

R9-29-210	Amend
R9-29-211	Repeal
R9-29-211	Renumber
R9-29-211	Amend
R9-29-212	Repeal
R9-29-212	New Section
R9-29-213	Renumber
R9-29-213	Amend
R9-29-214	Repeal
R9-29-215	Renumber
R9-29-216	Repeal
R9-29-217	Repeal
R9-29-218	Repeal
R9-29-219	Renumber
R9-29-220	Renumber
R9-29-221	Renumber
R9-29-222	Renumber
R9-29-223	Repeal
R9-29-224	Renumber
R9-29-301	Amend
R9-29-302	Amend
R9-29-303	Repeal
R9-29-303	New Section
R9-29-304	New Section
Article 4	Repeal
R9-29-401	Repeal
Article 5	Amend
R9-29-501	Amend

R9-29-503

Repeal

R9-29-601

Amend

2. Citations to the agency’s statutory rulemaking authority to include both the authorizing statute (general) and the implementing statute (specific):

Authorizing statute: A.R.S. § 36-2972

Implementing statute: A.R.S. §§ 36-2972, 36-2973, 36-2974, 36-2975, and 36-2976

3. The effective date of the rule:

The rules will be effective 60 days from the date of filing with the Secretary of State as specified in A.R.S. § 41-1032(A).

4. Citations to all related notices published in the Register to include the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 18 A.A.R. 1503, June 29, 2012

Notice of Proposed Rulemaking: 18 A.A.R. 1438, June 29, 2012

5. The agency’s contact person who can answer questions about the rulemaking:

Name: Mariaelena Ugarte

Address: 701 E. Jefferson St.

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSrules@azahcccs.gov

Web site: www.azahcccs.gov

6. An agency’s justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

The AHCCCS Administration is initiating this rulemaking for purposes of amending its existing rules that define the scope of benefits for persons eligible for both Medicaid and Medicare. In general, the Medicare program has primary responsibility for the cost of care for these individuals, and Medicaid (that is, AHCCCS) is responsible for paying for the cost of Medicare Part B premiums, and/or Medicare coinsurance, copayments, and deductibles depending on the individual’s Medicare entitlement under the Medicaid program to “Medicare Cost Sharing” (MCS).

AHCCCS has implemented several significant statutory and regulatory changes to benefits, such as limitations of inpatient hospital days for adults. With respect to persons eligible for Medicare Cost Sharing, AHCCCS is responsible in many instances for the cost of services that have been excluded or limited by AHCCCS but are still

covered by Medicare. In light of the recent benefit changes and limitations in AHCCCS benefits, there is a heightened need to ensure that the MCS rules clearly identify the rights of persons eligible for MCS and the extent of AHCCCS' responsibility for payment for services. In addition, the Administration intends to update MCS regulations with any necessary technical changes to ensure clarity and conciseness of the rule.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

A study was not referenced or relied upon when revising the regulations.

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

Not applicable.

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

The majority of the changes are clarifications of the existing MCS rules, policies and practices; however, this rule does propose to require all contractors to cover cost sharing for QMB Duals when services are received out of network based on recent clarification from the federal government.

Based on preliminary analysis, some of the plans have made payments of coinsurance deductible and copayment for services out of network. To the extent that plans making the payments and encountering payments, those costs will be reflected in the existing capitation rates of federal and state revenues of \$2.9M.

To the extent that this rule amendment would mandate that all plans make the payment for coinsurance and deductibles, we currently do not have sufficient data to determine whether the increase costs would be significant enough to warrant an increase in capitation payments.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

No significant changes were made between the proposed rulemaking and the final rulemaking. The Administration has made grammatical or formatting changes as required.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

No comments were received as of the close of the comment period of July 31, 2012.

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

No other matters are applicable.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

Not applicable.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

Yes, although Medicare is a federal program and applies to the subject matter of the rules promulgated, these rules are not more stringent than the corresponding federal law.

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

None

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:

None

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 29. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

MEDICARE COST SHARING PROGRAM

ARTICLE 1. DEFINITIONS

Section

R9-29-101. Location of Definitions

R9-29-102. ~~Dually Eligible~~ Repealed

ARTICLE 2. ELIGIBILITY

Section

R9-29-201. General

R9-29-202. ~~Opportunity to Apply~~ Application Process

~~R9-29-203.~~ ~~How to File an Application~~

~~R9-29-207.~~R9-29-203. Assignment of Rights

R9-29-204. ~~Date of Application~~ Eligibility Requirements

~~R9-29-205.~~ ~~Complete Application~~

~~R9-29-213.~~R9-29-205. Income Standards

~~R9-29-206.~~ ~~Assistance with Application~~

~~R9-29-215.~~R9-29-206. Institutionalized Person

R9-29-207. Resources

~~R9-29-208.~~ ~~Medical Support Obligation~~

~~R9-29-219.~~R9-29-208. Eligibility Determination

~~R9-29-209.~~ ~~Social Security Number (SSN)~~

~~R9-29-220.~~R9-29-209. Notice of Eligibility Determination

~~R9-29-210.~~ ~~Citizenship~~

~~R9-29-221.~~R9-29-210. Effective Date of Eligibility

~~R9-29-211.~~ ~~Residency~~

~~R9-29-222~~R9-29-211. Discontinuance

R9-29-212. ~~Income Calculation~~ Renewals

~~R9-29-224~~ Reporting Changes

R9-29-214. ~~Application for Other Benefits~~ Repealed

R9-29-215. Renumbered

R9-29-216. ~~Resources~~ Repealed

R9-29-217. ~~Verification~~ Repealed

R9-29-218. ~~Medicare Requirements~~ Repealed

R9-29-219. Renumbered

R9-29-220. Renumbered

R9-29-221. Renumbered

R9-29-222. Renumbered

R9-29-223. ~~Redetermination~~ Repealed

R9-29-224. Renumbered

ARTICLE 3. BENEFITS AND SERVICES

Section

R9-29-301. QMB Only

R9-29-302. ~~Dually Eligible~~ QMB Dual Member

R9-29-303. ~~SLMB and QI-1~~ Non-QMB Dual Member

R9-29-304. SLMB and QI-1

ARTICLE 4. ~~CONTRACTOR, PROVIDER, AND NONCONTRACTING PROVIDER REQUIREMENTS~~

REPEALED

Section

R9-29-401. ~~Contractor, Provider, and Noncontracting Provider Requirements~~ Repealed

ARTICLE 5. ~~GRIEVANCE AND APPEAL~~ SYSTEM PROCESS

Section

R9-29-501. General Provisions for a Grievance and a Request for Hearing

R9-29-503. ~~Eligibility Hearing for an Applicant or a Member~~ Repealed

ARTICLE 6. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES

Section

R9-29-601. First- and Third-party Liability and Recoveries

ARTICLE 1. DEFINITIONS

R9-29-101. Location of Definitions

A. Location of definitions. ~~Definitions for this Chapter are contained in A.R.S. § 36-2971. Definitions include "Qualified Medicare Beneficiary only" (QMB), "Specified Low Income Medicare Beneficiary" (SLMB), and "Qualified Individual 1" (QI-1). For the purpose of Article 2 of this Chapter, QMB includes members defined in A.R.S. § 36-2971(5). Definitions applicable to this Chapter are found in the following:~~

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

B. ~~"AHCCCS" means the Arizona Health Care Cost Containment System.~~ General definitions. In addition to definitions contained in A.R.S. § 36-2971, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

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

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

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

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

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

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

R9-29-102. ~~Dually Eligible~~ Repealed

~~Under A.R.S. § 36-2971, a person determined eligible under Article 2 of this Chapter for QMB, may also be eligible for Acute Care services provided for in 9 A.A.C. 22 or ALTCS services provided for in 9 A.A.C. 28.~~

ARTICLE 2. ELIGIBILITY

R9-29-201. General

- A. Eligibility determination. AHCCCS shall determine eligibility for a QMB, SLMB, or QI-1 under this Article.
- B. Confidentiality. ~~AHCCCS shall maintain the confidentiality of a person's financial information except as provided under Article 5.~~ The Administration shall maintain the confidentiality of an applicant or member's records and limit the release of safeguarded information under A.A.C. R9-22-512.
- C. The Administration will accept applications for the QI-1 program subject to the availability of funds. If the Director determines that monies may be insufficient for the program, the Administration shall stop processing applications for the program. If the Administration stops processing an application because the monies are

insufficient, the Administration shall place an applicant on a waiting list and notify the applicant. After the Administration has verified that funding is sufficient, it will resume processing applications.

R9-29-202. Opportunity to Apply Application Process

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

~~R9-29-203. How to File an Application~~

- A.** Written application. To apply for the MCS Program, a person shall submit a written application form prescribed by AHCCCS to any AHCCCS office or outstation location approved by AHCCCS.
- B.** Who shall submit. An application shall be submitted by a person listed in A.A.C. R9-22-1405(B).

~~R9-29-207, R9-29-203. Assignment of Rights~~

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

R9-29-204. Date of Application Eligibility Requirements

~~The date of application is the date a signed application is received at an AHCCCS office or outstation location approved by AHCCCS.~~

To be eligible for MCS a person shall:

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

~~R9-29-205. Complete Application~~

~~AHCCCS shall determine whether an application is complete under A.A.C. R9-22-1405(E).~~

~~R9-29-213, R9-29-205. Income Standards~~

A. To be eligible, a person's income shall meet the following federal poverty levels (FPL), adjusted annually:

1. QMB. Income is equal to or less than 100 ~~per cent~~ percent of the FPL.
2. SLMB. Income is greater than 100 ~~per cent~~ percent but equal to or less than 120 ~~per cent~~ percent of the FPL.
3. QI-1. Income is at least 120 ~~per cent~~ percent but equal to or less than 135 percent of the FPL.

B. AHCCCS shall calculate income under A.A.C. R9-22-1503.

~~R9-29-206. Assistance with Application~~

~~A.~~ ~~Applicant's representative. AHCCCS shall allow a person of an applicant's choice to accompany, assist, and represent the applicant in the application process.~~

~~B.~~ ~~Assistance by AHCCCS. If requested, AHCCCS shall help a person complete an application.~~

~~R9-29-215.~~ R9-29-206. Institutionalized Person

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

R9-29-207. Resources

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

~~R9-29-208.~~ Medical Support Obligation

~~To be eligible for QMB, a person shall provide information necessary to establish paternity and enforce medical support obligations, when requested by AHCCCS.~~

~~R9-29-219.~~ R9-29-208. Eligibility Determination

A. AHCCCS shall make an eligibility determination within 45 days of the date of application, except when:

1. The agency cannot reach a decision because the applicant delays or fails to take a required action, or
2. When there is an administrative or other emergency beyond the agency's control.

B. AHCCCS shall not use the time to determine eligibility as a waiting period before determining eligibility; or as a reason for denying eligibility when a determination has not been made within the time standards.

~~R9-29-209.~~ Social Security Number (SSN)

~~To be eligible for MCS a person shall furnish a SSN or apply for a SSN.~~

~~R9-29-220.~~ R9-29-209. Notice of Eligibility Determination

A. Notice. AHCCCS shall send an applicant written notice of the eligibility decision. The notice shall include a statement of the action and an explanation of the person's hearing rights specified in Article 5.

B. Approval. If AHCCCS determines that the applicant is eligible, the notice shall contain the effective date of eligibility.

C. Denial. If AHCCCS determines that the applicant is not eligible, the notice shall contain:

1. The effective date of the decision;
2. A statement detailing the reason for the decision, including specific financial calculations and the financial eligibility standard if applicable; and
3. The legal authority supporting the decision.

~~R9-29-210.~~ Citizenship

To be eligible for MCS, a person shall be a United States citizen or a qualified alien under A.R.S. § 36-2903.03.

~~R9-29-221.~~ R9-29-210. Effective Date of Eligibility

- A. QMB. The effective date of eligibility is the first day of the month following the month in which AHCCCS makes the eligibility decision.
- B. SLMB and ~~QI-1~~. The effective date of eligibility is the first day of the first month AHCCCS determines the person is eligible under this Article, but no earlier ~~then~~ than the first day of the month of application.
- C. QI-1. The effective date of eligibility is the first day of the first month AHCCCS determines the person is eligible under this Article, but no earlier than the first day of the month of application. QI-1 members are entitled to receive cost sharing assistance through the end of the calendar year in which they qualified for the program.

~~R9-29-211.~~ Residency

To be eligible for MCS, a person shall be a current resident of this state.

~~R9-29-222.~~ R9-29-211. Discontinuance

- A. Discontinuance. AHCCCS shall discontinue a person's eligibility if any of the conditions of eligibility under this Article are not met.
- B. Notice. AHCCCS shall follow the discontinuance notice requirements under ~~R9-22-1413~~ A.A.C. R9-22-1415, except where it states "Department" replace the term with "Administration".

~~R9-29-212.~~ Income Calculation Renewals

AHCCCS shall calculate income under ~~A.A.C. R9-22-1503.~~

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

~~R9-29-224.~~ R9-29-213. Income Standards Reporting Changes

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

1. A change of address;

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

~~R9-29-214. Application for Other Benefits Repealed~~

~~To be eligible for MCS, a person shall apply for other benefits, if requested by AHCCCS.~~

~~R9-29-215. Renumbered~~

~~R9-29-216. Resources Repealed~~

~~Resources mean property that a person owns including, but not limited to cash, financial accounts, real property, vehicles, trusts, and life insurance. Resources are not considered in determining a person's MCS eligibility.~~

~~R9-29-217. Verification Repealed~~

~~To be eligible for MCS, a person shall provide verification, or authorize the release of verification, for all information necessary to complete the determination of eligibility.~~

~~R9-29-218. Medicare Requirements Repealed~~

~~To be eligible for MCS, a person shall either be receiving Medicare Part A benefits or determined conditionally entitled to Medicare Part A benefits by the Social Security Administration. A person may request that the Social Security Administration determine the person to be conditionally entitled to Medicare Part A if the person is required to pay a Part A premium. A person who is conditionally entitled to Medicare Part A is not enrolled in Part A unless approved for QMB.~~

R9-29-219. Renumbered

R9-29-220. Renumbered

R9-29-221. ~~Renumbered~~

R9-29-222. ~~Renumbered~~

R9-29-223. ~~Redetermination~~ Repealed

~~A. QMB and SLMB. AHCCCS shall redetermine a person's eligibility for QMB or SLMB at least one time every 12 months.~~

~~B. QI-1. A person receiving QI-1 benefits shall reapply each calendar year.~~

R9-29-224. Renumbered

ARTICLE 3. BENEFITS AND SERVICES

R9-29-301. QMB Only

A. QMB benefits. ~~A~~ For a person determined eligible as a QMB Only ~~only member shall receive~~, the Administration shall provide payment of:

1. Medicare Part A premium,
2. Medicare Part B premium, and
3. Medicare coinsurance and Medicare deductible for Medicare ~~covered~~ services covered under Title XVIII of the Social Security Act to the provider.

B. Payment of QMB Only ~~only~~ benefits. The Administration shall not pay coinsurance or deductible to a member.

- ~~1. The Administration shall:~~
 - ~~a. Pay Medicare Part A and Part B premiums, and~~
 - ~~b. Pay the coinsurance and deductible to the provider.~~
- ~~2. The Administration shall not pay:~~
 - ~~a. More than the Medicare approved amounts, or~~
 - ~~b. Coinsurance or deductible to a member.~~

R9-29-302. ~~Dually Eligible~~ QMB Dual Member

~~A. Covered services. A person determined to be a dually eligible member shall receive medical services and provisions under 9 A.A.C. 22, Article 2, or services and provisions under 9 A.A.C. 28, Article 2, in addition to the Medicare-related payments under R9-29-301(A).~~

~~B. Payment responsibilities. AHCCCS shall pay the Medicare Part A and Part B premiums. The contractor shall pay the coinsurance and deductibles in accordance with the contract with AHCCCS.~~

~~C. Member responsibilities. A dually eligible member who receives services under 9 A.A.C. 22, Article 2 or 9 A.A.C. 28, Article 2 from a provider within the contractor's network is not liable for any Medicare coinsurance, deductible, or copayment associated with those services and is not liable for any balance.~~

A. Covered services. A person determined to be a QMB Dual eligible member shall receive medical services provided under 9 A.A.C. 22, Article 2, or services provided under 9 A.A.C. 28, Article 2, in addition to the Medicare-related payments under R9-29-301(A).

B. Premiums. The Administration pays Medicare part A and B premiums for a QMB Dual member enrolled with a contractor in a plan or AHCCCS Fee-For-Service.

C. The Administration's payment responsibilities.

1. The Administration shall pay the following costs for members not enrolled with contractors. When services are received from an AHCCCS registered provider and the service is covered:

- a. By Medicare only, the Administration shall pay the Medicare coinsurance and deductible.
- b. By Medicaid only, the Administration shall pay the lesser of billed charges or the Capped Fee-For-Service Schedule rate for the services covered under 9 A.A.C. 22 Article 2 and 9 A.A.C. 28 Article 2.
- c. By both Medicare and Medicaid, the Administration shall pay Medicare coinsurance and deductible.

2. When services are received from a non-registered provider and the service is covered, the Administration shall not pay the Medicare coinsurance and deductible.

D. The contractor's payment responsibilities. Unless the subcontract with the provider sets forth different terms, when the enrolled member receives services from an AHCCCS registered provider in or out of network and the service is covered:

1. By Medicare only, the contractor shall pay the Medicare coinsurance and deductible.
2. By Medicaid only, the contractor shall pay the provider in accordance with the contract.
3. By both Medicare and Medicaid, the contractor shall pay the lesser of:

- a. The Medicare copay, coinsurance or deductible, or
- b. The difference between the Health plan contracted rate and the Medicare paid amount.

E. Member responsibilities. A QMB Dual eligible member who receives services under 9 A.A.C. 22, Article 2 or 9 A.A.C. 28, Article 2 from a registered provider is not liable for any Medicare copay, coinsurance or deductible associated with those services and is not liable for any balance of billed charges.

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

R9-29-303. ~~SLMB and QI-1~~ Non-QMB Dual Member

AHCCCS shall ~~pay Medicare Part B premiums.~~

A. Covered services. A person determined to be a Non-QMB Dual eligible member shall receive medical services and provided under 9 A.A.C. 22, Article 2, or services and provided under 9 A.A.C. 28, Article 2.

B. Premiums. The Administration pays Medicare part B premiums for a Non-QMB dual member enrolled with a contractor in a plan or AHCCCS Fee-For-Service for the following individuals:

1. An individual described in 42 CFR 431.625;
2. An individual enrolled in ALTCS but who does not qualify as a QMB, SLMB or QI;
3. An individual who is eligible for Medicaid under a mandatory or optional Title XIX coverage group for the aged, blind, or disabled (SSI-MAO);
4. An individual who is eligible for continued coverage while eligibility redetermination is pending as described under 42 CFR 435.1003;
5. An individual who is in the guaranteed enrollment period described in 42 CFR 435.212 and the State was paying the individual's Part B premium before eligibility terminated.

C. The Administration's payment responsibilities.

1. The Administration shall pay the following costs for members not enrolled with contractors. When services are received from an AHCCCS registered provider and the service is covered up to the limitations described within 9 A.A.C. 22, Article 2:

- a. By Medicare only, the Administration shall not pay the Medicare copay, coinsurance or deductible.
 - b. By Medicaid only, the Administration shall pay the lesser of billed charges or the Capped Fee-For-Service Schedule rate for the services covered under 9 A.A.C. 22 Article 2 and 9 A.A.C. 28 Article 2.
 - c. By both Medicare and Medicaid, the Administration shall pay the Medicare copay, coinsurance or deductible.
2. When services are received from a non-registered provider and the service is covered, the Administration shall not pay the Medicare copay, coinsurance or deductible.

D. The contractor's payment responsibilities.

1. When an enrolled member receives services within the network of contracted providers and the service is covered up to the limitations described within 9 A.A.C. 22, Article 2:
 - a. By Medicare only, the contractor shall not pay the Medicare copay, coinsurance or deductible.
 - b. By Medicaid only, the contractor shall pay the provider in accordance with the subcontract.
 - c. By both Medicare and Medicaid, unless the subcontract with the provider sets forth different terms, the contractor shall pay the lessor of:
 - i. The Medicare copay, coinsurance or deductible, or
 - ii. Any amount remaining after the Medicare paid amount is deducted from the subcontracted rate.
2. When an enrolled member receives services from a non-contracting provider and the service is covered:
 - a. By Medicare only, the contractor has no responsibility for payment.
 - b. By Medicaid only, and the contractor has not referred the member to the provider or has not authorized the provider to render services and the services are not emergent, the contractor has no responsibility for payment.
 - c. By Medicaid only, and the contractor has referred the member to the provider or has authorized the provider to render services or the services are emergent, the contractor shall pay in accordance with A.A.C. R9-22-705.
 - d. By both Medicare and Medicaid, and the contractor has not referred the member to the provider or has not authorized the provider to render services and the services are not emergent, the contractor has no responsibility for payment.

- e. By both Medicare and Medicaid, and the contractor has referred the member to the provider or has authorized the provider to render services or the services are emergent, the contractor shall pay the lessor of:
 - i. The Medicare copay, coinsurance or deductible, or
 - ii. Any amount remaining after the Medicare paid amount is deducted from the amount otherwise payable under A.A.C. R9-22-705.

E. Member responsibilities.

- 1. A Non-QMB Dual eligible member who receives covered services under 9 A.A.C. 22, Article 2 or 9 A.A.C. 28, Article 2 from a provider within the contractor's network is not liable for any Medicare copay, coinsurance or deductible associated with those services and is not liable for any balance of billed charges unless services have reached the limitations described within 9. A.A.C. 22, Article 2.
- 2. When an enrolled member chooses to receive services out of network that are covered by both Medicare and Medicaid, the member is responsible for any Medicare copay, coinsurance or deductible associated with those services unless the contractor is responsible as described in A.A.C. R9-22-705 and the provider has complied with A.A.C. R9-22-702.

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

R9-29-304. SLMB and OI-1

AHCCCS shall pay the Medicare Part B premiums.

ARTICLE 4. CONTRACTOR, PROVIDER, AND NONCONTRACTING PROVIDER REQUIREMENTS

Repealed

R9-29-401. Contractor, Provider, and Noncontracting Provider Requirements Repealed

- A. For dually eligible members, a contractor is responsible for benefits and services under R9-29-302(B) and either 9 A.A.C. 22 or 9 A.A.C. 28, as applicable.**

- ~~B. A contractor shall pay a copayment for services provided to a dually eligible member by or under referral from the member's primary care physician or primary care practitioner, under A.R.S. § 36-2974.~~
- ~~C. Providers and noncontracting providers shall submit all claims for copayments, deductibles, and coinsurance for services rendered to a QMB-only member under A.R.S. § 36-2904(H).~~

ARTICLE 5. GRIEVANCE AND APPEAL SYSTEM PROCESS

R9-29-501. General Provisions for a Grievance and a Request for Hearing

A request for hearing under this Chapter shall comply with ~~A.A.C. R9-22-801 and R9-22-802~~ 9 A.A.C.34. For the purposes of this Article, "hearing" means an administrative hearing under Title 41, Chapter 6, Article 10.

R9-29-503. Eligibility Hearing for an Applicant or a Member Repealed

~~An eligibility hearing for a member or an applicant under this Chapter shall comply with A.A.C. R9-22-803.~~

ARTICLE 6. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES

R9-29-601. First- and Third-party Liability and Recoveries

- A.** The provisions specified in 9 A.A.C. 22, Article 10 apply to this Section. For the purposes of this Article, "third-party liability" means the resources available from a person, entity, or program that is or may be, by agreement, circumstance, or otherwise, liable to pay all or part of the medical expenses incurred by an applicant or member.
- ~~**B.** AHCCCS shall not be liable for payment of coinsurance and deductibles when Medicare denies payment.~~