider of emergency transportation shall meet the licensure requirements in 9 A.A.C. 13;
13. A day care provider for the developmentally disabled under A.R.S. § 36-2939 shall meet the licensure requirements in 6 A.A.C. 6;
14. A habilitation provider shall meet the requirements in A.A.C. R6-6-1523 or the therapy requirements in this Section;
15. A service provider, other than a provider specified in subsections (B)(1) through (B)(14), approved by the Director shall meet the requirements specified in a program contractor's contract with the Administration;
16. A behavioral health provider shall have all applicable state licenses or certifications and meet the service specifications in A.A.C. R9-22-1205; and
17. An assisted living home or a residential unit shall meet the requirements as defined in A.R.S. § 36-401 and as authorized in A.R.S. § 36-2939.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4).

R9-28-505. Standards, Licensure, and Certification for Providers of Hospital and Medical Services

A provider shall not provide hospital services to a member unless the hospital is licensed by the Arizona Department of Health Services, and meets the requirements in 42 CFR 441 and 482, as of October 1, 2004, and 42 CFR 456, Subpart C, as of October 1, 2004, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation contains no future editions or amendments. An Indian Health Service (IHS) hospital and a Veterans Administration hospital shall not provide services to a member unless accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4406, effective January 3, 2009 (Supp. 08-4).

R9-28-506. Requirements for Spouse as Paid Caregiver

- A.** For purposes of this Section, the following definitions apply:
1. "Extraordinary care" means care that exceeds the range of activities that a spouse would ordinarily perform in the household on behalf of the ALTCS member if the member did not have a disability or chronic illness, and that is necessary to ensure the health and welfare of the member and avoid institutionalization.
 2. "Personal care or similar services" means assistance provided to an ALTCS member with a disability or chronic illness to enable the member to perform Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL) that the member would normally perform for himself or herself if the member did not have a disability or chronic illness. Assistance may involve performing a personal care task for the member or cuing the member so that the member performs the task for himself or herself.
- B.** As authorized by the Section 1115 Waiver, a member may choose to have personal care or similar services provided by the member's spouse as a paid caregiver if the following conditions and limitations are met:
1. The member resides in his or her own home;
 2. The Administration or a Program Contractor offers the member the choice of a provider of personal care or similar services other than the member's spouse;
 3. The personal care or similar services is described in the member's plan of care prepared by the member's case manager;
 4. The case manager records at least annually in the member's plan of care the member's choice to have personal care or similar services provided by the member's spouse as a paid caregiver;
 5. The personal care or similar services provided by the spouse are extraordinary care;
 6. The spouse is one of the following:
 - a. Employed by a provider that subcontracts with the member's Program Contractor;
 - b. If the member is developmentally disabled, the spouse is either employed by a provider that subcontracts with the member's Program Contractor, or registered with AHCCCS as an independent provider; or
 - c. If the member is a Native American enrolled in FFS, the spouse is either employed by an AHCCCS regis-

- tered provider or registered with AHCCCS as an independent provider;
7. The spouse meets the training and other qualifications that apply to other providers of personal care or similar services registered with AHCCCS;
 8. The Program Contractor does not pay a spouse providing personal care or similar services at a rate that exceeds the rate that would be paid to a provider of personal care or similar services who is not a spouse and the Administration does not pay a spouse providing personal care or similar services at a rate that exceeds the capped fee-for-service payment for personal care or similar services; and
 9. A spouse providing personal care or similar services as a paid caregiver is not paid for more than 40 hours of services in a seven-day period.
- C.** For a member who elects to have the member's spouse provide personal care or similar services as a paid caregiver, personal care or similar services in excess of 40 hours in a seven-day period are not covered. If a spouse elects to provide less than the hours authorized by the Administration or Program Contractor, the remaining hours of medically necessary personal care or similar services may be provided by another personal caregiver, but the total hours of care provided by the spouse and any other personal caregiver shall not exceed 40 hours in a seven-day period.
- D.** By electing to have the member's spouse provide personal care and similar services as a paid caregiver, the member is not precluded from receiving medically necessary, cost effective home and community based services other than personal care or similar services.

Historical Note

New Section made by final rulemaking at 13 A.A.R. 3587, effective October 2, 2007 (Supp. 07-4).

R9-28-507. Program Contractor General Requirements

- A.** To participate in the ALTCS program, through a program contractor or directly through the Administration, a provider of ALTCS-covered services shall be registered with the Administration.
- B.** An ALTCS program contractor shall ensure that providers of service meet the requirements of this Article.
- C.** Each ALTCS program contractor shall maintain member service records for five years, that include, at a minimum, a case management plan, medical records, encounter data, grievances, complaints, and service information for each ALTCS member.
- D.** An ALTCS program contractor shall produce and distribute informational materials that are approved by the Administration to each enrolled ALTCS member or designated representative within 12 business days after the program contractor receives notification of enrollment from the Administration. The program contractor shall ensure that the informational materials include:
 1. A description of all covered services as specified in contract;
 2. An explanation of service limitations and exclusions;
 3. An explanation of the procedure for obtaining services, including a notice stating that the program contractor is liable only for those services authorized by an ALTCS member's case manager;
 4. An explanation of the procedure for obtaining emergency services;
 5. An explanation of the procedure for filing a grievance and appeal; and
 6. An explanation of when plan changes may occur as specified in contract.
- E.** A subcontractor shall collect the member's share of cost and report to the program contractor the amount collected as specified in the subcontractor contract. The program contractor shall report the share of cost collected to the Administration.
- F.** An ALTCS program contractor shall monitor a trust fund account for an institutionalized ALTCS member to verify that expenditures from the member's trust fund account are in compliance with federal regulations 42 U.S.C. 1396p(d)(4) and A.R.S. § 36-2934.01.
- G.** A program contractor shall ensure that an institutionalized ALTCS member transferred to an acute care facility to receive services is, whenever possible, returned to the original institution upon completion of acute care.
- H.** A program contractor shall ensure that an institutionalized ALTCS member granted therapeutic leave is, whenever medically appropriate, returned to the same bed in the original institution upon completion of the therapeutic leave.
- I.** A program contractor shall ensure that services are paid under A.A.C. R9-22-705.
- J.** A program contractor shall comply with the marketing provisions in A.A.C. R9-22-504.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4).

R9-28-508. Self-directed Attendant Care (SDAC)

- A.** For purposes of this Article the following terms are defined:
- “Competent member” means a person who is oriented, exhibits evidence of logical thought, and can provide directions.
- “Fiscal and Employer Agent” or “FEA” is a company specified by the program contractor or the Administration in contract to serve as an employment/payroll processing center for attendant care workers employed by the member to provide SDAC services.
- “Medically stable” means the member's skilled-care medical needs are routine and not subject to frequent change because of health issues.
- “Personal care” means activities of daily life such as dressing, bathing, eating and mobility.
- B.** In lieu of receiving other attendant care services a competent member who meets the requirements of A.R.S. § 36-2951 or the member's legal guardian may choose to employ through the FEA a person to provide Self-directed Attendant Care (SDAC) services. A paid caregiver described under R9-28-506 and a parent of a minor child shall not receive reimbursement for SDAC services.
 - C.** The attendant care worker chosen to provide SDAC services does not need to be a registered provider. The attendant care worker shall have, at a minimum, hands-on training in First Aid, CPR, Universal Precautions, and state and federal laws regarding privacy of health information or training of similar efficacy as approved by the Administration.
 - D.** The Administration or Program Contractor shall cover SDAC services only if the member resides in the member's home, and shall not cover SDAC services if the member is institutionalized or residing in an alternative residential setting. If the member has a legal guardian, the legal guardian shall be present when SDAC services are provided.

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- E.** A member who chooses to receive SDAC services is not precluded from receiving medically necessary, cost-effective home health services from other agencies or providers if the services provided are not duplicative of the specific attendant care or skilled service already received through the program contractor.
- F.** A competent member or legal guardian may employ an SDAC attendant care worker to provide personal care, homemaker and general supervision services.
- G.** A competent member, who is medically stable, or the member's legal guardian may employ an attendant care worker to also provide the following skilled services:
1. Bowel care, including suppositories, enemas, manual evacuation, and digital stimulation;
 2. Bladder catheterizations (non-indwelling) that do not require a sterile procedure;
 3. Wound care (non-sterile);
 4. Glucose monitoring;
 5. Glucagon as directed by the health care provider;
 6. Insulin by subcutaneous injection only if the member is not able to self-inject;
 7. Permanent gastrostomy tube feeding; and
 8. Additional services requested in writing with the approval of the Director and the Arizona State Board of Nursing.
- H.** The Administration or program contractor shall not cover services under subsection (G) unless:
1. For each SDAC attendant care worker employed by a member or legal guardian, a registered nurse licensed under A.R.S. Title 32, Chapter 15 visits the member and SDAC attendant care worker before a skilled service is provided. The registered nurse will assess, educate, and train the member and SDAC attendant care worker regarding the specific skilled service that the member requires; and
 2. The registered nurse determines in writing that the attendant care worker understands how and demonstrates the skill to perform the processes or procedures required to provide the specific skilled service.
- “Individual’s representative” means a parent, family member, guardian, advocate, or other person authorized by the member to serve as a representative in connection with the provision of services and supports. This authorization should be in writing, when feasible, or by another method that clearly indicates the individual’s free choice. An individual’s representative may not also be a paid caregiver of an individual receiving services and supports.
- “Standardized training” means minimum training standards required of all paid caregivers by the Administration as specified in contract.
- B.** Purpose. The Agency with Choice program is an ALTCS member directed service model for the provision of home and community based services. Under this model, the ALTCS member or individual’s representative and the agency enter into a co-employment relationship.
- C.** In lieu of receiving HCBS services under a traditional service model, a member or the member’s individual’s representative may choose to participate in the Agency with Choice service model. Under the Agency with Choice service model, the agency shall maintain the authority to hire and fire paid caregivers and provide standardized training to the caregiver, and the member or individual representative may elect to recruit, select, dismiss, determine duties, schedule, specify training to meet the unique needs of the member, and supervise the paid caregivers on a day-to-day basis.
- D.** Setting. This program is applicable to ALTCS members who reside in their own home.
- E.** A member who chooses to receive services under the Agency with Choice service model is not precluded from receiving medically necessary, cost-effective services and supports from other agencies or providers if the services provided are not duplicative of the specific attendant care or skilled service already received through the contractor.

Historical Note

Section made by final rulemaking at 18 A.A.R. 3380, effective January 1, 2013 (Supp. 12-4).

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

New Section made by final rulemaking at 16 A.A.R. 2386, effective January 16, 2011 (Supp. 10-4). Amended by final rulemaking at 18 A.A.R. 2344, effective November 11, 2012 (Supp. 12-3).

R9-28-509. Agency with Choice

- A.** Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings specific to this Section:
- “Agency” means a provider of home and community based services, other than an individual, that has a co-employment relationship with one or more members for purposes of this Section.
- “Co-employment relationship” means a situation where the Agency serves as the legal employer of record and the ALTCS member or authorized representative assumes certain responsibilities related to directing and or managing care.
- R9-28-510. Case Management**
- A.** A program contractor shall assign to each member a case manager to identify, plan, coordinate, monitor, and reassess the need for and provision of long-term care services.
- B.** A case manager shall:
1. Ensure that appropriate ALTCS placement and services are provided for a member within 30 days of enrollment;
 2. Develop a service plan by:
 - a. Completing a case management plan when a member is enrolled in ALTCS and authorizing services for a member who continues to be financially and medically eligible for services;
 - b. Ensuring that a member participates in the preparation of the member’s case management plan;
 - c. Specifying the paid and natural support services to be received by the member, including the duration, scope of services, units of service, frequency of service delivery, provider of services, and effective time period; and
 - d. Coordinating with the primary care provider in determining the necessary services for the member, including hospital and medical services;
 3. Submit a written justification to the case manager’s supervisor to include HCBS in the case management plan if the services exceed 80 percent of the institutional cost;
 4. Manage a case management plan by:

- a. Re-evaluating and revising the case management plan when the member transfers to another facility, transfers to a hospital, has a change in level of care; and
 - b. Monitoring receipt of services by a member;
5. Assist the member to maintain or progress toward the highest level of functioning;
 6. Ensure that records are transferred when the member is transferred from a facility or provider to a new facility or provider;
 7. Perform additional monitoring of a member with rehabilitation potential and whose condition is fragile or unstable, whose case management plan is marginally cost effective, or whose use of medical and hospital services is unusual;
 8. Arrange behavioral health services, if necessary. The case manager shall have initial and quarterly consultation and collaboration with a behavioral health professional to review the treatment plan, unless the case manager meets the definition of a behavioral health professional under A.A.C. R9-20-101.
- C. A program contractor shall submit a service plan and other information related to the case management plan upon request to the Administration.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 18 A.A.R. 3380, effective January 1, 2013 (Supp. 12-4).

R9-28-511. Quality Management/Utilization Management (QM/UM) Requirements

A program contractor shall:

1. Comply with all requirements specified in A.A.C. R9-22-522; and
2. Submit a quarterly utilization control report within time lines specified in contract, and meet the requirements in 42 CFR 456 Subparts C, D, and F, October 1, 2004, incorporated by reference in R9-28-505.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 1, 1993 (Supp. 93-1). Amended effective November 5, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4).

R9-28-512. Expired**Historical Note**

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 4851, effective October 9, 2002 (Supp. 02-4).

R9-28-513. Program Compliance Audits

The Administration shall meet the requirements specified under A.A.C. R9-22-521 for a program contractor.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4).

R9-28-514. Release of Safeguarded Information by the Administration and Contractors

The Administration, program contractors, providers, and noncontracting providers shall meet the requirements specified under A.A.C. R9-22-512 for an ALTCS applicant, or member.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4).

R9-28-515. Repealed**Historical Note**

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Section repealed by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4).

ARTICLE 6. RFP AND CONTRACT PROCESS

Article 6, consisting of Sections R9-28-601 through R9-28-610, repealed; new Article 6, consisting of Sections R9-28-601 through R9-28-608, adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-601. General Provisions

- A. The Director has full operational authority to adopt rules for the RFP process and the award of contract under A.R.S. § 36-2944.
- B. The Administration shall follow the provisions under 9 A.A.C. 22, Article 6 for members, subject to limitations and exclusions under that Article, unless otherwise specified in this Chapter.
- C. The Administration shall award contracts under A.R.S. § 36-2932 to provide services under A.R.S. § 36-2939.
- D. The Administration is exempt from the procurement code under A.R.S. § 41-2501.
- E. The Administration and contractors shall retain all records relating to contract compliance for five years under A.R.S. § 36-2932 and dispose of the records under A.R.S. § 41-2550.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-602. RFP

The ALTCS RFP for a program contractor serving members who are EPD shall meet the requirements of A.R.S. §§ 36-2944, A.R.S. § 36-2939, A.A.C. R9-22-602, and Articles 2 and 11 of this Chapter.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000

(Supp. 00-1). Amended by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-603. Contract Award

The Administration shall award a contract under A.R.S. § 36-2944 and A.A.C. R9-22-603.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-604. Contract or Proposal Protests; Appeals

Contract or proposal protests or appeals shall be under A.A.C. R9-22-604 and 9 A.A.C. 34.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2502, effective November 13, 2012 (Supp. 12-3).

R9-28-605. Waiver of Contractor's Subcontract with Hospitals

A contractor's subcontract with hospitals may be waived under A.A.C. R9-22-605.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-606. Contract Compliance Sanction

- A. The Administration shall follow sanction provisions under A.A.C. R9-22-606.
- B. The Administration shall apply remedies found in 42 CFR 488, Subpart F, effective January 1, 2012, incorporated by reference and on file with the Administration and the Office of the Secretary of State, for a nursing facility that does not meet requirements of participation under 42 U.S.C. 1396r. This incorporation by reference contains no future editions or amendments.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2502, effective November 13, 2012 (Supp. 12-3).

R9-28-607. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-608. Repealed

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-609. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Section repealed by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-610. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 1, 1993 (Supp. 93-1). Section repealed by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-28-701. Standards for Payment Related Definitions

Definitions. In this Article, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, the following phrase has the following meaning unless the context of the Article explicitly requires another meaning:

"County of fiscal responsibility" means the county that is financially responsible for the state's share of ALTCS funding.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1). Section repealed; new Section made by final rulemaking at 11 A.A.R. 3165, effective October 1, 2005 (Supp. 05-3).

R9-28-701.10. General Requirements

The following Sections of A.A.C. Chapter 22, Articles 2 and 7, are applicable to reimbursement for services provided under the ALTCS program, except that the term "program contractor" shall be substituted for "contractor."

1. Scope of the Administration's and Contractor's Liability, R9-22-701.10;
2. Charges to Members, R9-22-702;
3. Payments by the Administration or by a program contractor, R9-22-703 and R9-22-705;
4. Contractor's Liability to Hospitals for the Provision of Emergency and Post-stabilization Care, R9-22-709;
5. Payment for Non-hospital services, R9-22-710;
6. Specialty Contracts, R9-22-712(G)(3), R9-22-712.01(10) and Article 2;

7. Payments by the Administration for Hospital Services Provided to an Eligible Person, R9-22-712; R9-22-712.01 and R9-22-712.10;
8. Overpayment and Recovery of Indebtedness, R9-22-713;
9. Payments to Providers, R9-22-714;
10. Hospital Rate Negotiations, R9-22-715; and
11. Reinsurance, R9-22-720.

Historical Note

New Section made by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-702. Repealed Nursing Facility Assessment

- A.** For purposes of this Section, in addition to the definitions under A.R.S. § 36-2999.51, the following terms have the following meaning unless the context specifically requires another meaning:

“820 transaction” means the standard health care premium payments transaction required by 45 CFR 162.1702.

“Assessment year” means the 12 month period beginning October 1st each year.

“Nursing Facility Assessment” means a tax paid by a qualifying nursing facility to the Department of Revenue on a quarterly basis established under A.R.S. § 36-2999.52.

“Medicaid days” means days of nursing facility services paid for by the Administration or its contractors as the primary payor and as reported in AHCCCS’ claim and encounter data.

“Medicare days” means resident days where the Medicare program, a Medicare advantage or special needs plan, or the Medicare hospice program is the primary payor.

“Payment year” means the 12 month period beginning October 1st each year. “Payment year” means the 12 month period beginning October 1st each year.

- B.** Subject to Centers for Medicare and Medicaid Services (CMS) approval, effective October 1, 2012, nursing facilities shall be subject to a provider assessment payable on a quarterly basis.
- C.** All nursing facilities licensed in the state of Arizona shall be subject to the provider assessment except for:
1. A continuing care retirement community,
 2. A facility with 58 or fewer beds,
 3. A facility designated by the Arizona Department of Health Services as an Intermediate Care Facility for the Mentally Retarded,
 4. A tribally owned or operated facility located on a reservation, or
 5. Arizona Veteran’s Homes.
- D.** The Administration shall calculate the prospective nursing facility provider assessment for qualifying nursing facilities as follows:
1. The Administration shall utilize each nursing facility’s Uniform Accounting Report (UAR) submitted to the Arizona Department of Health Services as of August 1st immediately preceding the assessment year. In addition, by August 1st each year, each nursing facility shall provide the Administration with any additional information necessary to determine the assessment. For any nursing facility that does not provide by August 1st the additional information requested by the Administration, the Administration shall determine the assessment based on the information available.

2. For each nursing facility, other than a nursing facility noted in subsection (D)(3), the provider assessment is calculated by multiplying the nursing facility’s non-Medicare resident day data for each assessment year by \$7.50.
3. For a nursing facility with the number of annual Medicaid days greater than or equal to the number required to achieve a slope of at least 1 applying the uniformity tax waiver test described in 42 CFR 433.68(e)(2), the provider assessment is calculated by multiplying the nursing facility’s non-Medicare resident day data for each assessment year by \$1.00.
4. The number of annual Medicaid days used in subsection (D)(3) shall be recalculated each August 1, to achieve a slope of at least 1 applying the uniformity tax waiver test described in 42 CFR 433.68(e)(2).
5. The assessment calculated under subsections (D)(2), (D)(3) and (D)(4), shall not exceed 3.5 percent of aggregate net patient service revenue of all assessed providers.
6. The Administration will forward the provider assessment by facility to the Department of Revenue by no later than December preceding the assessment year.
7. In the event a nursing facility closes during the assessment year, the nursing facility shall cease to be responsible for the portion of the assessment applied to the dates the nursing facility is not operating.
8. In the event a nursing facility begins operation during the assessment year, that facility would have no responsibility for the assessment until such time as the facility has UAR data that falls within the collection period for the assessment calculation.
9. In the event a nursing facility has a change of ownership such that the facility remains open and the ownership of the facility changes, the assessment liability transfers with the change in ownership.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 3244, effective October 1, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1). New Section made by final rulemaking at 19 A.A.R. 137, effective January 8, 2013 (Supp. 13-1). Amended by final rulemaking at 19 A.A.R. 4168, effective February 1, 2014 (Supp. 13-4).

R9-28-703. Nursing Facility Supplemental Payments

- A.** Nursing Facility Supplemental Payments
1. Using Medicaid resident bed day information from the most recent and complete twelve months of adjudicated claims and encounter data, for every combination of contractor and every facility eligible for a supplemental payment, the Administration shall determine annually a ratio equal to the number of bed days for the facility paid by each contractor divided by the total number of bed days paid to all facilities by all contractors and the Administration.
 2. Using the same information as used in (A)(1), for every facility eligible for a supplemental payment, the Administration shall determine annually a ratio equal to the number of bed days for the facility paid by the Administration divided by the total number of bed days paid to all facilities by all contractors and the Administration.

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3. Quarterly, each contractor shall make payments to each facility in an amount equal to 98% of the amounts identified as Nursing Facility Enhanced Payments in the 820 transaction sent from AHCCCS to the contractor for the quarter multiplied by the percentage determined in subsection (A)(2) applicable to the contractor and to each facility.
 4. Quarterly, the Administration shall make payments to each facility in an amount equal to 99% of the amounts collected during the preceding quarter under R9-28-702, less amounts collected and used to fund the Nursing Facility Enhanced Payments included in the capitation paid to contractors and the corresponding federal financial participation, multiplied by the percentage determined in subsection (A)(2) applicable to the Administration and to each facility. The Administration shall make the supplemental payments to the nursing facilities within 20 calendar days of the determination of the quarterly supplemental payment.
 5. Neither the Administration nor the Contractors shall be required to make quarterly payments to facilities otherwise required by subsections (A)(3) or (A)(4) until the assessment collected and actually available in the nursing facility assessment fund, plus the corresponding federal financial participation, are equal to or greater than 101% of the amount necessary for contractors to make the payments to facilities described in subsections (A)(4) and (A)(5).
 6. Contractors shall not be required to make quarterly payments to facility otherwise required by subsection (A)(4) until the Administration has made a retroactive adjustment to the capitation rates paid to contractors to correct the Nursing Facility Enhanced payments based on actual member months for the specified quarter.
- B.** Each contractor must pay each facility the amount computed within 20 calendar days of receiving the nursing facility enhanced payment from the Administration. The contractors must confirm each payment and payment date to the Administration within 20 calendar days from receipt of the funds.
- C.** After each assessment year, the Administration shall reconcile the payments made by contractors under subsection (A) and (B) to the portion of the annual collections under R9-28-702 attributable to Medicaid resident bed days paid for by contractors for the same year, less one percent, plus available federal financial participation. The proportion of each nursing facility's Medicaid resident bed days as described in subsection (A)(2)(ii) shall be used to calculate the reconciliation amounts. Contractors shall make additional payments to or recoup payments from nursing facilities based on the reconciliation in compliance with the requirements of subsection (B).
- D.** General requirements for all payments.
1. A facility must be open on the date the supplemental payment is made in order to receive a payment. In the event a nursing facility closes during the assessment year, the nursing facility shall cease to be eligible for supplemental payments.
 2. In the event a nursing facility begins operation during the assessment year, that facility shall not receive a supplemental payment until such time as the facility has claims and encounter data that falls within the collection period for the payment calculation.
 3. In the event a nursing facility has a change of ownership, payments shall be made to the owner of the facility as of the date of the supplemental payment.
4. Subsection (E)(3) shall not be interpreted to prohibit the current and prior owner from agreeing to a transfer of the payment from the current owner to the prior owner.
- E.** The Arizona Veterans' Homes are not eligible for supplemental payments.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1). New Section made by final rulemaking at 19 A.A.R. 137, effective January 8, 2013 (Supp. 13-1). Amended by final rulemaking at 19 A.A.R. 4168, effective February 1, 2014 (Supp. 13-4).

R9-28-704. Repealed**Historical Note**

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-705. Repealed**Historical Note**

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective November 5, 1993 (Supp. 93-4). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 11 A.A.R. 3165, effective October 1, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-706. Repealed**Historical Note**

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsections (A) and (B) effective June 6, 1989 (Supp. 89-2). Amended effective April 25, 1990 (Supp. 90-2). Amended effective November 5, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 10 A.A.R. 4658, effective January 1, 2005 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 3852, effective November 12, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-707. Repealed**Historical Note**

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

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

R9-28-708. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 26, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective November 5, 1993 (Supp. 93-4). Amended by final rulemaking at 11 A.A.R. 3852, effective November 12, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-709. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsection (B) effective June 6, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-710. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsections (C) and (D) effective June 6, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-711. Repealed

Historical Note

Adopted effective November 5, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 3165, effective October 1, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-712. County of Fiscal Responsibility

A. General requirements.

1. The Administration shall determine the county of fiscal responsibility under A.R.S. § 36-2913 for an applicant or member who is elderly or physically disabled.
2. A program contractor shall cover services and provisions specified in 9 A.A.C. 22, Articles 2 and 7 and Article 11 of this Chapter.

B. Criteria for determining county of fiscal responsibility for an applicant.

1. If the applicant resides in the applicant's own home, the county of fiscal responsibility is the county where the applicant currently resides.
2. This applies only if subsection (B)(3) does not apply. If the applicant is residing in a NF or alternative HCBS set-

ting, the county of fiscal responsibility is the county in which the applicant last resided in the applicant's own home.

3. If the applicant moves from another state directly into a NF or alternative HCBS setting in this state, the county of fiscal responsibility is the county in which the person currently resides.
4. If the applicant moves from the Arizona State Hospital (ASH) into a NF or alternative HCBS setting, or is an inmate of a public institution moving from the public institution into a NF or alternative HCBS setting, the county of fiscal responsibility is the county in which the applicant resided in the applicant's own home prior to admission to ASH or the public institution.

C. Criteria for determining if there is a change in county of fiscal responsibility for a member moving from one county to another county.

1. No change in the county of fiscal responsibility. There is no change in the county of fiscal responsibility for a member if:
 - a. The member moves from a NF to another NF in a different county,
 - b. The member moves from a NF to an alternative HCBS setting in a different county,
 - c. The member moves from an alternative HCBS setting to another alternative HCBS setting in a different county,
 - d. The member moves from an alternative HCBS setting to a NF in a different county,
 - e. The member moves from the member's own home to an alternative HCBS setting in a different county,
 - f. The member moves from the member's own home to a NF in a different county,
 - g. The member moves from a NF or alternative HCBS setting into ASH, or
 - h. The member moves from ASH to a NF or alternative HCBS setting.
2. Change in the county of fiscal responsibility. If a member moves from one county to another, the county of fiscal responsibility changes to the new county if the member moves from:
 - a. An alternative HCBS setting to the member's own home in a different county,
 - b. A NF to the member's own home in a different county,
 - c. The member's own home to the member's own home in a different county, or
 - d. ASH to the member's own home.
3. Transfers between program contractors. The county of fiscal responsibility changes if the Administration transfers a member from one program contractor to a different program contractor and if:
 - a. Both program contractors agree, or
 - b. The Administration determines that it is in the best interest of the member.

Historical Note

Adopted effective November 4, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3).

R9-28-713. Repealed

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 3165, effective October 1, 2005 (Supp. 05-3). Section repealed by final rulemak-

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ing at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-714. Repealed**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-715. Repealed**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

ARTICLE 8. TEFRA LIENS AND RECOVERIES**R9-28-801. Definitions Related to TEFRA Liens**

In addition to the definitions in A.R.S. §§ 36-2901 and 36-2931, 9 A.A.C. 22, Article 1, and 9 A.A.C. 28, Article 1, the following definitions apply to this Article:

“Consecutive days” means days following one after the other without an interruption resulting from a discharge.

“File” means the date that AHCCCS receives a request for a State Fair Hearing under R9-28-805, as established by a date stamp on the request or other record of receipt.

“Home” means property in which a member has an ownership interest and that serves as the member’s principal place of residence. This property includes the shelter in which a member resides, the land on which the shelter is located, and related outbuildings.

“Recover” means that AHCCCS takes action to collect from a claim.

“TEFRA lien” means a lien under 42 U.S.C. 1396p of the Tax Equity and Fiscal Responsibility Act of 1982.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004 (Supp. 04-1). New Section made by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-801.01. TEFRA Liens – General

Purpose. The purpose of TEFRA is to allow AHCCCS to file a lien on an AHCCCS member’s interest in any real property before the member is deceased, including but not limited to life estates and beneficiary deeds.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-802. TEFRA Liens – Affected Members

- A. Except for members under R9-28-803, AHCCCS shall file a TEFRA lien against the real property of all members who are:
1. Receiving ALTCS services,
 2. 55 years of age or older, and
 3. Permanently institutionalized.

- B. A rebuttable presumption exists that a member is permanently institutionalized if the member has continually resided in a nursing facility, ICF/MR, or other medical institution defined in 42 CFR 435.1010 for 90 or more consecutive days. A member may rebut the presumption by providing a written opinion from a treating physician, rendered to a reasonable degree of medical certainty, that the member’s condition is likely to improve to the point that the member will be discharged from the medical institution and will be capable of returning home by a date certain.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004 (Supp. 04-1). New Section made by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-803. TEFRA Liens – Prohibitions

AHCCCS shall not file a TEFRA lien against a member’s home if one of the following individuals is lawfully residing in the member’s home:

1. Member’s spouse;
2. Member’s child who is under the age of 21;
3. Member’s child who is blind or disabled under 42 U.S.C. 1382c; or
4. Member’s sibling who has an equity interest in the home and who was residing in the member’s home for at least one year immediately before the date the member was admitted to a nursing facility, ICF/MR, or other medical institution as defined under 42 CFR 435.1010.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Section repealed; new Section adopted effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004 (Supp. 04-1). New Section made by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-804. TEFRA Liens – AHCCCS Notice of Intent

- A. Time-frame. At least 30 days before filing a TEFRA lien, AHCCCS shall send the member or member’s representative a Notice of Intent.
- B. Content of the Notice of Intent. The Notice of Intent shall include the following information:
1. A description of a TEFRA lien and the action that AHCCCS intends to take,
 2. How a TEFRA lien affects a member’s property,
 3. The legal authority for filing a TEFRA lien,
 4. The time-frames and procedures involved in filing a TEFRA lien, and
 5. The member’s right to request an exemption.
- C. Request for exemption. A member or a member’s representative may request an exemption. To request an exemption the member or the member’s representative shall submit a written statement to AHCCCS within 30 days from the receipt of the Notice of Intent describing the factual basis for a claim that the property should be exempt from placement of a TEFRA lien or from recovery of lien based on R9-28-802, R9-28-803, or R9-

28-806. AHCCCS shall respond to the member or member's representative in writing within 30 days of receiving a request for exemption, unless the parties mutually agree to a longer period of time.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Section repealed effective August 11, 1997 (Supp. 97-3). New Section made by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-805. TEFRA Liens and Estate Recovery – Member's Request for a State Fair Hearing

- A. If the member or member's representative does not request an exemption under R9-28-804(C), the Administration shall send the member or representative a Notice of TEFRA Lien. The member or representative may file a request for a State Fair Hearing within 30 days of the receipt of the Notice of TEFRA Lien.
- B. If the member requests an exemption and the request is denied, the Administration shall send the member or representative a Denial of a Request for Exemption. The member or representative may file a request for a State Fair Hearing within 30 days of the receipt of the Denial of Request for Exemption. After the 30-day time-frame to file a State Fair Hearing, the member or representative is sent a Notice of a TEFRA Lien.
- C. Hearings regarding TEFRA liens shall be conducted under 9 A.A.C. 34.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-806. TEFRA Liens – Recovery

- A. AHCCCS shall seek to recover a TEFRA lien upon the sale or transfer of the real property subject to the lien. However, AHCCCS shall not seek to recover the TEFRA lien or attempt recovery against any real property subject to the TEFRA lien so long as the member is survived by the member's:
 1. Spouse;
 2. Child under the age of 21; or
 3. Child who receives benefits under either Title II or Title XVI of the Social Security Act as blind or disabled, as defined under 42 U.S.C. 1382c.
- B. AHCCCS shall not seek to recover a TEFRA lien on an individual's home if the member is survived by:
 1. A sibling of the member who currently resides in the deceased member's home and who was residing in the member's home for a period of at least one year immediately before the date of the member's admission to the nursing facility, ICF/MR, or other medical institution as defined under 42 CFR 435.1010; or
 2. A child of the member who resides in the deceased member's home and who:
 - a. Was residing in the member's home for a period of at least two years immediately before the date of the member's admission to the nursing facility, ICF/MR, or other medical institution as defined under 42 CFR 435.1010; and
 - b. Provided care to the member that allowed the member to reside at home rather than in an institution.
- C. To determine whether a child of the member provided care under subsection (B)(2), AHCCCS shall require the following information:

1. A physician's written statement that describes the member's physical condition and service needs for the previous two years before the member's death;
2. Verification that the child actually lived in the member's home;
3. A written statement from the child providing the services that describes and attests to the services provided;
4. A written statement, if any, made by the member prior to death regarding the services received; and
5. A written statement from physician, friend, or relative as witness to the care provided.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-807. TEFRA Liens – Release

AHCCCS shall issue a release of a TEFRA lien within 30 days of:

1. Satisfaction of the lien;
2. Notice that the member has been discharged from the nursing facility, ICF/MR, or other medical institution, defined under 42 CFR 435.1010, and the member has returned home and is physically residing in the home with the intention of remaining in the home. Discharge to an alternative HCBS setting defined at R9-28-101 does not constitute a return to the home; or
3. Notice of the member's death, if a lien has been filed on a life estate.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

ARTICLE 9. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES

R9-28-901. Definitions

In addition to the definitions in A.R.S. §§ 36-2901 and 36-2931, 9 A.A.C. 22, Article 1, and 9 A.A.C. 28, Article 1, the following definitions apply to this Article:

"Estate" has the meaning in A.R.S. § 14-1201.

"Member" means a person eligible for AHCCCS-covered services under A.R.S. Title 36, Chapter 29, Article 2.

"Recover" means that AHCCCS takes action to collect from a claim.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-902. General Provisions

The provisions in A.A.C. R9-22-1002 apply to this Section.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended effective November 7, 1997 (Supp. 97-4). Amended by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-903. Cost Avoidance

The provisions in A.A.C. R9-22-1003 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-904. Member Participation

The provisions in A.A.C. R9-22-1004 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-905. Collections

The provisions in A.A.C. R9-22-1005 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-906. AHCCCS Monitoring Responsibilities

The provisions in A.A.C. R9-22-1006 apply to this Section.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-907. Notification for Perfection, Recording, and Assignment of AHCCCS Liens

The provisions in A.A.C. R9-22-1007 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-908. Notification Information for Liens

The provisions in A.A.C. R9-22-1008 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-909. Notification of Health Insurance Information

The provisions in A.A.C. R9-22-1009 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-910. Recoveries

AHCCCS shall recover funds paid before or after the death of a member for ALTCS benefits including: capitation payments, Medicare Parts A and B premium payments, coinsurance and deductibles paid by AHCCCS, fee-for-service payments, and reinsurance payments from:

1. The estate of a member who was 55 years of age or older when the member received benefits; or
2. The estate or the property of a member under A.R.S. §§ 36-2935, 36-2956, and 42 U.S.C. 1396p.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-911. Estate Recovery and Undue Hardship

A. Any recovery of a claim by AHCCCS against a member's estate shall be made only after the death of the member's surviving spouse and only at a time:

1. When there exists no surviving minor child under age 21; and
2. When there exists no surviving child who receives benefits under either Title II or Title XVI of the Social Security Act because the child is blind or disabled as defined in 42 U.S.C. 1382c.

B. Undue hardship exemption request. A member's representative may request an undue hardship exemption. If the member's representative wishes to request an undue hardship exemption, the member's representative shall submit the request within 30 days from the receipt of the notification of the AHCCCS claim against the estate. The member's representative shall submit a written statement to AHCCCS describing the factual basis for a claim that the property should be exempt from estate recovery as provided under this Section. AHCCCS shall respond to the member or member's representative in writing within 30 days of receiving an undue hardship exemption request, unless the parties mutually agree to a longer period of time.

C. AHCCCS shall waive a claim against a member's estate because of undue hardship if any of the following situations exist:

1. The estate consists only of real property that is listed as residential property by the Arizona Department of Revenue or County Assessor's Office, and the heir or devisee:
 - a. Owns a business that is located at the residential property and:
 - i. The business was in operation at the residential property for at least 12 months preceding the death of the member,
 - ii. The business provides more than 50 percent of the heir's or devisee's livelihood, and
 - iii. The recovery of the property would result in the heir or devisee losing the heir's or devisee's means of livelihood; or
 - b. Currently resides in the residence and:
 - i. Resided there at the time of the member's death,
 - ii. Made the residence his or her primary residence for the 12 months immediately before the death of the member, and
 - iii. Owns no other residence; or
2. The estate consists only of personal property and:
 - a. The heir's or devisee's gross annual income for the household size is less than 100 percent of the Federal Poverty Level (FPL). New sources of income such as employment or Social Security that may not have yet been received are included in determining the household's annual gross income; and
 - b. The heir or devisee does not own a home, land, or other real property.

D. When the estate consists of both personal property and real property that qualify for the undue hardship exemption criteria under subsections (B) and (C), AHCCCS shall not grant an undue hardship waiver; however, AHCCCS shall adjust its claim to the value of the personal property.

E. AHCCCS shall exempt the following income, resources, and property of Native Americans (NA) and Alaska Natives (AN) from estate recovery:

1. Income and resources from tribal land and other resources currently held in trust and judgment funds from the Indian Claims Commission or U.S. Claims Court;

2. Ownership interest in trust or non-trust property;
3. Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources;
4. Any other ownership interests or rights in a property that has unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional life style according to applicable Tribal law or custom; and
5. Income left as a remainder in an estate derived from any property listed in subsection (E)(1) through (4), that was either collected by a NA, or by a Tribe or Tribal organization and distributed to a NA.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-912. Partial Recovery

AHCCCS shall use the following factors in determining whether to seek a partial recovery of funds when an heir or devisee does not meet the requirements of R9-28-911 and requests a partial recovery:

1. Financial and medical hardship to the heir or devisee;
2. Income of the heir or devisee and whether the heir or devisee's household gross annual income is less than 100 percent of the FPL;
3. Resources of the heir or devisee;
4. Value and type of assets;
5. Amount of AHCCCS' claim against the estate; and
6. Whether other creditors have filed claims against the estate or have foreclosed on the property.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-913. Repealed**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-914. Repealed**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-915. Repealed**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-916. Repealed**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-917. Repealed**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-918. Repealed**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-919. Repealed**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

ARTICLE 10. CIVIL MONETARY PENALTIES AND ASSESSMENTS**R9-28-1001. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims**

AHCCCS shall use the provisions in 9 A.A.C. 22, Article 11 for the determination and collection of penalties, assessments, and penalties and assessments.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective June 9, 1998 (Supp. 98-2). Amended by final rulemaking at 10 A.A.R. 3065, effective September 11, 2004 (Supp. 04-3).

R9-28-1002. Repealed**Historical Note**

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Repealed effective June 9, 1998 (Supp. 98-2).

R9-28-1003. Repealed**Historical Note**

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Repealed effective June 9, 1998 (Supp. 98-2).

R9-28-1004. Repealed**Historical Note**

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Repealed effective June 9, 1998 (Supp. 98-2).

ARTICLE 11. BEHAVIORAL HEALTH SERVICES**R9-28-1101. General Requirements**

General requirements. The following general requirements apply to behavioral health services provided under this Article, subject to all exclusions and limitations.

1. Administration. The program shall be administered under A.R.S. § 36-2932.
2. Provision of services. Behavioral health services shall be provided under A.R.S. § 36-2939, this Chapter and 9 A.A.C. 22, Article 12, as applicable.

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3. Definitions. The definitions in A.A.C. R9-22-1201 and R9-22-102 apply to this Article, in addition to the following definitions:

“Case management” means the activities described in R9-28-510.

“Cost avoid” means the same as in A.A.C. R9-22-1201.

“Intergovernmental agreement” or “IGA” means an agreement for services or joint or cooperative action between the Administration and a tribal contractor.

“Qualified behavioral health service provider” means a behavioral health service provider that meets the requirements of R9-28-1106.

“Tribal contractor” means a tribal organization (The Tribe) or urban Indian organization defined in 25 U.S.C. 1603 and recognized by CMS as meeting the requirements of 42 U.S.C. 1396d(b), that provides or is accountable for providing the services or delivering the items described in the intergovernmental agreement.

4. Enrollment of Native American member. The Administration shall enroll an EPD Native American member with a tribal contractor on a FFS basis if:
- The member lives on-reservation of a Native American tribal organization that is an ALTCS tribal contractor, or
 - The member lived on-reservation of a Native American tribal organization that is an ALTCS tribal contractor immediately before placement in an off-reservation Nursing Facility or an alternative HCBS setting.
5. Case management. A tribal contractor shall provide case management services to FFS Native American members living on or off-reservation as delineated in the IGA.
6. Services. A tribal contractor or the Administration may authorize behavioral health services for FFS Native American members enrolled with a tribal contractor as delineated in the intergovernmental agreement.
7. Enrollment of Native American members off-reservation. Except as provided in R9-28-1101(4)(b), an EPD Native American who resides off-reservation shall be enrolled with an ALTCS program contractor to receive behavioral health services, including case management, under R9-28-415.
8. Enrollment of developmentally disabled Native American member. A developmentally disabled Native American member who resides on or off-reservation shall be enrolled with the Department of Economic Security’s Division of Developmental Disabilities under R9-28-414 and shall receive behavioral health services from the Department of Economic Security’s Division of Developmental Disabilities.
9. Reimbursement. For FFS Native Americans, the Administration is exclusively responsible for providing reimbursement for covered behavioral health services that are authorized by a tribal contractor or the Administration under the intergovernmental agreement as specified in this Article. A program contractor is exclusively responsible for providing reimbursement for covered behavioral health services that are authorized by a program contractor as specified in this Article.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Section

repealed; new Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 1090, effective May 5, 2007 (Supp. 07-1).

R9-28-1102. Program or Tribal Contractor Responsibilities

- Program contractor. A program contractor shall provide behavioral health services to all enrolled members, including Native American members who are not enrolled with a tribal contractor under R9-28-1101.
- Tribal contractor. A tribal contractor shall provide behavioral health services to a Native American member who is enrolled with a tribal contractor as prescribed in R9-28-1101. When a tribal contractor determines that an EPD Native American member residing on a reservation needs behavioral health services under R9-28-415, the member shall receive services as authorized by the Administration or a tribal contractor under A.A.C. R9-22-1205 from any AHCCCS-registered provider.
- A program or tribal contractor shall cooperate when a transition of care occurs and ensure that medical records are transferred in accordance with A.R.S. §§ 36-2932, 36-509, and R9-28-514 when a member transitions from:
 - A behavioral health provider to another behavioral health provider,
 - A RBHA or TRBHA to a program contractor,
 - A program or tribal contractor to a RBHA or TRBHA, or
 - A program contractor to a tribal contractor or vice versa.
- The Administration, a tribal contractor, or a program contractor, as appropriate, shall authorize behavioral health services for Native American members.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Office of the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 13 A.A.R. 1090, effective May 5, 2007 (Supp. 07-1).

R9-28-1103. Eligibility for Covered Services

- Eligibility for covered services. A member determined eligible under A.R.S. § 36-2934 shall receive medically necessary covered services specified in A.A.C. R9-22-1205 and R9-28-202.
- Limitations. Behavioral health services are covered as specified in A.A.C. R9-22-201 and R9-22-1205.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Office of the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at

6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 1090, effective May 5, 2007 (Supp. 07-1).

R9-28-1104. General Service Requirements

- A.** Services. Behavioral health services include both mental health and substance abuse services.
- B.** Prior authorization for emergency behavioral health services. A provider is not required to obtain prior authorization for emergency behavioral health services.
- C.** Prohibition against denial of payment. A program contractor, tribal contractor, or the Administration shall not limit or deny payment to an emergency behavioral health provider for emergency behavioral health services to a member for the following reasons:
1. On the basis of lists of diagnoses or symptoms,
 2. Prior authorization was not obtained, or
 3. The provider does not have a contract.
- D.** A program contractor or the Administration shall not limit or deny payment to an emergency behavioral health provider for emergency behavioral health services provided to a member if the member received those services as directed by an employee of the program contractor or the Administration.
- E.** Grounds for denial for persons enrolled with a program or tribal contractor. A program contractor or the Administration may deny payment to an emergency behavioral health provider for emergency behavioral health services for reasons including but not limited to the following:
1. The claim was not a clean claim,
 2. The claim was not submitted timely, or
 3. The provider failed to provide timely notification to the Administration or the program contractor, as applicable.
- F.** Notification to program contractor for persons enrolled with a program contractor. A hospital, emergency room provider, or fiscal agent shall notify a program contractor no later than the 11th day from presentation of the member enrolled with a program contractor for emergency inpatient behavioral health services.
- G.** Notification to Administration for Native Americans enrolled with a tribal contractor. A provider shall notify the Administration no later than 72 hours after a Native American member enrolled with a tribal contractor presents to a hospital for inpatient emergency behavioral health services.
- H.** Behavioral health evaluation. Subject to A.R.S. § 36-545.06 and R9-28-903, an emergency behavioral health evaluation is covered as an emergency service for a member under this Section if:
1. Required to evaluate or stabilize an acute episode of mental disorder or substance abuse; and
 2. Provided by a qualified provider who is a behavioral health medical practitioner as defined in A.A.C. R9-22-1201, including a licensed psychologist, a licensed clinical social worker, a licensed professional counselor, or a licensed marriage and family therapist.
- I.** Post-stabilization requirements for members enrolled with a program contractor.
1. A program contractor is financially responsible for behavioral health post-stabilization services obtained within or outside the network that have received prior authorization from the program contractor.
 2. The program contractor is financially responsible for behavioral health post-stabilization services obtained within or outside the network that have not received prior authorization from the program contractor, but are administered to maintain the member's stabilized condition within one hour of a request to the program contractor for prior authorization of further post-stabilization services;
- 3.** The program contractor is financially responsible for behavioral health post-stabilization services obtained within or outside the network that have not received prior authorization from the program contractor, but are administered to maintain, improve, or resolve the member's stabilized condition if:
- a. The program contractor does not respond to a request for prior authorization within one hour;
 - b. The program contractor authorized to give the prior authorization cannot be contacted; or
 - c. The representative of the program contractor and the treating physician cannot reach an agreement concerning the member's care and the program contractor's physician is not available for consultation. The treating physician may continue with care of the member until the program contractor's physician is reached, or:
 - i. A program contractor's physician with privileges at the treating hospital assumes responsibility for the member's care;
 - ii. A program contractor's physician assumes responsibility for the member's care through transfer;
 - iii. A representative of the program contractor and the treating physician reach agreement concerning the member's care; or
 - iv. The member is discharged.
- 4.** Transfer or discharge. The attending physician or the provider actually treating the member for the emergency behavioral health condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the program contractor.
- J.** Prior authorization for non-emergency behavioral health services. When a member's behavioral health condition is determined by the provider not to require emergency behavioral health services, the provider shall follow the program contractor's or the Administration's prior authorization requirements.
- K.** E.P.S.D.T. services. For Title XIX members under age 21, E.P.S.D.T. services shall include all medically necessary Title XIX-covered behavioral health services to a member.
- L.** Experimental services. Experimental services and services that are provided primarily for the purpose of research are not covered.
- M.** Gratuities. A service or an item, if furnished gratuitously to a member by a provider, is not covered and payment to a provider shall be denied.
- N.** GSA. Behavioral health services rendered to a member enrolled with a program contractor shall be provided within the program contractor's GSA except when:
1. A primary care provider refers a member to another area for medical specialty care;
 2. A member's medically necessary covered service is not available within the GSA;
 3. A net savings in behavioral health service delivery costs can be documented by the program contractor for a member. Undue travel time or hardship shall be considered for a member or a member's family; or
 4. A member is placed by the program contractor in a NF or an Alternative HCBS setting located out of the program contractor's GSA, but remains enrolled with that program contractor.
- O.** Travel. If a member travels or temporarily resides outside of a program contractor's GSA, covered services are restricted to

emergency behavioral health care, unless authorized by the member's program contractor.

- P.** Non-covered services. If a member requests a behavioral health service that is not covered or is not authorized by a program contractor, the tribal contractor, or the Administration, the behavioral health service may be provided by an AHC-CCS-registered behavioral health service provider according to A.A.C. R9-22-702.
- Q.** Restrictions and limitations.
1. The restrictions, limitations, and exclusions in this Article do not apply to a program contractor that elects to provide a noncovered service.
 2. Room and board is not a covered service unless provided by the Administration or a program contractor in a Level 1, inpatient, sub-acute, or residential center under A.A.C. R9-22-1205.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993; amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective January 1, 1996; filed with the Office of the Secretary of State December 22, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 1090, effective May 5, 2007 (Supp. 07-1).

R9-28-1105. Scope of Behavioral Health Services

- A.** Scope of Services. The provisions of A.A.C. R9-22-1205 are the scope of behavioral health services for a member under this Article. A member in an institutional or Alternative HCBS setting as defined in R9-28-101 may receive covered behavioral health therapeutic home care services from a program contractor.
- B.** Applicability. References in A.A.C. R9-22-1205 to ADHS/DBHS apply to a program contractor.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Office of the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by exempt rulemaking at 8 A.A.R. 933, effective February 12, 2002

(Supp. 02-1). Amended by final rulemaking at 13 A.A.R. 1090, effective May 5, 2007 (Supp. 07-1).

R9-28-1106. General Provisions and Standards for Service Providers

- A.** Applicability. The provisions of A.A.C. R9-22-1206 are the general provisions and standards for service providers. References in A.A.C. R9-22-1206 to ADHS/DBHS or to a RBHA apply to a program contractor.
- B.** Qualified service provider. A qualified behavioral health service provider shall:
1. Have all applicable state licenses or certifications, or comply with alternative requirements established by the Administration;
 2. Register with the Administration as a behavioral health service provider; and
 3. Comply with all requirements under Article 5 and this Article.
- C.** Quality and utilization management.
1. Service providers shall cooperate with the program contractor's quality and utilization management programs and the Administration as under R9-28-511 and in contract.
 2. Service providers shall comply with applicable procedures under 42 CFR 456, incorporated by reference in A.A.C. R9-22-1206.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 1090, effective May 5, 2007 (Supp. 07-1).

R9-28-1107. General Provisions for Payment

- A.** Prior authorization. For ALTCS members enrolled with a program contractor, payment to a provider for behavioral health services that require prior authorization may be denied as specified in R9-22-705. References in A.A.C. R9-22-705 to a contractor apply to a program contractor.
- B.** For ALTCS FFS members, payment to a provider for behavioral health services that require prior authorization may be denied if a provider does not obtain prior authorization from a tribal contractor or the Administration, as applicable.
- C.** The Administration or a program contractor shall cost avoid any behavioral health service claims if the Administration or the program contractor establishes the probable existence of first-party liability or third-party liability.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 13 A.A.R. 1090, effective May 5, 2007 (Supp. 07-1).

R9-28-1108. Repealed

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3). Section repealed by final

rulemaking at 13 A.A.R. 1090, effective May 5, 2007 (Supp. 07-1).

ARTICLE 12. REPEALED

Article 12, consisting of Section R9-28-1201, repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004. The subject matter of Article 12 is now in 9 A.A.C. 34 (Supp. 04-1).

R9-28-1201. Repealed

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004 (Supp. 04-1).

ARTICLE 13. FREEDOM TO WORK

Article 13, consisting of Sections R9-28-1301 through R9-28-1324, made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1301. General Freedom to Work Requirements

The Administration shall determine eligibility for AHCCCS medical services under Article 2 of this Chapter and A.A.C. R9-22-1901.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1302. General Administration Requirements

The Administration shall comply with the confidentiality rule under A.A.C. R9-22-512(C).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1303. Application for Coverage

- A. A person may apply by submitting an application to an Administration office.
- B. The application date is the date the application is received at an Administration office.
- C. The provisions of A.A.C. R9-22-1406(B) and (D) apply to this Section.
- D. An applicant or representative who files an application may withdraw the application either orally or in writing. The Administration shall send an applicant withdrawing an application a denial notice under R9-28-1304.
- E. Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 45 days.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 5138, effective January 3, 2004 (Supp. 03-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1304. Notice of Approval or Denial

The Administration shall send an applicant a written notice of the decision regarding the application. This notice shall include a statement of the action and:

1. If approved:
 - a. The effective date of eligibility,
 - b. The amount the person shall pay, and

- c. An explanation of the person's hearing rights specified in 9 A.A.C. 34; or
2. If denied, the information required by R9-28-401.01(G)(2).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1305. Reporting and Verifying Changes

An applicant or member shall report and verify changes as described under R9-28-411(A), to the Administration, including any changes in the spouse's income that may affect the share of cost.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1306. Actions that Result from a Redetermination or Change

The processing of a redetermination or change shall result in one of the following actions:

1. No change in eligibility, share-of-cost, or premium,
2. Discontinuance of eligibility if a condition of eligibility is no longer met,
3. A change in the person's share-of-cost,
4. A change in premium amount, or
5. A change in the coverage group under which a person receives AHCCCS medical coverage.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1307. Notice of Adverse Action

- A. The requirements under R9-28-411(D)(1) apply.
- B. Advance notice of a change in eligibility, share of cost, or premium amount. Advance notice means a notice of proposed action that is issued to the member at least 10 days before the effective date of the proposed action. Except under subsection (C), advance notice shall be issued whenever an adverse action is taken to:
 1. Discontinue eligibility,
 2. Increase a person's share-of-cost,
 3. Increase the premium amount, or
 4. Reduce benefits from ALTCs to acute care services.
- C. Exceptions from advance notice. A notice shall be issued to the member to discontinue eligibility no later than the effective date of action if:
 1. A member provides a clearly written statement, signed by that member, that services are no longer wanted;
 2. A member provides information that requires termination of eligibility or reduction of services, indicates that the member understands that termination of eligibility or reduction of services will be the result of supplying the information and signs a written statement waiving advance notice;
 3. A member cannot be located and mail sent to the member's last known address has been returned as undeliverable. A member whose eligibility is discontinued under this subsection is subject to reinstatement of discontinued services under 42 CFR 431.231(d);
 4. A member has been admitted to a public institution where a person is ineligible for coverage;

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5. A member has been approved for Medicaid in another state; or
6. The Administration receives information confirming the death of a member.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1308. Request for Hearing

An applicant or member may request a hearing under 9 A.A.C. 34.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1309. Conditions of Eligibility

An applicant or member shall meet the following conditions to qualify for the Freedom to Work program:

1. Furnish a valid Social Security Number (SSN);
2. Be a resident of Arizona;
3. Be a citizen of the United States, or meet requirements for a qualified alien under A.R.S. § 36-2903.03(B);
4. Be at least 16 years of age, but less than 65 years of age;
5. Have countable income that does not exceed 250 percent of FPL. The Administration shall count income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K with the following exceptions:
 - a. The unearned income of the applicant or member shall be disregarded,
 - b. The income of a spouse or other family members shall be disregarded, and
 - c. The deduction for a minor child shall not apply;
6. Reside in a living arrangement specified under R9-28-406(A);
7. Be determined as physically disabled by meeting the medical criteria under Article 3 of this Chapter; and
8. Comply with the member responsibility provisions under A.A.C. R9-22-1502(D) and (F).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed; new Section made by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1310. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1311. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1312. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed

by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1313. Premium Requirements

- A. As a condition of eligibility, an applicant or member shall:
1. Pay the premium required under subsection (B).
 2. Not have any unpaid premiums that exceed the premium amount for one month.
- B. The Administration shall process premiums under 9 A.A.C. 31, Article 14 with the following exceptions:
1. A member who has countable income:
 - a. Under \$500, the monthly premium payment shall be \$0.
 - b. Over \$500 but not greater than \$750, the monthly premium payment shall be \$10.
 2. The premium for a member shall be increased by \$5 for each \$250 increase in countable income above \$750.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1314. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1315. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1316. Institutionalized Person

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

1. An inmate of a public institution and federal financial participation (FFP) is not available, or
2. Older than age 20 but younger than age 65 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except when allowed under the Administration's Section 1115 IMD waiver or allowed under a managed care contract approved by CMS.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1317. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1318. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1319. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1320. Additional Eligibility Criteria for the Basic Coverage Group

As a condition of eligibility, an applicant or member shall be employed. Employed means that an applicant or member is paid for working and Social Security or Medicare taxes are paid on the applicant's or member's income.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1321. Share of Cost

The Director shall determine the amount a person shall pay for the cost of ALTCS services (share-of-cost) under A.R.S. § 36-2932(L) and 42 CFR 435.725 or 42 CFR 435.726. Share of cost shall be calculated for people who reside in a medical institution for an entire calendar month under R9-28-408(G) and R9-28-410(C) except that the personal-needs allowance shall be increased by 50 percent of the member's earned income.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1322. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1323. Enrollment

The Administration shall enroll members under R9-28-412 through R9-28-418.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1324. Redetermination of Eligibility

- A. Redetermination. Except as provided in subsection (B), the Administration shall complete a redetermination of eligibility at least once a year.
- B. Change in circumstance. The Administration may complete a redetermination of eligibility if there is a change in the member's circumstances, including a change in disability or employment that may affect eligibility.
- C. Medical Improvement. If a member is no longer disabled under Article 3 of this Chapter, the Administration shall determine if the member is eligible under other coverage groups.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).