

## C-1

### **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)**

Title 9, Chapter 21

**Amend:** R9-21-101, R9-21-104, R9-21-105, R9-21-201, R9-21-202, R9-21-203, R9-21-206, R9-21-211, R9-21-401, R9-21-402, R9-21-403, R9-21-404, R9-21-405, R9-21-406, R9-21-407, R9-21-408, R9-21-409, R9-21-410, R9-21-501, R9-21-502, Exhibit C, R9-21-503, R9-21-504, R9-21-505, R9-21-507, R9-21-508, R9-21-509



# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - REGULAR RULEMAKING

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**MEETING DATE:** March 7, 2023

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** February 17, 2023

**SUBJECT:** Arizona Health Care Cost Containment System (AHCCCS)  
Title 9, Chapter 21

**Amend:** R9-21-101, R9-21-104, R9-21-105, R9-21-201, R9-21-202,  
R9-21-203, R9-21-206, R9-21-211, R9-21-401, R9-21-402,  
R9-21-403, R9-21-404, R9-21-405, R9-21-406, R9-21-407,  
R9-21-408, R9-21-409, R9-21-410, R9-21-50, Exhibit C.,  
R9-21-503, R9-21-504, R9-21-505, R9-21-507, R9-21-508,  
R9-21-509

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### **Summary:**

This regular rulemaking from AHCCCS relates to rules in Title 9, Chapter 21, regarding Behavioral Health Services for Persons with Serious Mental Illness. AHCCCS is seeking to make technical and conforming changes to the rules in order to update them and bring them into compliance with practice and prior session laws. Additionally, this rulemaking is also adding two additional options for seeking Emergency Admission for Evaluation; Persistently or Acutely Disabled, and Gravely Disabled.

AHCCCS is requesting the regular 60-day delayed effective date for the rules.

1. **Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?**

Yes, AHCCCS cites both general and specific statutory authority for these rules.

2. **Do the rules establish a new fee or contain a fee increase?**

No, the rules do not establish a new fee or contain a fee increase.

3. **Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

AHCCCS did not review or rely on any study for this rulemaking.

4. **Summary of the agency's economic impact analysis:**

The AHCCCS Administration does not anticipate that these rulemaking changes will have an economic, small business or consumer financial impact due to the technical and conforming nature of them. The authority for all these changes is legislative or current agency practice, therefore the rules are being brought into alignment with already authorized practices and will not require a change to agency practice or financial impact.

5. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Administration believes this is the least intrusive or less costly method for meeting federal law and state statute with the rulemaking.

6. **What are the economic impacts on stakeholders?**

AHCCCS states that the primary group impacted by these rules would be providers and members who would have increased understanding of the rules, but no additional costs.

7. **Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

No changes were made between the proposed and final rulemaking.

8. **Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**

AHCCCS indicates they did not receive any comments on the proposed rules.

9. **Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

Not applicable. The rules do not require the issuance of a general permit or license.

10. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

Not applicable. There are no corresponding federal laws to the rules.

11. **Conclusion**

As mentioned above, AHCCCS is seeking to make technical and conforming changes to the rules in order to update them and bring them into compliance with practice and prior session laws. AHCCCS is requesting the regular 60-day delayed effective date for the rules.

Council staff finds the proposed changes will make the rules more clear, concise, understandable and consistent with other rules and statutes. Council Staff recommends approval of this rulemaking.

January 24, 2022

VIA EMAIL: [grrc@azdoa.gov](mailto:grrc@azdoa.gov)

Nicole Sornsin, Chair

Governor's Regulatory Review Council

100 North 15th Avenue, Suite 305

Phoenix, Arizona 85007

RE: R9-21 Rulemaking

Dear Ms. Sorenson:

- |    |  |            |
|----|--|------------|
| 1. | The close of record date:  | 01/17/2023 |
| 2. | Does the rulemaking activity relate to a Five Year Review Report:    | No         |
| a. | If yes, the date the Council approved the Five Year Review Report:   | N/A        |
| 3. | Does the rule establish a new fee:                                   | No         |
| a. | If yes, what statute authorizes the fee:                             | N/A        |
| 4. | Does the rule contain a fee increase:                                | No         |
| 5. | Is an immediate effective date requested pursuant to A.R.S. 41-1032: | No         |

AHCCCS certifies that the preamble discloses a reference to any study relevant to the rule that the agency reviewed. AHCCCS certifies that the preamble states that it did not rely on any such study in the agency's evaluation of or justification for the rule.

AHCCCS certifies that the preparer of the economic, small business, and consumer impact statement has notified the Joint Legislative Budget Committee of the number of new full-time employees necessary to implement and enforce the rule.

The following documents are enclosed:

1. Notice of Final Rulemaking, including the preamble, table of contents, and text of each rule;
2. An economic, small business, and consumer impact statement that contains the information required by A.R.S. 41-1055;
3. If applicable: The written comments received by the agency concerning the proposed rule and a written record, transcript, or minutes of any testimony received if the agency maintains a written record, transcript or minutes;
4. If applicable: Any analysis submitted to the agency regarding the rule's impact on the competitiveness of businesses in this state as compared to the competitiveness of business in other states;
5. If applicable: Material incorporated by reference;
6. General and specific statutes authorizing the rules, including relevant statutory definitions; and
7. If applicable: If a term is defined in the rule by referring to another rule or a statute other than the general and specific statutes authorizing the rule, the statute or other rule referred to in the definition.

Sincerely,



Kasey Rogg  
Assistant Director

Attachments

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) -  
BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

PREAMBLE

<u>1. Article, Part, or Section Affected (as applicable)</u>	<u>Rulemaking Action</u>
R9-21-101.	Amend
R9-21-104.	Amend
R9-21-105.	Amend
R9-21-201	Amend
R9-21-202	Amend
R9-21-203	Amend
R9-21-206	Amend
R9-21-211	Amend
R9-21-401.	Amend
R9-21-402.	Amend
R9-21-403.	Amend
R9-21-404.	Amend
R9-21-405.	Amend
R9-21-406.	Amend
R9-21-407.	Amend
R9-21-408.	Amend
R9-21-409.	Amend
R9-21-410.	Amend
R9-21-501.	Amend
R9-21-502.	Amend
Exhibit C.	Amend
R9-21-503.	Amend

R9-21-504.	Amend
R9-21-505.	Amend
R9-21-507.	Amend
R9-21-508.	Amend
R9-21-509.	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. § 36-502

Implementing statute: A.R.S. §§ 36-504-546.01, 41-3803, Laws 2022, Chapter 299

**3. The effective date of the rule:**

AHCCCS requests the regular 60-day delayed effective date.

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

Notice of Rulemaking Docket Opening: 28 A.A.R. 3853

Notice of Proposed Rulemaking: 28 A.A.R. 3823

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

Name: Nicole Fries

Address: AHCCCS  
Office of the General Counsel  
801 E. Jefferson, Mail Drop 6200  
Phoenix, AZ 85034

Telephone: (602) 417-4232

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

Web site: [www.azahcccs.gov](http://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 proposed rulemaking makes a number of technical and conforming changes to the rules to update them and bring them into compliance with practice and prior session laws. These changes include:

- Changing references from the human rights committee to the Independent Oversight Committee, per A.R.S. § 41-3803;
- Changing references from the regional behavioral health authorities to health plans, per AHCCCS Complete Care joining of physical and behavioral health care administration through one health plan;
- Removing references to eligible children because Chapter 21 only pertains to adult Seriously Mentally Ill and General Behavioral Health services, not those provided to minors under age 18;
- Changing references to the Department of Health Services have been updated to the AHCCCS Administration, where appropriate, as the agency regulating the provision of services under Chapter 21; and
- Update the language of Exhibit C, in R9-22-502 to make permanent the change proposed in a prior emergency rulemaking, adding Persistently or Acutely Disabled and Gravely Disabled as categories for Emergency Application for Evaluation, per S.B. 1114.

The proposed rulemaking will also add two additional options for seeking an Emergency Admission for Evaluation; Persistently or Acutely Disabled, and Gravely Disabled. This rulemaking is requested to align the form with the language in S.B. 1114, that was signed into law by the Governor earlier this year and became effective September 24, 2022. This change is anticipated to be non-controversial but will have a significant impact on members of the Arizona community in need of emergency evaluation for mental/behavioral health conditions.

**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:**

No study was relied upon.

**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:**

The rulemaking will not diminish a previous grant of authority of a political subdivision.

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

The AHCCCS Administration does not anticipate that these rulemaking changes will have an economic, small business or consumer financial impact due to the technical and conforming nature of them. The authority for all of these changes is legislative or current agency practice, therefore the rules are being brought into alignment with already authorized practices and will not require a change to agency practice or financial impact.

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

There were no changes between the proposed and final rulemakings.

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

There were no public comments about the rulemaking.

**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 have been prescribed.

**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:**

The rules does not require a permit.

**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:**

A federal law is not applicable.

**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:**

No analysis was submitted.

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

No materials incorporated by reference.

**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:**

Notice of Emergency Rulemaking: 28 A.A.R. 3848

The emergency rulemaking was for Arizona Administrative Register Title 9, Chapter 21, Article 502, Exhibit C. Only Exhibit C was amended in the emergency rule, to align the form with the language in S.B. 1114, that was signed into law by the Governor earlier this year and became effective September 24, 2022. This change was significant for members of the Arizona community in need of emergency evaluation for mental/behavioral health conditions.

**15. The full text of the rules follows:**

**CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) -**

**BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS**

**ARTICLE 1. GENERAL PROVISIONS**

**Sections**

- R9-21-101. Definitions and Locations of Definitions
- R9-21-104. Office of Human Rights; Human Rights Advocates
- R9-21-105. ~~Human Rights Committees~~Independent Oversight Committees

**ARTICLE 2. RIGHTS OF PERSONS WITH SERIOUS MENTAL ILLNESS**

**Sections**

- R9-21-201. Civil and Other Legal Rights
- R9-21-202. Right to Support and Treatment
- R9-21-203. Protection from Abuse, Neglect, Exploitation, and Mistreatment
- R9-21-206. Competency and Consent
- R9-21-211. Notice of Rights

**ARTICLE 4. APPEALS, GRIEVANCES, AND REQUESTS FOR INVESTIGATION FOR PERSONS**

**WITH SERIOUS MENTAL ILLNESS**

**Sections**

- R9-21-401. Appeals
- R9-21-402. General
- R9-21-403. Initiating a Grievance or Investigation
- R9-21-404. Persons Responsible for Resolving Grievances and Requests for Investigation
- R9-21-405. Preliminary Disposition
- R9-21-406. Conduct of Investigation
- R9-21-407. Administrative Appeal
- R9-21-408. Further Appeal to Administrative Hearing
- R9-21-409. Notice and Records

R9-21-410. Miscellaneous

**ARTICLE 5. COURT-ORDERED EVALUATION AND TREATMENT**

**Sections**

R9-21-501. Court-ordered Evaluation

R9-21-502. Emergency Admission for Evaluation

Exhibit C. Application for Emergency Admission for Evaluation

R9-21-503. Voluntary Admission for Evaluation

R9-21-504. Court-ordered Treatment

R9-21-505. Coordination of Court-ordered Treatment Plans with ISPs and ITDPs

R9-21-507. Transfers of Court-ordered Persons

R9-21-508. Requests for Notification

R9-21-509. Voluntary Admission for Treatment

**ARTICLE 1. GENERAL PROVISIONS**

**R9-21-101. Definitions and Location of Definitions**

A. Location of definitions. Unless the context otherwise requires, terms used in this Chapter that are defined in A.R.S. § 36-501 shall have the same meaning as in A.R.S. § 36-501. In addition, the following definitions applicable to this Chapter are found in the following Section or Citation:

“Abuse”	R9-21-101
“ADHS”	R9-22-101
“Administration”	A.R.S. § 36-2901
<del>“Agency director”</del>	<del>R9 21 101</del>
<del>“AHCCCS”</del>	<del>R9 22 101</del>
<del>“Applicant”</del>	<del>R9 21 101</del>
<del>“ASH”</del>	<del>R9 21 101</del>
<del>“Authorization”</del>	<del>R9 21 101</del>
<del>“Behavioral health issue”</del>	<del>R9 21 101</del>
<del>“Burden of proof”</del>	<del>R9 21 101</del>
<del>“Case manager”</del>	<del>R9 21 101</del>
<del>“Client”</del>	<del>R9 21 101</del>
<del>“Client record”</del>	<del>R9 21 101</del>
<del>“Client who needs special assistance”</del>	<del>R9 21 101</del>
<del>“Clinical team”</del>	<del>R9 21 101</del>
<del>“Community services”</del>	<del>R9 21 101</del>
<del>“Condition requiring investigation”</del>	<del>R9 21 101</del>
<del>“County Annex”</del>	<del>R9 21 101</del>
“Court”	A.R.S. § 36-501
<del>“Court ordered treatment”</del>	<del>R9 21 101</del>
<del>“Crisis services” or “emergency services”</del>	<del>R9 21 101</del>
“Danger to others”	A.R.S. § 36-501
<del>“Dangerous”</del>	<del>R9 21 101</del>

“Department”	R9-21-101, A.R.S. § 36-501
“Designated representative”	R9 21 101
“Director”	A.R.S. § 36-501
“Discharge plan”	R9 21 101
“Division”	R9 21 101
“Drug used as a restraint”	R9 21 101
“DSM” or “Diagnostic and Statistical Manual of Mental Disorders”	R9 21 101
“Emergency safety situation”	R9 21 101
“Enrolled Children”	R9 21 101
“Evaluation”	A.R.S. § 36-501
“Exploitation”	R9 21 101
“Family member”	A.R.S. § 36-501
“Frivolous”	R9 21 101
“Generic services”	R9 21 101
“Grievance”	R9 21 101
“Guardian”	R9 21 101
“Hearing officer”	R9 21 101
“Human rights advocate”	R9 21 101
“Human rights committee”	R9 21 101
“Illegal”	R9 21 101
“Individual service plan” or “ISP”	R9 21 101
“Informed consent”	A.R.S. § 36-501
“Inhumane”	R9 21 101
“Inpatient facility”	R9 21 101
“Inpatient treatment and discharge plan” or “ITDP”	R9 21 101
“Licensed physician”	A.R.S. § 36-501
“Long term view”	R9 21 101
“Mechanical restraint”	R9 21 101

<del>“Medical practitioner”</del>	R9 21 101
<del>“Meeting”</del>	R9 21 101
“Mental disorder”	A.R.S. § 36-501
<del>“Mental health agency”</del>	R9 21 101
“Mental health provider”	A.R.S. § 36-501
<del>“Nurse”</del>	R9 21 101
“Outpatient treatment”	A.R.S. § 36-501
<del>“Party” or “parties”</del>	R9 21 101
“Persistent or acute disability”	A.R.S. § 36-501
<del>“Personal restraint”</del>	R9 21 101
<del>“PRN order” or “Pro re rata medication”</del>	R9 21 101
“Professional”	A.R.S. § 36-501
<del>“Program director”</del>	R9 21 101
“Proposed patient”	A.R.S. § 36-501
“Psychiatrist”	A.R.S. § 36-501
“Psychologist”	A.R.S. § 36-501
<del>“Qualified clinician”</del>	R9 21 101
“Records”	A.R.S. § 36-501
<del>“Region”</del>	R9 21 101
<del>“Regional authority”</del>	R9 21 101
“Regional Behavioral Health Authority (RBHA)”	A.R.S. § 36-3401
<del>“Restraint”</del>	R9 21 101
<del>“Seclusion”</del>	R9 21 101
“Seriously Mentally Ill (SMI)”	A.R.S. § 36-550
<del>“Service provider”</del>	R9 21 101
“Social worker”	A.R.S. § 36-501
<del>“State Protection and Advocacy System”</del>	R9 21 101
<del>“Title XIX”</del>	R9 21 101

**B.** In this Chapter, unless the context otherwise requires:

“Abuse” means, with respect to a client, the infliction of, or allowing another person to inflict or cause, physical pain or injury, impairment of bodily function, disfigurement or serious emotional damage which may be evidenced by severe anxiety, depression, withdrawal or untoward aggressive behavior. Such abuse may be caused by acts or omissions of an individual having responsibility for the care, custody or control of a client receiving behavioral health services or community services under this Chapter. Abuse shall also include sexual misconduct, assault, molestation, incest, or prostitution of, or with, a client under the care of personnel of a mental health agency.

“Administration” means the Arizona Health Care Cost Containment System.

“Agency director” means the person primarily responsible for the management of an outpatient or inpatient mental health agency, service provider, ~~regional authority~~ health plan or the Administration, or their designees.

“AHCCCS” means the Arizona Health Care Cost Containment System.

“Applicant” means an individual who:

- a. Submits to a regional authority health plan an application for behavioral health services under this Chapter or on whose behalf an application has been submitted; or
- b. Is referred to a regional authority health plan for a determination of eligibility for behavioral health services according to this Chapter.

“ASH” means the Arizona State Hospital.

“Authorization” means written permission for a mental health agency to release or disclose a client’s record or information, containing:

- a. The name of the mental health agency releasing or disclosing the client’s record or information;
- b. The purpose of the release or disclosure;
- c. The individual, mental health agency, or entity requesting or receiving the client’s record or information;
- d. A description of the client’s record or information to be released or disclosed;
- e. A statement:

- i. Of permission for the mental health agency to release or disclose the client’s record or information; and
- ii. That permission may be revoked at any time;
- f. The date when or conditions under which the permission expires;
- g. The date the document is signed; and
- h. The signature of the client or, if applicable, the client’s guardian.

“Behavioral health issue” means an individual’s condition related to a mental disorder, personality disorder, substance abuse, or a significant psychological or behavioral response to an identifiable stressor or stressors.

“Behavioral health service” means the assessment, diagnosis, or treatment of an individual’s behavioral health issue.

“Burden of proof” means the necessity or obligation of affirmatively proving the fact or facts in dispute.

“Case manager” means the person responsible for locating, accessing and monitoring the provision of services to clients in conjunction with a clinical team.

“Client” means an individual who ~~is~~ has a qualifying seriously mentally ~~illness~~ illness and is being evaluated or treated for a mental disorder by or through a ~~regional authority~~ health plan.

“Client record” means the written compilation of information that describes and documents the evaluation, diagnosis or treatment of a client.

“Client who needs special assistance” means a client who has been:

- a. Deemed by a qualified clinician, case manager, clinical team, or ~~regional authority~~ health plan to need special assistance in participating in the ISP or ITDP process, which may include, but is not limited to:
  - i. A client who requires 24-hour supervision;
  - ii. A client who is, in fact, incapable of making or communicating needs but is without a court-appointed fiduciary; or
  - iii. A client with physical disabilities or language difficulties impacting the client’s ability to make or communicate decisions or to prepare or participate in meetings; or

- b. Otherwise deemed by a program director, the Administration, or an Administrative Law Judge to need special assistance to effectively file a written grievance, to understand the grievance and investigation procedure, or to otherwise effectively participate in the grievance process under this Chapter.

“Clinical team” refers to the interdisciplinary team of persons who are responsible for providing continuous treatment and support to a client and for locating, accessing and monitoring the provision of behavioral health services or community services. A clinical team consists of a psychiatrist, case manager, vocational specialist, psychiatric nurse, and other professionals or paraprofessionals, such as a psychologist, social worker, consumer case management aide, or rehabilitation specialist, as needed, based on the client’s needs. The team shall also include a team leader who is a certified behavioral health supervisor.

“Community services” means services such as clinical case management, outreach, housing and residential services, crisis intervention and resolution services, mobile crisis teams, day treatment, vocational training and opportunities, rehabilitation services, peer support, social support, recreation services, advocacy, family support services, outpatient counseling and treatment, transportation, and medication evaluation and maintenance.

“Condition requiring investigation” means, within the context of the grievance and investigation procedure set forth in Article 4 of this Chapter, an incident or condition which appears to be dangerous, illegal, or inhumane, including a client death.

~~“County Annex” means the Maricopa County Psychiatric Annex of the Maricopa Medical Center.~~

“Court-ordered treatment” means treatment ordered by the court under A.R.S. Title 36, Chapter 5.

“Court-ordered evaluation” means evaluation ordered by the court under A.R.S. Title 36, Chapter 5.

“Crisis services” or “emergency services” means immediate and intensive, time-limited, crisis intervention and resolution services which are available on a 24-hour basis and may include information and referral, evaluation and counseling to stabilize the situation, triage to an inpatient setting, clinical crisis intervention services, mobile crisis services, emergency crisis shelter services, and follow-up counseling for clients who are experiencing a psychiatric emergency.

“Dangerous” as used in Article 4 of this Chapter means a condition that poses or posed a danger or the potential of danger to the health or safety of any client.

“Department” means the Arizona Department of Health Services.

“Designated representative” means a parent, guardian, relative, advocate, friend, or other person, designated in writing by a client or guardian who, upon the request of the client or guardian, assists the client in protecting the client’s rights and voicing the client’s service needs.

“Determining Entity” means either the AHCCCS designee authorized to make SMI determinations or a Tribal Regional Behavioral Health Authority (for each TRBHA, tribal members only) authorized to make the final determination of SMI eligibility.

“Discharge plan” means a hospital or community treatment and discharge plan prepared according to Article 3 of these rules.

“Drug used as a restraint” means a pharmacological restraint as used in A.R.S. § 36-513 that is not standard treatment for a client’s medical condition or behavioral health issue and is administered to:

- a. Manage the client’s behavior in a way that reduces the safety risk to the client or others,
- b. Temporarily restrict the client’s freedom of movement.

“DSM” means the latest edition of the “Diagnostic and Statistical Manual of Mental Disorders,” edited by the American Psychiatric Association.

“Emergency safety situation” means unanticipated client behavior that creates a substantial and imminent risk that the client may inflict injury, and has the ability to inflict injury, upon:

- a. The client, as evidenced by threats or attempts to commit suicide or to inflict injury on the client;  
or
- b. Another individual, as evidenced by threats or attempts to inflict injury on another individual or individuals, previous behavior that has caused injury to another individual or individuals, or behavior that places another individual or individuals in reasonable fear of sustaining injury.

~~“Enrolled Children” means persons under the age of 18 who receive behavioral health services by or through a regional authority.~~

“Exploitation” means the illegal or improper use of a client or a client’s resources for another’s profit or advantage.

“Frivolous” as used in this Chapter, means a grievance that is devoid of merit. Grievances are presumed not to be frivolous unless the grievance:

- a. Involves conduct that is not within the scope of this Chapter,
- b. Is impossible on its face, or
- c. Is substantially similar to conduct alleged in two previous grievances within the past year that have been determined to be unsubstantiated as provided in this Chapter.

“Generic services” means services other than behavioral health ~~services~~ or ~~community~~other services for which clients may have a need and include, but are not limited to, health, dental, vision care, housing arrangements, social organizations, recreational facilities, jobs, and educational institutions.

“Grievance” means a complaint regarding an act, omission or condition, as provided in this Chapter.

“Guardian” means an individual appointed by court order according to A.R.S. Title 14, Chapter 5, or similar proceedings in another state or jurisdiction where said guardianship has been properly domesticated under Arizona law.

“Health Plan” means a Regional Behavioral Health Authority (RBHA), health plan, or Arizona Long Term Care Plan under contract with the Administration to coordinate the delivery of behavioral health services members in a geographically specific service area of the state for eligible persons.

“Hearing officer” refers to an impartial person designated by the Office of Administrative Hearing to hear a dispute and render a written decision.

“Human rights advocate” means the human rights advocates appointed by the Administration under R9-21-105.

~~“Human rights~~Independent Oversight committee” means the ~~human rights~~ committee established under A.R.S. § 41-3803.

“Illegal” means, within the context of the grievance and investigation procedure set forth in Article 4 of this Chapter, an incident or occurrence which is or was likely to constitute a violation of a state or federal statute, regulation, court decision or other law, including the provisions of these Articles.

“Individual service plan” or “ISP” means the written plan for services to a client, prepared in accordance with Article 3 of this Chapter.

“Inhumane” as used in Article 4 of this Chapter means an incident, condition or occurrence that is demeaning to a client, or which is inconsistent with the proper regard for the right of the client to humane treatment.

“Inpatient facility” means the Arizona State Hospital, the County Annex, or any other inpatient treatment facility registered with or funded by or through the Administration to provide behavioral health services, including psychiatric health facilities, psychiatric hospitals, and psychiatric units in general hospitals.

“Inpatient treatment and discharge plan” or “ITDP” means the written plan for services to a client prepared and implemented by an inpatient facility in accordance with Article 3 of this Chapter.

“Long-term view” means a planning statement that identifies, from the client’s perspective, what the client would like to be doing for work, education, and leisure and where the client would like to be living for up to a three-year period. The long-term view is based on the client’s unique interests, strengths, and personal desires. It includes predicted times for achievement.

“Mechanical restraint” means any, device, article, or garment attached or adjacent to a client’s body that the client cannot easily remove and that restricts the client’s freedom of movement or normal access to the client’s body, but does not include a device, article, or garment:

- a. Used for orthopedic or surgical reasons, or
- b. Necessary to allow a client to heal from a medical condition or to participate in a treatment program for a medical condition.

“Medical practitioner” means a

- a. Physician,
- b. Physician assistant, or
- c. Nurse practitioner.

“Meeting” means an encounter or assembly of individuals which may be conducted in person or by telephone or by video-conferencing.

“Mental health agency” includes a ~~regional authority~~ health plan, service provider, inpatient facility, or an entity that conducts screening and evaluation under Article 5.

“MIHS Behavioral Health Annex” means the Maricopa County Psychiatric Annex of the Maricopa Medical Center.

“Nurse” means an individual licensed as a registered nurse or a practical nurse according to A.R.S. Title 32, Chapter 15.

“Party” or “parties” as used in Articles 3 and 4 of these rules means the person filing a grievance under this Chapter, the agency director who issued any final resolution or decision of such a grievance, the person whose conduct is complained of in the grievance, any client or applicant who is the subject of the request or grievance, the legal guardian of client or applicant, and, in selected cases, the appropriate ~~human rights~~ Independent Oversight committee.

“Personal restraint” means the application of physical force without the use of any device, for the purpose of restricting the free movement of a client’s body; ~~but for a behavioral health agency licensed as a level I Residential Treatment Center RTC or a Level I sub-acute agency does not include:~~

a. ~~Holding a client for no longer than five minutes, without undue force, in order to calm or comfort the client; or~~

b. ~~Holding a client’s hand to escort the client from one area to another.~~

“PRN order” or “Pro re nata medication” means medication given as needed.

“Program director” means the person with the day-to-day responsibility for the operation of a programmatic component of a service provider, such as a specific residential, vocational, or case management program.

“Qualified clinician” means a behavioral health professional who is licensed or certified under A.R.S. Title 32, or a behavioral health technician who is supervised by a licensed or certified behavioral health professional.

“Region” means the geographical region designated by the Administration in its contract with the ~~regional authority~~ health plan.

~~“Regional authority” means the Regional Behavioral Health Authority (RBHA) under contract with the Administration to organize and administer the delivery of behavioral health services or community services to clients and enrolled children within a defined geographic area.~~

“Restraint” means personal restraint, mechanical restraint, or drug used as a restraint.

“Seclusion” means restricting a client to a room or area through the use of locked doors or any other device or method which precludes a client from freely exiting the room or area or which a client reasonably believes precludes his unrestricted exit. In the case of an inpatient facility, confining a client to the facility, the grounds of the facility, or a ward of the facility does not constitute seclusion. In the case of a

community residence, restricting a client to the residential site, according to specific provisions of an individual service plan or court order, does not constitute seclusion.

“Seriously mentally ill” means a person 18 years of age or older as defined in A.R.S. § 36-550.

“Service provider” means an agency, inpatient facility or other mental health provider funded by or through, under contract or subcontract with, certified by, approved by, registered with, or supervised by the Administration or receiving funds under Title XIX, to provide behavioral health services or community services.

“State Protection and Advocacy System” means the agency designated as the Protection and Advocacy System for individuals with mental illness, according to 42 U.S.C. 10801-10851.

“Title XIX” means Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq.

“Treatment team” means the multidisciplinary team of persons who are responsible for providing continuous treatment and support to a client who is in an inpatient facility.

**R9-21-104. Office of Human Rights; Human Rights Advocates**

- A. An Office of Human Rights shall be established within the Administration. The office shall have its own chief officer who shall be responsible for the management and control of the office, as well as the hiring, training, supervision, and coordination of human rights advocates.
- B. The chief officer shall appoint at least one human rights advocate for each 2,500 clients in each region. Each region shall have at least one human rights advocate. The chief officer shall appoint at least one human rights advocate for ASH. All clients shall have the right of access to ~~a human rights advocate~~ The Office of Human Rights in order to understand, exercise, and protect their rights. The human rights advocate shall advocate on behalf of clients and shall assist clients in understanding and protecting their rights and obtaining needed services. The human rights advocate shall also assist clients in resolving appeals and grievances under Article 4 of this Chapter and shall coordinate and assist the ~~human rights~~ Independent Oversight committees in performing their duties.
- C. The human rights advocates shall be given access to all:
1. Clients; and
  2. Client records from a service provider, ~~regional authority health plan~~, or the Administration, except as prohibited by federal or state law.
- D. Staff of inpatient facilities, ~~regional authorities health plans~~, and service providers shall cooperate with the advocate by providing relevant information, reports, investigations, and access to meetings, staff persons, and facilities except as prohibited by federal or state law and the client's right to privacy.
- E. An agency director shall notify the health plan and the Office of Human Rights ~~and the applicable human rights committee~~ of each client who needs special assistance.
- F. The Office of Human Rights shall:
1. Assign a designated representative to each Special Assistance member;
    - a. The Office of Human Rights shall assign a natural support if one exists and is willing to act as a designated representative, (e.g. a family member or friend), or
    - b. If a natural support does not exist or is unwilling, an Advocate from the Office of Human Rights.

2. \_\_\_\_\_ Maintain a list that contains the names of each client who needs special assistance and, if applicable, the name and address of the residential program providing behavioral services to the client; and
- 2.3. Provide each ~~human rights~~ Independent Oversight committee with a list of all clients who need special assistance who reside in the respective jurisdiction of the ~~human rights~~ Independent Oversight committee.
- G. ~~The Office of Human Rights shall promptly distribute to all appropriate human rights committees~~ The Administration shall ensure appropriate Independent Oversight committees have access to copies of all reports received according to this Chapter (e.g., reports regarding clients who need special assistance, allegations of mistreatment, denial of rights, restraint, and seclusion).

**R9-21-105. ~~Human Rights Committees~~Independent Oversight Committees**

- A. According to A.R.S. §§ 41-3803 and 41-3804, the Department of Administration shall establish ~~human rights-Independent Oversight~~ committees to provide independent oversight to ensure that the rights of clients ~~and enrolled children~~ are protected. The Administration shall establish at least one human rights committee for each region and the Arizona State Hospital. Upon the establishment of a human rights committee, if more than 2,500 clients reside within a region, the Administration shall establish additional human rights committees until there is one human rights committee for each 2,500 clients in a region.
- B. Each human rights committee shall be composed of at least seven and not more than 15 members. At least two members of the committee shall be clients or former clients, at least two members shall be relatives of clients, two members shall be parents of enrolled children and at least three members shall have expertise in one of the following areas: psychology, law, medicine, education, special education, social work, or behavioral health services.
- C. The Department of Administration shall appoint the initial members to each regional committee and the ~~human rights-Independent Oversight~~ committee for the Arizona State Hospital. Members shall be appointed to fill vacancies on an ~~human rights-Independent Oversight~~ committee, subject to the approval of the committee.
- D. Each committee shall meet at least four times each year. Within three months of its formation, each committee shall establish written guidelines governing the committee's operations. These guidelines shall be consistent with A.R.S. §§ 41-3803 and 41-3804. The adoption and amendment of the committee's guidelines shall be by a majority vote of the committee and shall be submitted to the Administration for approval.
- E. No employee or individual under contract with the Administration, regional authority, or service provider may be a voting member of a committee.
- F. If a member of an ~~human rights-Independent Oversight~~ committee or the ~~human rights-Independent Oversight~~ committee determines that a member has a conflict of interest regarding an agenda item, the member shall refrain from:
1. Participating in a discussion regarding the agenda item, and
  2. Voting on the agenda item.

- G.** Each committee shall, within its respective jurisdiction, provide independent oversight and review of:
1. Allegations of illegal, dangerous, or inhumane treatment of clients ~~and enrolled children~~;
  2. Reports filed with the committee under R9-21-203 and R9-21-204 concerning the use of seclusion, restraint, abuse, neglect, exploitation, mistreatment, accidents, or injuries;
  3. The provision of services to clients identified under R9-21-301 in need of special assistance
  4. Violations of rights of clients ~~and enrolled children~~ and conditions requiring investigation under Article 4 of this Chapter;
  5. Research in the field of mental health according to A.R.S. § 41-3804(E)(2); and
  6. Any other issue affecting the human rights of clients ~~and enrolled children~~.
- H.** Within its jurisdiction, each ~~human rights~~ Independent Oversight committee shall, for a client who needs special assistance, and may, for other clients ~~and enrolled children~~:
1. Make regular site visits to residential environments;
  2. Meet with the client, including a client who needs special assistance, in residential environments to determine satisfaction of the clients with the residential environments; and
  3. Inspect client records, upon written request to the Administration, including client records for clients who need special assistance, except as prohibited by federal or state law and a client's right to privacy.
- I.** A committee may request the services of a consultant or staff person to advise the committee on specific issues. The cost of the consultant or staff person shall be assumed by the Administration or ~~regional authority~~ health plan subject to the availability of funds specifically allocated for that purpose. A consultant or staff person may, in the sole discretion of the committee, be a member of another committee or an employee of the Administration, ~~regional authority~~ health plan, or service provider. No committee consultant or staff person shall vote or otherwise direct the committee's decisions.
- J.** Committee members and committee consultants and staff persons shall have access to client records according to A.R.S. §§ 36-509(A)(11) and 41-3804(I). If an ~~human rights~~ Independent Oversight committee's request for information or records is denied, the committee may request a review of the decision to deny the request according to A.R.S. § 41-3804(J). Nothing in this rule shall be construed to

require the disclosure of records or information to the extent that such information is protected by A.R.S. § 36-445 et seq.

- K.** On the first day of the months of January, April, July, and October of each year, each committee shall issue a quarterly report summarizing its activities for the prior quarter, including any written objections to the Department of Administration according to A.R.S. § 41-3804(F), and make any recommendations for changes it believes the Administration or ~~regional authorities~~ health plans should implement. In addition, the committee may, as it deems appropriate, issue reports on specific problems or violations of client's rights. The report of a regional committee shall be delivered to the ~~regional authority and the~~ Administration.
- L.** The Department of Administration shall provide training and support to ~~human rights~~ Independent Oversight committees.
- M.** An ~~human rights~~ Independent Oversight committee may request:
1. An investigation for a client according to ~~Article 4 of~~ this Chapter, or
  2. A ~~regional authority~~ health plan or the Arizona State Hospital, as applicable, to conduct an investigation for an enrolled child.
- N.** The ~~regional authority~~ health plan or the Arizona State Hospital, as applicable, when requested by an ~~human rights~~ Independent Oversight committee, shall conduct an investigation concerning:
1. ~~A~~ a client as provided in Article 4 of this Chapter, ~~and~~
  2. ~~An enrolled child.~~
- O.** An ~~human rights~~ Independent Oversight committee shall submit an annual report of the ~~human rights~~ Independent Oversight committee's activities and recommendations to the Director at the end of each calendar year according to A.R.S. § 41-3804(G).

## ARTICLE 2. RIGHTS OF PERSONS WITH SERIOUS MENTAL ILLNESS

### R9-21-201. Civil and Other Legal Rights

- A. Clients shall have all rights accorded by applicable law, including but not limited to those prescribed in A.R.S. §§ 36-504 through 36-517.02. Any individual or agency providing behavioral health services or community services as defined in R9-21-101 shall not abridge these rights, including the following:
1. Those civil rights set forth in A.R.S. § 36-506;
  2. The right to acquire and dispose of property, to execute instruments, to enter into contractual relationships, to hold professional or occupational or vehicle operator's licenses, unless the client has been adjudicated incompetent or there has been a judicial order or finding that such client is unable to exercise the specific right or category of rights. In the case of a client adjudicated incompetent, these rights may be exercised by the client's guardian, in accordance with applicable law;
  3. The right to be free from unlawful discrimination by the Administration or by any mental health agency on the basis of race, creed, religion, sex, sexual preference, age, physical or mental handicap or degree of handicap; provided, however, classifications based on age, sex, category or degree of handicap shall not be considered discriminatory, if based on written criteria of client selection developed by a mental health agency and approved by the Administration as necessary to the safe operation of the mental health agency and in the best interests of the clients involved;
  4. The right to equal access to all existing behavioral health services, community services, and generic services provided by or through the state of Arizona;
  5. The right to religious freedom and practice, without compulsion and according to the preference of the client;
  6. The right to vote, unless under guardianship, including reasonable assistance when desired in registering and voting in a nonpartisan and noncoercive manner;
  7. The right to communicate including:
    - a. The right to have reasonable access to a telephone and reasonable opportunities to make and receive confidential calls and to have assistance when desired and necessary to implement this right;

- b. The unrestricted right to send and receive uncensored and unopened mail, to be provided with stationery and postage in reasonable amounts, and to receive assistance when desired and necessary to implement this right;
8. The right to be visited and visit with others, provided that reasonable restrictions may be placed on the time and place of the visit but only to protect the privacy of other clients or to avoid serious disruptions in the normal functioning of the mental health agency;
9. The right to associate with anyone of the client's choosing, to form associations, and to discuss as a group, with those responsible for the program, matters of general interest to the client, provided that these do not result in serious disruptions in the normal functioning of the mental health agency. Clients shall receive cooperation from the mental health agency if they desire to publicize and hold meetings and clients shall be entitled to invite visitors to attend and participate in such meetings, provided that they do not result in serious disruptions in the normal functioning of the mental health agency;
10. The right to privacy, including the right not to be fingerprinted and photographed without authorization, except as provided by A.R.S. § 36-507(2);
11. The right to be informed, in appropriate language and terms, of client rights;
12. The right to assert grievances with respect to infringement of these rights, including the right to have such grievances considered in a fair, timely, and impartial procedure, as set forth in Article 4 of these rules, and the right not to be retaliated against for filing a grievance;
13. The right of access to ~~a human rights advocate~~ the Office of Human Rights to request assistance in order to understand, exercise, and protect a client's rights;
14. The right to be assisted by an attorney or designated representative of the client's own choice, including the right to meet in a private area at the program or facility with an attorney or designated representative. Nothing in this Chapter shall be construed to require the Administration or any mental health agency to pay for the services of an attorney who consults with or represents a client;

15. The right to exercise all other rights, entitlements, privileges, immunities provided by law, and specifically those rights of consumers of behavioral health services or community services set forth in A.R.S. §§ 36-504 through 36-517.02;
16. The same civil rights as all other citizens of Arizona, including the right to marry and to obtain a divorce, to have a family, and to live in the community of their choice without constraints upon their independence, except those constraints to which all citizens are subject.

**B.** Nothing in this Article shall be interpreted to:

1. Give the power, right, or authority to any person or mental health agency to authorize sterilization, abortion, or psychosurgery with respect to any client, except as may otherwise be provided by law;  
or
2. Restrict the right of physicians, nurses, and emergency medical technicians to render emergency care or treatment in accordance with A.R.S. § 36-512; or
3. Construe this rule to confer constitutional or statutory rights not already present.

## **R9-21-202. Right to Support and Treatment**

- A.** A client has the following rights with respect to the client's support and treatment:
1. The right to behavioral health services or community services:
    - a. Under conditions that support the client's personal liberty and restrict personal liberty only as provided by law or in this Chapter;
    - b. From a flexible service system that responds to the client's needs by increasing, decreasing and changing services as needs change;
    - c. Provided in a way that:
      - i. Preserves the client's human dignity;
      - ii. Respects the client's individuality, abilities, needs, and aspirations without regard to the client's psychiatric condition;
      - iii. Encourages the client's self-determination, freedom of choice, and participation in treatment to the client's fullest capacity;
      - iv. Ensures the client's freedom from the discomfort, distress and deprivation that arise from an unresponsive and inhumane environment;
      - v. Protects and promotes the client's privacy, including an opportunity whenever possible to be provided clearly defined private living, sleeping and personal care spaces; and
      - vi. Maximizes integration of the client into the client's community through ~~housing and residential~~ services which are located in residential neighborhoods, rely as much as possible on generic support services to provide training and assistance in ordinary community experiences, and utilize specialized mental health programs that are situated in or near generic community services;
      - vii. Offers the client humane and adequate support and treatment that is responsive to the client's needs, recognizes that the client's needs may vary, and is capable of adjusting to the client's changing needs; and
    - d. That provide the client with an opportunity to:

- i. Receive services that are adequate, appropriate, consistent with the client's individual needs, and least restrictive of the client's freedom;
  - ii. Receive treatment and services that are culturally sensitive in structure, process and content;
  - iii. Receive services on a voluntary basis to the maximum extent possible and entirely if possible;
  - iv. Live in the client's own home;
  - v. Undergo normal experiences, even though the experiences may entail an element of risk, unless the client's safety or well-being or that of others is unreasonably jeopardized; and
  - vi. Engage in activities and styles of living, consistent with the client's interests, which encourage and maintain the integration of the client into the community.
2. The right to ongoing participation in the planning of services as well as participation in the development and periodic revision of the individual service plan;
3. The right to be provided with a reasonable explanation of all aspects of one's condition and treatment;
4. The right to give informed consent to all behavioral health services and the right to refuse behavioral health services in accordance with A.R.S. §§ 36-512 and 36-513, except as provided for in A.R.S. §§ 36-520 through 36-544 and 13-3994;
5. The right not to participate in experimental treatment without voluntary, written informed consent; the right to appropriate protection associated with such participation; and the right and opportunity to revoke such consent;
6. The right to a humane treatment environment that affords protection from harm, appropriate privacy, and freedom from verbal or physical abuse;
7. The right to enjoy basic goods and services without threat of denial or delay. For residential service providers, these basic goods and services include at least the following:
  - a. A nutritionally sound diet of wholesome and tasteful food available at appropriate times and in as normal a manner as possible;

- b. Arrangements for or provision of an adequate allowance of neat, clean, appropriate, and seasonable clothing that is individually chosen and owned;
  - c. Assistance in securing prompt and adequate medical care, including family planning services, through community medical facilities;
  - d. Opportunities for social contact in the client's home, work or schooling environments;
  - e. Opportunities for daily activities, recreation and physical exercise;
  - f. The opportunity to keep and use personal possessions; and
  - g. Access to individual storage space for personal possessions;
8. The right to be informed, in advance, of charges ~~for services~~;
  9. The right to a continuum of care in a unified and cohesive system of community services that is well integrated, facilitates the movement of clients among programs, and ensures continuity of care;
  10. The right to a continuum of care that consists of, but is not limited to, clinical case management, outreach, supportive housing and residential services, crisis intervention and resolution services, mobile crisis teams, vocational training and opportunities, day treatment, rehabilitation services, peer support, social support, recreation services, advocacy, family support services, outpatient counseling and treatment, transportation, and medication evaluation and maintenance;
  11. The right to a continuum of care with programs that offer different levels of intensity of services in order to meet the individual needs of each client;
  12. The right to appropriate mental health treatment, based on each client's individual and unique needs, and to those community services from which the client would reasonably benefit;
  13. The right to community services provided in the most normal and least restrictive setting, according to the least restrictive means appropriate to the client's needs;
  14. The right to clinical case management services and a case manager. The clinical team negotiates and oversees the provision of services and ensures the client's smooth transition with service providers and among agencies;

15. The right to participate in treatment decisions and in the development and implementation of the client's ISP, and the right to participate in choosing the type and location of services, consistent with the ISP;
16. The right to prompt consideration of discharge from an inpatient facility and the identification of the steps necessary to secure a client's discharge as part of an ISP;
17. The rights prescribed in Articles 3 and 4 of this Chapter, including the right to:
  - a. A written individual service plan;
  - b. Assert grievances; and
  - c. Be represented by a qualified advocate or other designated representative of the client's choosing in the development of the ISP and the inpatient treatment and discharge plan and in the grievance process, in order to understand, exercise and protect the client's rights.

**B.** Subsection (A) shall not be construed to confer constitutional or statutory rights not already present.

**R9-21-203. Protection from Abuse, Neglect, Exploitation, and Mistreatment**

**A.** No mental health agency shall mistreat a client or permit the mistreatment of a client by staff subject to its direction. Mistreatment includes any intentional, reckless or negligent action or omission which exposes a client to a serious risk of physical or emotional harm. Mistreatment includes but is not limited to:

1. Abuse, neglect, or exploitation;
2. Corporal punishment;
3. Any other unreasonable use or degree of force or threat of force not necessary to protect the client or another person from bodily harm;
4. Infliction of mental or verbal abuse, such as screaming, ridicule, or name calling;
5. Incitement or encouragement of clients or others to mistreat a client;
6. Transfer or the threat of transfer of a client for punitive reasons;
7. Restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
8. Any act in retaliation against a client for reporting any violation of the provisions of this Chapter to the Administration; or
9. Commercial exploitation.

**B.** The following special sanctions shall be available to the Department and/or the Administration, in addition to those set forth in 9 A.A.C. 10, Article 10 of the Department's rules, to protect the interests of the client involved as well as other current and former clients of the mental health agency.

1. Mistreatment of a client by staff or persons subject to the direction of a mental health agency may be grounds for suspension or revocation of the license of the mental health agency or the provision of financial assistance, and, with respect to employees of the mental health agency, grounds for disciplinary action, which may include dismissal.
2. Failure of an employee of the Administration to report any instance of mistreatment within any mental health agency subject to this Chapter shall be grounds for disciplinary action, which may include dismissal.
3. Failure of a mental health agency to report client deaths and allegations of sexual and physical abuse to the Administration and to comply with the procedures described in Article 4 of this Chapter for the processing and investigation of grievances and reports shall be grounds for

~~suspension of the license~~ revocation of provider participation agreement of the mental health agency or the provision of financial assistance, and, with respect to a service provider directly operated by the Department, grounds for disciplinary action, which may include dismissal.

4. A mental health agency shall report all allegations of mistreatment and denial of rights to the Office of Human Rights and the ~~regional authority~~ health plan for review and monitoring in accordance with R9-21-105.
- C.** A mental health agency shall report all incidents of abuse, neglect, or exploitation to the appropriate authorities as required by A.R.S. § 46-454 and shall document all such reports in the mental health agency's records.
- D.** If a mental health agency has reasonable cause to believe that a felony relevant to the functioning of the program has been committed by staff persons subject to the agency's direction, a report shall be filed with the county attorney.
- E.** The identity of persons making reports of abuse, neglect, exploitation, or mistreatment shall not be disclosed by the mental health agency or by the Administration, except as necessary to investigate the subject matter of the report.

### **R9-21-206. Competency and Consent**

- A.** A client shall not be deemed incompetent to manage the client's affairs, to contract, to hold professional, occupational or vehicle operator's licenses, to make wills, to vote or to exercise any other civil or legal right solely by reason of admission to a mental health agency.
- B.** An applicant or client is presumed to be legally competent to conduct the client's personal and financial affairs, unless otherwise determined by a court in a guardianship or conservatorship proceeding.
- C.** Only an applicant or client who is competent may provide informed consent, authorization, or permission as required in this Chapter. A mental health agency shall use the following criteria to determine if an applicant or client is competent and the appropriateness of establishing or removing a guardianship, temporary guardianship, conservatorship, or guardianship ad litem for the client:

  - 1. An applicant or client shall be determined to be in need of guardianship or conservatorship only if the applicant's or client's ability to make important decisions concerning the applicant or client or the applicant's or client's property is so limited that the absence of a person with legal authority to make such decisions for the applicant or client creates a serious risk to the applicant's or client's health, welfare or safety.
  - 2. Although the capability of the applicant or client to make important decisions is the central factor in determining the need for guardianship, the capabilities of the applicant's or client's family, the applicant's or client's living circumstances, the probability that available treatment will improve the applicant's or client's ability to make decisions on the applicant's or client's behalf, and the availability and utility of nonjudicial alternatives to guardianships such as trusts, representative payees, citizen advocacy programs, or community support services should also be considered.
  - 3. If the applicant or client has been determined to be incapable of making important decisions with regard to the applicant's or client's personal or financial affairs, and if nonjudicial, less restrictive alternatives such as trusts, representative payees, cosignatory bank accounts, and citizen advocates are inadequate to protect the applicant or client from a substantial and unreasonable risk to the applicant's or client's health, safety, welfare, or property, the applicant's or client's nearest living relatives shall be notified with an accompanying recommendation that a guardian or conservator be appointed.

4. If the applicant or client is capable of making important decisions concerning the applicant's or client's health, welfare, and property, either independently or through other less restrictive alternatives such as trusts, representative payees, cosignatory bank accounts, and citizen advocates, the applicant's or client's nearest living relative shall be notified with an accompanying recommendation that any existing guardian or conservator be removed.
  5. If the client has been determined to require or no longer require assistance in the management of financial or personal affairs, and the nearest living relative cannot be found or is incapable of or not interested in caring for the client's interest, the mental health agency shall assist in the recruitment or removal of a trustee, representative payee, advocate, conservator, or guardian. Nothing in this Chapter shall be construed to require the Administration or any ~~regional authority~~ health plan or service provider to pay for the recruitment, appointment or removal of a trustee, representative payee, advocate, conservator, or guardian.
  6. The assessment or periodic review shall identify the specific area or areas of the client's functioning that forms the basis of the recommendation for the appointment or removal of a guardian or conservator, such as an inability to respond appropriately to health problems or consent to medical care, or an inability to manage savings or routine expenses.
- D.** Mental health agencies shall devise and implement procedures to ensure that suspected improprieties of a guardian, conservator, trustee, representative payee, or other fiduciary are reported to the court or other appropriate authorities.

**R9-21-211. Notice of Rights**

- A.** Every mental health agency shall provide written notice of the civil and legal rights of its clients by posting a copy of ~~ADHS~~ADHSAHCCCS Form MH-211, “Notice of Client’s Rights,” set forth in Exhibit A, in one or more areas of the agency so that it is readily visible to clients and visitors.
- B.** In addition to posting as required by subsection (A), a copy of ADHS Form MH-211, set forth in Exhibit B, shall be given to each client, or guardian if any, at the time of admission to the agency for evaluation or treatment. The person receiving the notice shall be required to acknowledge in writing receipt of the notice and the acknowledgment shall be retained in the client’s record.
- C.** Every mental health agency shall provide written notice of the terms of A.R.S. § 36-506 to each client upon discharge by giving the client a copy of ADHS Form MH-209, “Discrimination Prohibited”.
- D.** All notices required by this rule shall be provided and posted in both English and Spanish.

**ARTICLE 4. APPEALS, GRIEVANCES, AND REQUESTS FOR INVESTIGATION FOR PERSONS  
WITH SERIOUS MENTAL ILLNESS**

**R9-21-401. Appeals**

- A.** A client or an applicant may file an appeal concerning decisions regarding eligibility for behavioral health services, including Title XIX services, fees and waivers; assessments and further evaluations; service and treatment plans and planning decisions; and the implementation of those decisions. Appeals regarding a determination of categorical ineligibility for Title XIX shall be directed to the agency that made the determination.
1. Disagreements among employees of the Administration, the ~~regional authority~~ health plan, clinical teams, and service providers concerning services, placement, or other issues are to be resolved using the Administration's guidelines, rather than this Article.
  2. The case manager shall attempt to resolve disagreements prior to utilizing this appeal procedure; however, the client's right to file an appeal shall not be interfered with by any mental health agency or the Administration.
  3. The Office of Human Rights shall assist clients in resolving appeals according to R9-21-104.
  4. If a client or, if applicable, an individual on behalf of the client, files an appeal of a modification to or termination of a behavioral health service according to this Section, the client's non-Title IXX services shall continue while the appeal is pending unless:
    - a. A qualified clinician, and, if applicable, the Department of Economic Security, determines that the modification or termination is necessary to avoid a serious or immediate threat to the health or safety of the client or another individual; or
    - b. The client or, if applicable, the client's guardian agrees in writing to the modification or termination.
- B.** Applicants and clients shall be informed of their right to appeal at the time an application for services is made, when an eligibility determination is made, when a decision regarding fees or the waiver of fees is made, upon receipt of the assessment report, during the ISP, ITDP, and review meetings, at the time an ISP, ITDP, and any modification to the ISP or ITDP is distributed, when any service is suspended or terminated,

and at any other time provided by this Chapter. The notice shall be in writing in English and Spanish and shall include:

1. The client's right to appeal and to an administrative hearing according to A.R.S. § 41-1092.03;
2. The method by which an appeal and an administrative hearing may be obtained;
3. That the client may represent himself or use legal counsel or other appropriate representative;
4. The services available to assist the client from the Office of Human Rights, ~~Human Rights~~ Independent Oversight Committees, State Protection and Advocacy System, and other peer support and advocacy services;
5. What action the mental health agency or ~~regional authority~~ health plan intends to take;
6. The reasons for the intended action;
7. The specific rules or laws that support such action; and
8. An explanation of the circumstances under which services will continue if an appeal or an administrative hearing is requested.

C. The right to appeal in this Section does not include the right to appeal a court order entered according to A.R.S. Title 36, Chapter 5, Articles 4 and 5. The following issues may be appealed:

1. Decisions regarding the individual's eligibility for behavioral health services;
2. The sufficiency or appropriateness of the assessment or any further evaluation;
3. The long-term view, service goals, objectives, or timelines stated in the ISP or ITDP;
4. The recommended services identified in the assessment report, ISP, or ITDP;
5. The actual services to be provided, as described in the ISP, plan for interim services, or ITDP;
6. The access to or prompt provision of services provided under Title XIX;
7. The findings of the clinical team with regard to the client's competency, capacity to make decisions, need for guardianship or other protective services, or need for special assistance;
8. A denial of a request for a review of, the outcome of a review of, a modification to or failure to modify, or a termination of an ISP, ITDP, or portion of an ISP or ITDP;
9. The application of the procedures and timetables as set forth in this Chapter for developing the ISP or ITDP;
10. The implementation of the ISP or ITDP;

11. The decision to provide service planning, including the provision of assessment or case management services, to a client who is refusing such services, or a decision not to provide such services to such a client; or
12. Decisions regarding a client's fee assessment or the denial of a request for a waiver of fees;
13. Denial of payment for a client; and
14. Failure of the ~~regional authority~~ health plan or the Administration to act within the time frames for appeal established in this Chapter.

**D.** Initiation of the appeal.

1. An appeal may be initiated by the client or by any of the following persons on behalf of a client or applicant requesting behavioral health services or community services:
  - a. The client's or applicant's guardian,
  - b. The client's or applicant's designated representative, or
  - c. A service provider of the client, if the client or, if applicable, the client's guardian gives permission to the service provider;
2. An appeal is initiated by notifying the ~~director of the regional authority or the director designee~~ health plan orally or in writing of the decision, report, plan or action being appealed, including a brief statement of the reasons for the appeal and the current address and telephone number, if available, of the applicant or client and designated representative if one is provided.
3. An appeal shall be initiated within 60 days of the decision, report, plan, or action being appealed. However, ~~the director of the regional authority or the director designee~~ the health plan shall accept a late appeal for good cause. If the ~~regional authority director or the director designee~~ health plan refuses to accept a late appeal or determines that the issue is not appealable under subsection C of this article, ~~the director or director designee~~ health plan shall notify the individual or client in writing, with a statement of reasons for the decision. Within 10 days of the notification, the client or applicant may request review of that decision by the -Administration, ~~whewhich~~ which shall act within 15 days of receipt of the request for review. The decision of the Administration shall be final.

4. Within five days of receipt of an appeal, the ~~director of the regional authority~~ health plan shall inform the client in writing that the appeal has been received and of the procedures that shall be followed during the appeal.
- E. Informal conference with the ~~regional authority~~ health plan.
1. Within seven days of receipt of the notice of appeal, the ~~director of the regional authority or the director designee~~ health plan shall hold an informal conference with the client, any designated representative and/or guardian, the case manager and representatives of the clinical team, and a representative of the service provider, if appropriate.
    - a. The ~~regional authority director or the director's designee~~ health plan shall schedule the conference at a convenient time and place and shall inform all participants in writing of the time, date, and location two days before the conference.
    - b. Individuals may participate in the conference by telephone.
  2. The ~~director of the regional authority or the director's designee~~ health plan shall chair the informal conference and shall seek to mediate and resolve the issues in dispute. To the extent that resolution satisfactory to the client or guardian is not achieved, the ~~regional authority director or director's designee~~ health plan shall clarify issues for further appeal and shall determine the agreement, if any, of the participants as to the material facts of the case.
  3. Except to the extent that statements of the participants are reduced to an agreed statement of facts, all statements made during the informal conference shall be considered as offers in compromise and shall be inadmissible in any subsequent hearing or court proceedings under this rule.
  4. If the informal conference with the ~~director of the regional authority or the director's designee~~ health plan does not resolve the issues in dispute to the satisfaction of the client or, if applicable, the client's guardian, and the issues in dispute are not related to the client's eligibility for behavioral health services, the client or, if applicable, the client's guardian shall be informed that the matter may be further appealed to the Administration, and of the procedure for requesting a waiver of the informal conference with the Administration.
  5. If a client or, if applicable, the client's guardian waives the right to an informal conference with the Administration according to subsection (E)(4) or, if the informal conference with the ~~director~~

~~of the regional authority or the director designee~~health plan does not resolve the issues in dispute to the satisfaction of the client or, if applicable, the client's guardian, and the issues in dispute are related to the client's eligibility for behavioral health services, the ~~regional authority~~health plan shall, at the informal conference:

- a. Provide written notice to the client or, if applicable, the client's guardian according to A.R.S. § 41-1092.03, and
  - b. Ask the client or, if applicable, the client's guardian whether the client or, if applicable, the client's guardian would like the ~~regional authority~~health plan to request an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client.
  - c. For a client who needs special assistance, send a copy of the notice in subsection (5)(a) to the appropriate ~~human rights~~Independent Oversight Committee in committee and the Office of Human Rights.
6. If, at the informal conference, a client or, if applicable, the client's guardian requests that the ~~regional authority~~health plan file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client, the ~~regional authority~~health plan shall file the request within three days of the informal conference.
7. If resolution satisfactory to the client or guardian is achieved, the ~~director of the regional authority or the director designee~~health plan shall issue a dated written notice to all parties which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved and the date by which the resolution will be implemented.

**F. Informal conference with the Administration.**

1. Within three days of the conclusion of an informal conference with the ~~regional authority~~health plan according to subsection (E)(4), the ~~director of the regional authority or the director designee~~health plan shall notify the Administration and shall immediately forward the client's notice of appeal, all documents relevant to the resolution of the appeal and any agreed statements of fact.
2. Within 15 days of the notification from the ~~regional authority director or the director designee~~health plan, the Administration shall hold an informal conference with the client, any

designated representative and/or guardian, the case manager, and representatives of the clinical team, the service provider, if appropriate, for the purpose of mediating and resolving the issues being appealed.

- a. The Administration shall schedule the conference at a convenient time and place and shall inform the participants in writing of the time, date, and location five days prior to the conference.
  - b. Individuals may participate in the conference by telephone.
  - c. If a client is unrepresented at the conference but needs/requests assistance, or if for any other reason the Administration determines the appointment of a representative to be in the client's best interest, the Administration may designate a human rights advocate or other person to assist the client in the appeal.
3. To the extent that resolution satisfactory to the client or guardian is not achieved, the Administration shall clarify issues for further appeal and shall determine the agreement, if any, of the participants as to the material facts of the case.
  4. If resolution satisfactory to the client or guardian is achieved, the Administration shall issue a dated written notice to all parties which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved, and the date by which the resolution will be implemented.
  5. Except to the extent that statements of the participants are reduced to an agreed statement of facts, all statements made during the informal conference shall be considered as offers in compromise and shall be inadmissible in any subsequent hearing or court proceedings under this rule.
  6. If all issues in dispute are not resolved to the satisfaction of the client or guardian at the informal conference with the Administration, the Administration shall, at the informal conference:
    - a. Provide written notice to the client or, if applicable, the client's guardian according to A.R.S. § 41-1092.03, and
    - b. Ask the client or, if applicable, the client's guardian whether the client or, if applicable, the client's guardian would like the Administration to file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client.

- c. For all clients including clients who needs special assistance, send a copy of the notice in subsection (6)(a) to the Office of Human Rights and make the notice available to the appropriate ~~human rights committee~~Independent Oversight Committee.
7. If, at the informal conference, a client or, if applicable, the client's guardian requests that the Administration file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client, the Administration shall file the request within three days of the informal conference according to subsection (G).

**G.** The state fair hearing.

1. Within three days of the informal conference with the Administration, if the conference failed to resolve the appeal, or within five days of the date the conference was waived, the Administration shall forward a request to schedule a state fair hearing.
2. Within five days of the notification, the Administration shall send a written notice of state fair hearing to all parties, informing them of the time and place of the hearing, the name, address, and telephone number of the Administrative Law Judge, and the issues to be resolved. The notice shall also be sent to the appropriate ~~human rights committee and~~Independent Oversight Committee in the Office of Human Rights for all clients, ~~including clients~~ who need special assistance.
3. A state fair hearing shall be held on the appeal in a manner consistent with A.R.S. § 41-1092 et seq., and those portions of 9 A.A.C. 1 which are consistent with this Article.
4. During the pendency of the appeal, the client, any designated representative and/or guardian, the clinical team, and representatives of any service providers may agree to implement any part of the ISP or ITDP or other matter under appeal without prejudice to the appeal.
5. The client or applicant shall have the right to be represented at the hearing by a person chosen by the client or applicant at the client's or applicant's own expense, in accordance with Rule 31, Rules of the Supreme Court.
6. The client, any designated representative and/or guardian, and the opposing party shall have the right to present any evidence relevant to the issues under appeal and to call and examine witnesses. The Administration shall have the right to appear to present legal argument.

7. The client and any designated representative and/or guardian shall have the right to examine and copy at a reasonable time prior to the hearing all records held by the Administration, ~~regional authority~~health plan, or service provider pertaining to the client and the issues under appeal, including all records upon which the ISP or ITDP decisions were based.
8. Any portion of the hearing may be closed to the public if the client requests or if the Administrative Law Judge determines that it is necessary to prevent the unwarranted invasion of a client's privacy or that public disclosure would pose a substantial risk of harm to a client.

**H.** Expedited appeal.

1. At the time an appeal is initiated, the applicant, client, or mental health agency may request orally or in writing an expedited appeal on issues related to crisis or emergency services or for good cause. Any appeal from a decision denying admission to or continued stay at an inpatient psychiatric facility due to lack of medical necessity shall be accompanied by all medical information necessary to resolution of the appeal and shall be expedited.
2. An expedited appeal shall be conducted in accordance with the provisions of this Section, except as provided for in this subsection.
3. Within one day of receipt of an expedited appeal, the ~~director of the regional authority~~health plan shall inform the client in writing that the appeal has been received.
4. The ~~director of the regional authority~~health plan shall accept an expedited appeal on issues related to crisis or emergency services. The ~~regional authority~~health plan shall also accept an expedited appeal for good cause. If the regional authority refuses to expedite the appeal based on a determination that good cause does not exist, the ~~director~~health plan shall notify the applicant or client in writing within one day of the initiation of the appeal, with a statement of reasons for the decision, and shall proceed with the appeal in accordance with the provisions of this Section. Within three days of the notification of refusal to expedite the appeal for good cause, the client or applicant may request review of the decision by the Administration, who shall act within one day. The decision of the Administration shall be final.
5. If the ~~regional authority~~health plan accepts the appeal for expedited consideration, the ~~director~~health plan shall hold the informal conference according to R9-21-401(E) within two days

of the initiation of the appeal. The ~~regional authority~~health plan shall schedule the conference at a convenient time and place and shall inform all participants of the time, date and location prior to the conference.

6. If the informal conference with the ~~director of the regional authority or the director's-~~designee~~health plan~~ does not resolve the issues in dispute to the satisfaction of the client or, if applicable, the client's guardian, and the issues in dispute are not related to the client's eligibility for behavioral health services, the client or, if applicable, the client's guardian shall be informed that the matter may be further appealed to the Administration, and of the procedure for requesting waiver of the informal conference with the Administration.
7. If a client or, if applicable, the client's guardian waives the right to an informal conference with the Administration or, if the informal conference with the ~~director of the regional authority or the director's designee~~health plan does not resolve the issues in dispute to the satisfaction of the client or, if applicable, the client's guardian, and the issues in dispute are related to the client's eligibility for behavioral health services, the ~~regional authority~~health plan shall, at the informal conference:
  - a. Provide written notice to the client or, if applicable, the client's guardian according to A.R.S. § 41-1092.03, and
  - b. Ask the client or, if applicable, the client's guardian whether the client or, if applicable, the client's guardian would like the ~~regional authority~~health plan to request an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client.
  - c. Send a copy of the notice in subsection (H)(7)(a) to the Office of Human Rights ~~and the appropriate human rights committee.~~
8. If, at the informal conference, a client or, if applicable, the client's guardian requests that the ~~regional authority~~health plan file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client, the Administration shall file the request within one day of the informal conference.
9. Within one day of the conclusion of an informal conference with the ~~regional authority~~health plan, the ~~director of the regional authority~~health plan shall notify the Administration if the informal conference failed to resolve the appeal and shall immediately forward the client's notice of appeal

and any agreed statements of fact unless the client or, if applicable, the client's guardian waived the client's right to an informal conference with the Administration or the issues in dispute are related to the client's eligibility for behavioral health services.

10. Within two days of the notification from the ~~regional authority~~ health plan, the Administration shall hold the informal conference pursuant to subsection (F).
11. If all issues in dispute are not resolved to the satisfaction of the client or if applicable, the client's guardian at the informal conference with the Administration, the Administration shall, at the informal conference:
  - a. Provide written notice to the client or, if applicable, the client's guardian according to A.R.S. § 41-1092.03, and
  - b. Ask the client or, if applicable, the client's guardian whether the client or, if applicable, the client's guardian would like the Administration to file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client.
  - c. For a client who needs special assistance, send a copy of the notice in subsection (H)(11)(a) to the Office of Human Rights ~~and the appropriate human rights committee~~.
12. If, at the informal conference, a client or, if applicable, the client's guardian requests that the Administration file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client, the Administration shall file the request within one day of the informal conference.
13. Within one day of the informal conference with the Administration, if the conference failed to resolve the appeal, or within two days of the date the conference was waived, the Administration shall forward a request to schedule a state fair hearing.
14. Within one day of notification, the Administration shall send a written notice of an expedited state fair hearing in accordance with subsection (G)(2) and A.R.S. 41-1092, et seq.
15. An expedited state fair hearing shall be held on the appeal in accordance with subsection (G)(3) and A.R.S. 41-1092, et seq.

**I.** Standard and burden of proof.

1. The standard of proof on all issues shall be by a preponderance of the evidence.

2. The burden of proof on the issue of the need for or appropriateness of behavioral health services or community services shall be on the person appealing.
3. The burden of proof on the issue of the sufficiency of the assessment and further evaluation, and the need for guardianship, conservatorship, or special assistance shall be on the agency which made the decision.
4. The burden of proof on issues relating to services or placements shall be on the party advocating the more restrictive alternative.

**J.** Implementation of final decision. Within five days after a satisfactory resolution is achieved at an informal conference or after the expiration of an appeal period when no appeal is taken, or after the exhaustion of all appeals and subject to the final decision thereon, the ~~regional authority~~ health plan shall implement the final decision and shall notify the client, any designated representative and/or guardian, and Administration of such action.

**K.** Appeal log.

1. The Administration and ~~regional authority~~ health plan shall maintain logs of appeals filed under this Section.
2. The log maintained by the Administration shall not include personally identifiable information and shall be a public record, available for inspection and copying by any person.
3. With respect to each entry, the logs shall contain:
  - a. A unique docket number or matter number;
  - b. A substantive but concise description of the appeal including whether the appeal related to the provision of Title XIX services;
  - c. The date of the filing of appeal;
  - d. The date of the initial decision appealed from;
  - e. The date, nature and outcome of all subsequent decisions, appeals, or other relevant events; and
  - f. A substantive but concise description of the final decision and the action taken by the agency director and the date the action was taken.

## **R9-21-402. General**

- A.** It is the policy of the Administration to conduct investigations and bring matters to a resolution in four circumstances: first, in the event of a death of a client; second, whenever there is alleged to have occurred a rights violation; third, whenever there is alleged to exist a condition requiring investigation because it is dangerous, illegal or inhumane; and fourth, in any other case where an investigation would be in the public interest, as determined by the Administration. The purpose of R9-21-402 through R9-21-410 is to implement that policy. All investigations according to R9-21-402 through R9-21-410 shall be carried out in a prompt and equitable manner and with due regard for the dignity and rights of all persons involved. R9-21-402 through R9-21-410 do not obviate the need for systematically reporting, where appropriate, accidents and injuries involving clients.
- B.** This grievance and investigation procedure applies to any allegation that a rights violation or a condition requiring investigation, as defined in R9-21-101, has occurred or currently exists.
1. A grievance may be filed by a client, guardian, human rights advocate, ~~human rights committee~~ Independent Oversight Committee, State Protection and Advocacy System, designated representative, or any other concerned person when a violation of the client's rights or of the rights of several clients has occurred.
  2. A request for an investigation may be filed by any person whenever a condition requiring investigation occurs or has occurred.
  3. Allegations about the need for or appropriateness of behavioral health services or community services ~~should generally~~ should be addressed according to the Individual Service Planning Sections R9-21-301 through R9-21-314 and according to R9-21-401, as applicable.

**R9-21-403. Initiating a Grievance or Investigation**

- A. Any individual may file a grievance regarding an abridgement by a mental health agency of one or more of a client's rights in Article 2 of this Chapter,
- B. Any individual may request an investigation regarding a condition requiring investigation.
- C. An employee of or individual under contract with one of the following shall file a grievance if the employee has reason to believe that a mental health agency has abridged one or more of a client's rights in Article 2 of this Chapter or that a condition requiring investigation exists, and shall receive disciplinary action for failure to comply with this subsection:
  - 1. A service provider,
  - 2. A ~~regional authority~~ health plan,
  - 3. An inpatient facility, or
  - 4. The Administration.
- D. A service provider or ~~regional authority~~ health plan shall file a grievance if it:
  - 1. Receives a non-frivolous allegation that:
    - a. A mental health agency has abridged one or more of a client's rights in Article 2 of this Chapter, or
    - b. A condition requiring investigation exists; or
  - 2. Has reason to believe that there exists or has occurred a condition requiring investigation in a mental health agency or program.
- E. The Administration shall request an investigation if:
  - 1. The Administration determines that it would be in the best interests of a client, the Administration, or the public; or
  - 2. The Administration receives a non-frivolous allegation or has reason to believe that:
    - a. A mental health agency has abridged one or more of a client's rights in Article 2 of this Chapter, or
    - b. A condition requiring investigation exists.
- F. To file a grievance, an individual shall communicate the grievance orally or submit the grievance in writing to ~~any employee of~~ a mental health agency who shall forward the grievance to the appropriate person as

identified in R9-21-404. If asked to do so by a client, an employee shall assist the client in making an oral or written grievance or shall direct the client to the available supervisory or managerial staff who shall assist the client in making an oral or written grievance.

**G.** Any grievance or request for investigation shall be accurately and completely reduced to writing on an Administration-provided grievance or request for investigation form by:

1. The individual filing the grievance or request for investigation, or
2. The mental health agency to whom the grievance or request for investigation is made.

**R9-21-404. Persons Responsible for Resolving Grievances and Requests for Investigation**

A. Allegations involving rights violations, except those involving physical abuse, sexual abuse, or sexual misconduct of a mental health agency, or as a result of an employee of a mental health agency, shall be addressed to and initially decided by the appropriate health plan.

1. ~~Of other than physical abuse, sexual abuse, or sexual misconduct that occurred in a mental health agency, or as a result of an action of a person employed by a mental health agency, shall be addressed to and initially decided by:~~If the mental health agency is operated exclusively by a governmental entity, then the allegation shall be addressed to and initially decided by the agency.

a. ~~The appropriate regional authority; or~~

b. ~~If the mental health agency is operated exclusively by a governmental entity the allegation shall be addressed to and initially decided by that agency; or~~

2. Allegations of ~~Of~~ physical abuse, sexual abuse, or sexual misconduct that occurred in a mental health agency, or as a result of an action of a person employed by a mental health agency, shall be addressed to and decided by the Administration.

B. Allegations involving conditions requiring investigation shall be addressed to and initially decided by the appropriate health plan.

1. ~~Of other than a client death, which occurred in a mental health agency, or as a result of a person employed by a mental health agency, shall be addressed to and initially decided by:~~If the mental health agency is operated exclusively by a governmental entity, the allegation shall be addressed to and initially decided by that agency.

a. ~~The appropriate regional authority; or~~

b. ~~If the mental health agency is operated exclusively by a governmental entity, the allegation shall be addressed to and initially decided by that agency; or~~

2. Allegations of ~~Of~~ a client death, which occurred in a mental health agency, or as a result of an action of a person employed by a mental health agency, shall be addressed to and decided by the Administration.

C. Within five days of receipt by a mental health agency of a grievance or request for investigation:

1. The mental health agency shall inform the person filing the grievance or request, in writing, that the grievance or request has been received;
2. If the mental health agency is operated exclusively by a governmental entity, the mental health agency shall provide a copy of the grievance to the appropriate ~~regional authority~~ health plan; and
3. If the client is in need of special assistance, the mental health agency shall immediately send a copy of the grievance or request to the Office of Human Rights and the ~~human rights committee~~ Independent Oversight Committee with jurisdiction over the agency.

**R9-21-405. Preliminary Disposition**

- A.** The agency director before whom a grievance or request for investigation has been initiated shall immediately take whatever action may be reasonable to protect the health, safety and security of any client, witness, individual filing the grievance or request for investigation, or individual on whose behalf the grievance or request for investigation is filed.
- B. Summary disposition.**
1. A mental health agency or the Administration may summarily dispose of any grievance or a request for an investigation where the alleged rights violation or condition occurred more than one year immediately prior to the date on which the grievance or request is made.
  2. A mental health agency or the Administration who receives a grievance or request which is primarily directed to the level or type of mental health treatment provided to a client, which can be fairly and efficiently addressed within the procedures set forth in Article 3 and in R9-21-401, and which do not directly or indirectly involve any rights set forth in A.R.S. Title 36 or Article 2, may refer the grievance for resolution through the Individual Service Plan process or the appeal process in R9-21-401.
- C. Disposition without investigation.**
1. Within seven days of receipt of a grievance or request for an investigation, a mental health agency or the Administration may promptly resolve a grievance or request without conducting a full investigation, where the matter:
    - a. Involves no dispute as to the facts;
    - b. Is patently frivolous; or
    - c. Is resolved fairly and efficiently within seven days without a formal investigation.
  2. Within seven days of receipt of the grievance or request described in subsection (C)(1), the mental health agency or the Administration shall prepare a written, dated decision.
    - a. The decision shall explain the essential facts, why the mental health agency or the Administration believes that the matter is appropriately resolved without the appointment of an investigator, and the resolution of the matter.

- b. The mental health agency or the Administration shall send copies of the decision to the parties, together with a notice of appeal rights according to A.R.S. § 41-1092.03, and to anyone else having a direct interest in the matter.
  - 3. After the expiration of the appeal period without appeal by any party, or after the exhaustion of all appeals and subject to the final decision on the appeal, the mental health agency or the Administration shall promptly take appropriate action and prepare and add to the case record a written, dated report of the action taken to resolve the grievance or request.
- D.** Matters requiring investigation.
  - 1. If the matter complained of cannot be resolved without a formal investigation according to the criteria set forth in subsection (C)(1), within seven days of receipt of the grievance or request the mental health agency or the Administration shall prepare a written, dated appointment of an impartial investigator who, in the judgment of the mental health agency or the Administration, is capable of proceeding with the investigation in an objective manner but who shall not be:
    - a. Any of the persons directly involved in the rights violation or condition requiring investigation; or
    - b. A staff person who works in the same administrative unit as, except a person with direct line authority over, any person alleged to have been involved in the rights violation or condition requiring investigation.
  - 2. Immediately upon the appointment of an investigator, the mental health agency or the Administration shall notify the person filing the grievance or request for investigation in writing of the appointment. The notice shall contain the name of the investigator, the procedure by which the investigation will be conducted and the method by which the person may obtain assistance or representation.
- E.** If a client is a client who needs special assistance, the mental health agency or the Administration shall immediately send a copy of the grievance or request to the Office of Human Rights and the ~~human rights committee~~ Independent Oversight Committee with jurisdiction over the agency and shall send a copy of all decisions required by this Chapter made by the mental health agency or the Administration regarding the

grievance or request to the Office of Human Rights and the ~~human rights committee~~ Independent Oversight Committee with jurisdiction over the agency.

**R9-21-406. Conduct of Investigation**

- A.** Within 10 days of the appointment, the investigator shall hold a private, face-to-face conference with the person who filed the grievance or request for investigation to learn the relevant facts that form the grounds for the grievance or request, unless the grievance or request has been initiated by a mental health agency or the Administration according to R9-21-403 (D) or (E).
1. In scheduling such conference, and again at the conference, if the client appears without a designated representative, the investigator shall advise the client that:
    - a. The client may be represented by a designated representative of the client's own choice. The investigator shall also advise the client of the availability of assistance from the State Protection and Advocacy System, the Office of Human Rights, and the relevant ~~human rights committee~~ Independent Oversight Committee.
    - b. The client may make an audio tape of the conference and all future conferences, meetings or hearings to which the client may be a party during the investigation, provided that the client notify all other parties not later than the beginning of the meeting or hearing that the client intends to do so.
    - c. In any case where the person initiating the grievance or request, or the person(s) who is alleged to have been responsible for the rights violation or condition, is a client and is in need of special assistance and is unrepresented, the investigator shall give the Office of Human Rights notice of the need for representation.
  2. Where the grievance has been initiated by the mental health agency or the Administration, the investigator shall promptly determine which persons have relevant information concerning the occurrence of the alleged rights violation or condition requiring investigation and proceed to interview such individuals.
- B.** Within 15 days of the appointment, but only after the conference with the person initiating the grievance or request for investigation, the investigator shall hold a private, face-to-face conference with the person(s) complained of or thought to be responsible for the rights violation or condition requiring investigation to discuss the matter and, in scheduling the conference with such person(s) or with any other witness, the investigator shall advise the person(s) or any other witness that:

1. The individual may make a recording of the conference and all future conferences, meetings or hearings during the course of the investigation, provided that the individual must notify all other parties to such meetings or hearings not later than the beginning of the meeting or hearing if the individual intends to so record.
  2. An employee of an inpatient facility, service provider, ~~regional authority~~health plan or the Administration has an obligation to cooperate in the investigation.
  3. Failure of an employee to cooperate may result in appropriate disciplinary action.
- C.** The investigator shall gather ~~whatever further information may seem~~ relevant and appropriate information, including interviewing additional witnesses, requesting and reviewing documents, and examining other evidence or locations.
- D.** Within 10 days of completing all interviews with the parties but not later than 30 days from the date of the appointment, the investigator shall prepare a written, dated report briefly describing the investigation and containing findings of fact, conclusions, and recommendations
- E.** Within five days of receiving the investigator's report, the agency director shall review the report and the case record and prepare a written, dated decision which shall either:
1. Accept the investigator's report in whole or in part, at least with respect to the facts as found, and state a summary of findings and conclusions and the intended action of the agency director; and send:
    - a. A copy of the decision to:
      - i. The investigator;
      - ii. The individual who filed the grievance or request for investigation;
      - iii. The individual who is the subject of the grievance or request for investigation, if applicable;
      - iv. The Office of Human Rights; and
      - v. The appropriate ~~human rights committee~~Independent Oversight Committee.
    - b. A notice to the individual who filed the grievance or request for investigation and, if applicable, the client who is the subject of the grievance or request for investigation or, if applicable, the client's guardian, of:

- i. If the decision is from an agency director, the client’s right to appeal to the Administration according to R9-21-406 and to an administrative hearing according to A.R.S. § 41-1092.03; and
  - ii. If the decision is from the Administration, the client’s right to an administrative hearing according to A.R.S. § 41-1092.03; or
- 2. Reject the report for insufficiency of facts and return the matter for further investigation. In such event, the investigator shall complete the further investigation and deliver a revised report to the agency director within 10 days. Upon receipt of the report, the agency director shall proceed as provided in subsection (E)(1).

**F.** Actions that an agency director may take according to subsection (E)(1) include:

- 1. Identifying training or supervision for or disciplinary action against an individual responsible for a rights violation or condition requiring investigation identified during the course of investigating a grievance or request for investigation;
- 2. Developing or modifying a mental health agency’s policies and procedures;
- 3. Notifying the regulatory entity that licensed or certified an individual according to A.R.S. Title 32, Chapter 33 of the findings from the investigation; or
- 4. Imposing sanctions, including monetary penalties, according to terms of a contract, if applicable.

**G.** After the expiration of the appeal period set forth in R9-21-407, or after the exhaustion of all appeals and subject to the final decision on the appeal, the agency director shall promptly take the action set forth in the decision and add to the case record a written, dated report of the action taken. A copy of the report shall be sent to the Office of Human Rights and the ~~human rights committee~~ Independent Oversight Committee if the client is in need of special assistance.

**R9-21-407. Administrative Appeal**

- A.** Any grievant or the client who is the subject of the grievance who is dissatisfied with the final decision of the agency director may, within 30 days of receipt of the decision, file a notice of appeal with the Administration. The appealing party shall send copies of the notice to the other parties and their representatives and to the agency director who shall forward the full case record to the Administration.
- B.** The Administration shall review the notice of appeal and the case record, and may discuss the matter with any of the persons involved or convene an informal conference. Within 15 days of the filing of the appeal, the Administration shall prepare a written, dated decision which shall either:
1. Accept the investigator's report, in whole or in part, at least with respect to the facts as found, and affirm, modify or reject the decision of the agency director with a statement of reasons; or
  2. Reject the investigator's report for insufficiency of facts and return the matter with instructions to the agency director for further investigation and decision. In such event, the further investigation shall be completed and a revised report and decision shall be delivered to the Administration within 10 days. Upon receipt of the report and decision, the Administration shall render a final decision, consistent with the procedures set forth in subsection (B)(1).
  3. A designated representative shall be afforded the opportunity to be present at any meeting or conference convened by the Administration to which the represented party is invited.
  4. The Administration shall send copies of the decision to:
    - a. The parties, together with a notice of appeal rights according to A.R.S. § 41-1092.03;
    - b. The agency director; and
    - c. The Office of Human Rights and the applicable ~~human rights committee~~ Independent Oversight Committee for all clients, including clients who are in need of special assistance.

**R9-21-408. Further Appeal to Administrative Hearing**

- A.** Any grievant or the client who is the subject of the grievance who is dissatisfied with the Director's decision of the Administration may request a state fair hearing before an Administrative Law Judge.
1. Within 30 days of the date of the Director's decision, the appealing party shall file with the Administration a notice requesting a state fair hearing.
  2. Upon receipt of the notice, the Administration shall send a copy to the parties, and to the Office of Human Rights and the ~~human rights committee~~ Independent Oversight Committee for clients who are in need of special assistance.
- B.** The hearing shall be conducted consistent with A.R.S. § 41-1092 et seq., and those portions of 9 A.A.C. 1 which are consistent with this Article.
1. The client shall have the right to be represented at the hearing by an individual chosen by the client at the client's own expense, in accordance with Rule 31, Rules of the Supreme Court. If the client has not designated a representative to assist the client at the hearing and is in need of special assistance, the human rights committee, or the human rights advocate unless refused by the client, shall make all reasonable efforts to represent the client.
  2. Any portion of the hearing may be closed to the public if the client requests or if the Administrative Law Judge determines that it is necessary to prevent an unwarranted invasion of the client's privacy or that public disclosure would pose a substantial risk of harm to the client.
  3. The Administration shall explain the Director's decision- to the client at the client's request, together with the right to seek rehearing and judicial review.

**R9-21-409. Notice and Records**

**A.** Notice to clients. All clients shall be informed of their right to file a grievance or request for investigation under these rules.

1. Notice of this grievance and investigation process shall be included in the information posted or otherwise provided to every current and new client and employee. Special efforts shall be made to inform current and new residents of mental health facilities of this process and of the right to file a grievance or request for investigation;
2. A copy of a brief memorandum explaining these rules shall be given to every current and new resident of a inpatient facility;
3. Such memorandum and blank copies of the forms for filing a grievance, request for investigation, and appeal shall be posted in a prominent place in plain sight on every unit of an inpatient facility or in a program operated by a service provider; and
4. Such memoranda, forms and copies of these rules shall be available at each inpatient facility, ~~regional authority~~ health plan and service provider upon request by any person at any time.

**B.** Notice and oversight by the Office of Human Rights and ~~human rights committee~~ Independent Oversight Committees.

1. Upon receipt of any grievance or request for investigation involving a client, including a client who is in need of special assistance, the agency director shall immediately forward a copy of such grievance or request to the Office of Human Rights and the appropriate regional ~~human rights committee~~ Independent Oversight Committee.
2. Upon receipt of such a grievance from the agency director, at the request of a client, or on its own initiative, the Office of Human Rights and/or the appropriate ~~human rights committee~~ Independent Oversight Committee shall assist a client in filing a grievance or request, if necessary. The Office and/or committee shall use its best efforts to see that such client is represented by an attorney, human rights advocate, committee member, or other person to protect the individual's interests and present information on the client's behalf. The Office and/or committee shall maintain a list of attorneys and other representatives, including the state protection and advocacy system, available to assist clients.

3. Whenever the ~~human rights committee~~ Independent Oversight Committee has reason to believe that a rights violation involving abuse or a dangerous condition requiring investigation, including a client death, has occurred or currently exists, or that any rights violation or condition requiring investigation occurred or exists which involves a client who is in need of special assistance, it may, upon written notice and a release signed by the member, or designated representative, giving permission for the IOC to join, sent to the official before whom the matter is pending, become a party to the grievance or request. As a party it shall receive copies of all reports, plans, appeals, notices and other significant documents relevant to the resolution of the grievance or request and be able to appeal any finding or decision.
4. The Office of Human Rights shall assist clients in resolving grievances according to R9-21-104.

**C.** Notification of other persons.

1. Whenever any rule, regulation, statute, or other law requires notification of a law enforcement officer, public official, medical examiner, or other person that an incident involving the death, abuse, neglect, or threat to a client has occurred, or that there exists a dangerous condition or event, such notice shall be given as required by law.
2. A mental health agency shall immediately notify the Administration when:
  - a. A client brings criminal charges against an employee;
  - b. An employee brings criminal charges against a client;
  - c. An employee or client is indicted or convicted because of any action required to be investigated by this Article;
  - d. A client of an inpatient facility, a mental health agency, or a service provider dies. The agency director shall report such death according to the Administration's policy on the reporting and investigation of deaths.
  - e. A client of an inpatient facility, a mental health agency, or a service provider allegedly is physically or sexually abused.
3. The investigation by the Administration provided for by this Article is independent of any investigation conducted by police, the county attorney, or other authority.

**D.** Case records.

1. A file, known as the case record, shall be kept for each grievance or request for investigation which is received by the Administration, ASH, ~~regional authority~~ health plan or service provider under contract or subcontract with the Administration. The record shall include the grievance or request, the docket number or matter number assigned, the names of all persons interviewed and the dates of those interviews, either a taped or written summary of those interviews, a summary of documents reviewed, copies of memoranda generated by the investigation, the investigator's report, the agency director's decision, and all documents relating to any appeal.
2. The investigator shall maintain possession of the case record until the investigation report is submitted. Thereafter, the agency director shall maintain control over the case record, except when the matter is on appeal. During any appeal, the record will be in the custody of the official who hears or decides the appeal.

**E.** Public logs.

1. The Administration and ~~regional authority~~ health plan shall maintain logs of deaths and non-frivolous grievances or requests for investigation for inpatient facilities, agencies, service providers, and mental health agencies which it operates, funds, or supervises.
2. The log maintained by the Administration shall not include personally identifiable information and shall be a public record, available for inspection and copying by any person.
3. With respect to each grievance or request for investigation, the Administration's log shall contain:
  - a. A unique docket number or matter number;
  - b. A substantive but concise description of the grievance or request for investigation;
  - c. The date of the filing of grievance;
  - d. The date of the initial decision or appointment of investigator;
  - e. The date of the filing of the investigator's final report;
  - f. A substantive but concise description of the investigator's final report;
  - g. The date of all subsequent decisions, appeals, or other relevant events; and
  - h. A substantive but concise description of the final decision and the action taken by the mental health agency or the Administration.

**R9-21-410. Miscellaneous**

- A.** Disqualification of official. The agency director, investigator, or any other official with authority to act on a grievance or request for investigation shall disqualify himself from acting, if such official cannot act on the matter impartially and objectively, in fact or in appearance. In the event of such disqualification, the official shall forthwith prepare and forward a written, dated memorandum explaining the reasons for the decision to the Administration, as appropriate, who shall, within 10 days of receipt of the memorandum make a determination upon the appropriateness of the disqualification and notify, ~~take such steps as are necessary to resolve the grievance in an impartial, objective manner.~~
- B.** Request for extension of time.
1. The investigator or any other official of a mental health agency acting according to this Article may secure an extension of any time limit provided in this Article with the permission of the ~~regional authority~~ health plan.
  2. The investigator or any other official of an inpatient facility operated exclusively by an governmental entity acting according to this Article may secure an extension of any time limit provided in this Article with the permission of the CEO of the entity or his designee.
  3. The investigator or any other official of the Administration acting according to this Article may secure an extension of any time limit provided in this Article with the permission of the Administration or designee.
  4. An extension of time may only be granted upon a showing of necessity and a showing that the delay will not pose a threat to the safety or security of the client.
  5. A request for extension shall be in writing, with copies to all parties. The request shall explain why an extension is needed and propose a new time limit which does not unreasonably postpone a final resolution of the matter.
  6. Such request shall be submitted to and acted upon prior to the expiration of the original time limit. Failure of the relevant official to act within the time allowed shall constitute a denial of the request for an extension.
- C.** Procedural irregularities.

1. Any party may protest the failure or refusal of any official with responsibility to take action in accord with the procedural requirements of this Article, including the time limits, by filing a written protest with the Administration.
2. Within 10 days of the filing of such a protest, the Administration shall take appropriate action to ensure that if there is or was a violation of a procedure or timeline, it is promptly corrected, including, if appropriate, disciplinary action against the official responsible for the violation or by removal of an investigator and the appointment of a substitute.

**D. Special Investigation.**

1. The Administration may at any time order that a special investigator review and report the facts of a grievance or condition requiring investigation, including a death or other matter.
2. The special investigator and the Administration shall comply with the time limits and other procedures for an investigation set forth in this Article.
3. Any final decision issued by the Administration based on such an investigation under this rule is appealable as provided in R9-21-408.
4. Nothing in this Article shall prevent the Administration from conducting an investigation independent of these rules.

## ARTICLE 5. COURT-ORDERED EVALUATION AND TREATMENT

### R9-21-501. Court-ordered Evaluation

- A. An application for court-ordered evaluation shall, according to A.R.S. § 36-521, be made on ~~Department~~AHCCCS form MH-100, Titled “Application for Involuntary Evaluation,” set forth in Exhibit A.
- B. Any mental health agency or service provider that receives an application for court-ordered evaluation shall immediately refer the applicant for pre-petition screening and petitioning for court-ordered evaluation, provided for in A.R.S. Title 36, Chapter 5, Article 4, to:
1. A ~~regional authority~~health plan; or
  2. If a county has not contracted with a ~~regional authority~~health plan for pre-petition screening and petitioning for court-ordered evaluation, the county.

**R9-21-502. Emergency Admission for Evaluation**

- A. An application for emergency evaluation pursuant to A.R.S. § 36-524 may be made to any evaluation agency licensed and approved by the ~~Department~~Administration to provide such services on ~~Department~~AHCCCS form MH-104, Titled “Application for Emergency Admission for Evaluation,” set forth in Exhibit C.
- B. Prior to admission of an individual under this rule, the evaluation agency shall notify the appropriate ~~regional authority~~health plan of the potential admission so that the ~~regional authority~~health plan may first:
1. Offer and pProvide services or treatment to the individual as an alternative to admission; or
  2. Authorize admission of the individual.
- C. If the evaluation agency does not provide notice pursuant to subsection (B) of this rule, the ~~regional authority~~health plan shall not be obligated to pay for the services provided.
- D. Only a mental health agency licensed by the ~~Department~~Administration to provide emergency services according to A.R.S. Title 36, Chapter 4 may provide court-ordered emergency admission services under A.R.S. Title 36, Chapter 5, Article 4.

**R9-21-502. Emergency Admission for Evaluation**  
**Exhibit C. Application for Emergency Admission for Evaluation**

APPLICATION FOR EMERGENCY ADMISSION FOR EVALUATION

(Pursuant to A.R.S. § 36-524)

STATE OF ARIZONA                    )  
  )ss  
COUNTY OF \_\_\_\_\_ )  
\_\_\_\_\_ )

The undersigned applicant, being first duly sworn/affirmed, hereby requests that \_\_\_\_\_ (Evaluation Agency) admit the person named herein for evaluation.

1. The undersigned applicant alleges that there is now in the County a person whose name and address are:

\_\_\_\_\_ (Name) \_\_\_\_\_ (Address)

and that s/he believes that the person has a mental disorder and, as a result of said mental disorder, is:

- A danger to self;  A danger to others;  Persistently or Acutely Disabled;  Gravely Disabled;

and that, during the time necessary to complete pre-petition screening under A.R.S. §§ 36-520 and 36-521, the person is likely without immediate hospitalization to suffer serious physical harm or serious illness or is likely to inflict serious physical harm up on another person.

2. The conclusion that the person has a mental disorder is based on the following facts:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. The specific nature of the danger posed by this person is:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. A summary of the personal observations upon which this statement is based is as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**R9-21-503. Voluntary Admission for Evaluation**

- A. An application for voluntary evaluation pursuant to A.R.S. § 36-522 shall be submitted on ~~Department~~AHCCCS form MH-103, Titled “Application for Voluntary Evaluation,” set forth in Exhibit D to a mental health agency.
- B. If a ~~regional authority~~health plan receives an application according to subsection (A), the ~~regional authority~~health plan shall provide for such evaluation under A.R.S. § 36-522 for any individual who:
1. Voluntarily makes application as provided in subsection (A);
  2. Gives informed consent; and
  3. Has not been adjudicated as an incapacitated person pursuant to A.R.S. Title 14, Chapter 5, or Title 36, Chapter 5.
- C. Any mental health agency, which is not a ~~regional authority~~health plan under R9-21-501, that receives an application for voluntary evaluation shall immediately refer the individual to:
1. The county responsible for voluntary evaluations; or
  2. If the county has contracted with a ~~regional authority~~health plan for voluntary evaluations, the appropriate ~~regional authority~~health plan.
- D. Any mental health agency providing voluntary evaluation services pursuant to this Article shall place in the medical record of the individual to be evaluated the following:
1. A completed copy of the application for voluntary treatment;
  2. A completed informed consent form pursuant to R9-21-511; and
  3. A written statement of the individual’s present mental condition.
- E. Voluntary evaluation shall proceed only after the individual to be evaluated has given informed consent on ~~Department~~AHCCCS form MH-103 and received information that the patient-physician privilege does not apply and that the evaluation may result in a petition for the individual to undergo court-ordered treatment or for guardianship in the method prescribed by A.R.S. § 36-522.

**R9-21-504. Court-ordered Treatment**

- A.** The ~~regional authority health plan~~ shall perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5 and this Article. In order to perform these functions, the ~~regional authority health plan~~ or its contractor must be licensed by the Department of Health Services.
- B.** A mental health agency may provide court-ordered treatment pursuant to A.R.S. Title 36, Chapter 5, Article 5, other than through contract with the ~~regional authority health plan~~, provided that:
1. The mental health agency is licensed by the Department to provide the court-ordered treatment;
  2. The mental health agency complies with all applicable requirements under A.R.S. Title 36, Chapter 5, Article 5; and
  3. The individual ordered to undergo treatment is not a client of the ~~regional authority health plan~~.
- C.** Upon a determination that an individual is a danger to self or others, gravely disabled, or persistently or acutely disabled, and if no alternatives to court-ordered treatment exist, the medical director of the agency that provided the court-ordered evaluation shall file the appropriate affidavits on ~~Department~~AHCCCS form MH-112, set forth in Exhibit E, with the court, together with one of the following petitions:
1. A petition for court-ordered treatment for an individual alleged to be gravely disabled, which shall be filed on ~~Department~~AHCCCS form MH-110, set forth in Exhibit F.
  2. A petition for court-ordered treatment for an individual alleged to be a danger to self or others, which shall be filed on ~~Department~~AHCCCS form MH-110, set forth in Exhibit F.
  3. A petition for court-ordered treatment for an individual alleged to be persistently or acutely disabled, which shall be filed on ~~Department~~AHCCCS form MH-110, set forth in Exhibit F.
- D.** Any mental health agency filing a petition for court-ordered treatment of a client pursuant to subsection (A) above shall do so in consultation with the client and the client's clinical team prior to filing the petition.
- E.** With respect to inpatient and outpatient treatment, the petition filed with the court shall request that the individual be committed to the care and supervision of the ~~regional authority health plan~~, if the individual is a client, or to an appropriate mental health treatment agency, if the individual is not a client.

**R9-21-505. Coordination of Court-ordered Treatment Plans with ISPs and ITDPs**

- A.** All inpatient and outpatient treatment plans prepared for clients according to A.R.S. §§ 36-533, 36-540 and 36-540.01, and any modifications to the treatment plans, shall be developed and implemented according to the individual service planning procedures in Article 3 of this Chapter, including the right of the client to request different services and to appeal the treatment plan.
- B.** If a client's ISP or ITDP is inconsistent with an inpatient or outpatient treatment plan ordered by the court, the mental health agency or ~~regional authority~~ health plan, whichever is appropriate, shall recommend to the court that the court-ordered plan be amended so that it is consistent with the client's ISP or ITDP.
- C.** If, during the period a client is on outpatient status, an emergency occurs that satisfies the standards for emergency admission under A.R.S. §§ 36-524 and 36-526, and that requires immediate revocation or modification of an outpatient order, a modification may be submitted to the court in consultation with the client's clinical team without complying with the individual service planning procedures, provided that the client and clinical team subsequently review any such modification according to the individual service planning procedures in Article 3 of this Chapter.

**R9-21-507. Transfers of Court-ordered Persons**

- A.** For the purpose of this Section, “non-client” means an individual who ~~have a qualifying~~are seriously mentally ~~illness~~ but is not currently being evaluated or treated for a mental disorder by or through a ~~regional authority~~health plan.
- B.** An individual ordered by the court to undergo treatment and without a guardian may be transferred from a mental health agency to another mental health agency, provided that the medical director of the mental health agency initiating the transfer has established that:
1. There is no reason to believe the individual will suffer more serious physical harm or serious illness as a result of the transfer; and
  2. The individual is being transferred to a level and kind of treatment more appropriate to the individual’s treatment needs and has been accepted for transfer by the medical director of the receiving mental health agency pursuant to subsection (D).
- C.** The medical director of the mental health agency initiating the transfer shall:
1. Be the medical director of the mental health agency to which the court committed the individual;  
or
  2. Obtain the court’s consent to the transfer as necessary.
- D.** All clients shall be transferred according to the procedures in Article 3 of this Chapter. With regard to non-clients, the medical director of the mental health agency initiating the transfer may not transfer a non-client to, or use the services of, any other mental health agency, unless the medical director of the other mental health agency has agreed to provide such services to a non-client to be transferred, and the Department has licensed and approved the mental health agency to provide those services.
- E.** The medical director of the mental health agency initiating the transfer shall notify the receiving mental health agency in sufficient time for the intended transfer to be accomplished in an orderly fashion, but not less than three days. This notification shall include:
1. A summary of the individual’s needs.
  2. A statement that, in the medical director’s judgment, the receiving mental health agency can adequately meet the individual’s needs.

3. If the individual is a client, a modification of a client's ISP according to R9-21-314, when applicable.
  4. Documentation of the court's consent, when applicable.
- F.** The medical director of the transferring mental health agency shall present a written compilation of the individual's clinical needs and suggestions for future care to the medical director of the receiving mental health agency, who shall accept and approve it before an individual can be transferred according to subsection (B).
- G.** The transportation of individuals transferred from one mental health agency to another shall be the responsibility of the mental health agency initiating the transfer, irrespective of the allocation of the cost of the transportation defined elsewhere.

**R9-21-508. Requests for Notification**

- A.** At any time during a specified period of court-ordered treatment in which an individual has been found to be a danger to others, a relative or victim wishing to be notified in the event of a individual being released prior to the expiration of the period of court-ordered treatment shall file a demand, according to A.R.S. § 36-541.01(D), on ~~Department~~AHCCCS form MH-127 in Exhibit G.
- B.** At any time during a specified period of court-ordered treatment in which an individual has been found to be a danger to others, a person other than a relative or victim wishing to be notified in the event of an individual being released prior to the expiration of the period of court-ordered treatment shall file a petition and form of order, to A.R.S. § 36-541.01(D) on ~~Department~~AHCCCS form MH-128 in Exhibit H.

**R9-21-509. Voluntary Admission for Treatment**

- A. Application for admission for voluntary treatment according to A.R.S. § 36-518 shall be made to a mental health agency on ~~Department~~AHCCCS form MH-210, Titled “Application for Voluntary Treatment,” in Exhibit I, by any individual who:
1. Voluntarily makes application as provided in subsection (A);
  2. Gives informed consent;
  3. Has not been adjudicated as an incapacitated person according to A.R.S. Title 14, Chapter 5, or Title 36, Chapter 5; and
  4. If a minor, is appropriately admitted according to A.R.S. § 36-518.
- B. Any mental health agency that is not a ~~regional authority~~health plan under R9-21-501 and that receives an application for voluntary treatment by a client shall immediately refer the client to the appropriate ~~regional authority~~health plan for treatment as provided under this rule, except that in the case of an emergency, a mental health treatment agency licensed by the Department to provide treatment under A.R.S. § 36-518 may accept an application for voluntary treatment and admit the client for treatment as follows:
1. Prior to admission of a client under this rule, the agency shall notify the appropriate ~~regional authority~~health plan of the potential admission and treatment so that the ~~regional authority~~health plan may first:
    - a. Provide other services or treatment to the client as an alternative; or
    - b. Authorize treatment of the client.
  2. If the agency does not provide notice according to subsection (B)(1) above, the ~~regional authority~~health plan shall not be obligated to pay for the treatment provided.
- C. Any mental health agency providing treatment according to A.R.S. § 36-518 shall place in the medical record of the individual to be treated the following:
1. A completed copy of the application for voluntary treatment;
  2. A completed informed consent form according to R9-21-511; and
  3. A written statement of the individual’s present mental condition.
- D. If the client admitted under this rule does not have an ISP, the ~~regional authority~~health plan shall prepare one in accordance with Article 3 of this Chapter. If the client already has an ISP, the ~~regional~~

~~authority~~ health plan shall commence a review of the ISP as provided in R9-21-313 and, if necessary, take steps to modify the ISP in accordance with R9-21-314.

**ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT**

**TITLE 9. HEALTH SERVICES**

**CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**

**BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS**

**Introduction:**

As of July 1, 2016, the AHCCCS Administration will take responsibility for the administration of behavioral health services for persons with a Serious Mental Illness. These services were previously under the administration of the Arizona Department of Health Services (ADHS). Rules promulgated under Title 9, Chapter 21 of the Arizona Administrative Code (A.A.C.), were first enacted in October 1993 and last amended in 2016; these rules apply to persons determined to be SMI, regardless of their Medicaid eligibility.

**Purpose of Rule:**

The proposed rulemaking makes a number of technical and conforming changes to the rules to update them and bring them into compliance with practice and prior session laws.

**1. Identification of rulemaking.**

The Administration has chosen to make changes to this Chapter in two phases. This rulemaking is the first phase, and contains those changes necessary to bring the rules into compliance with statutory changes, regulatory updates and agency procedures. These changes include:

- Changing references from the human rights committee to the Independent Oversight Committee, per A.R.S. § 41-3803;
- Changing references from the regional behavioral health authorities to health plans, per AHCCCS Complete Care joining of physical and behavioral health care administration through one health plan;
- Removing references to eligible children because Chapter 21 only pertains to adult Seriously Mentally Ill and General Behavioral Health services, not those provided to minors under age 18;
- Changing references to the Department of Health Services have been updated to the AHCCCS Administration, where appropriate, as the agency regulating the provision of services under Chapter 21;

and

- Update the language of Exhibit C, in R9-22-502 to make permanent the change proposed in a prior emergency rulemaking, adding Persistently or Acutely Disabled and Gravely Disabled as categories for Emergency Application for Evaluation, per S.B. 1114.

The proposed rulemaking will also add two additional options for seeking an Emergency Admission for Evaluation; Persistently or Acutely Disabled, and Gravely Disabled. This rulemaking is requested to align the form with the language in S.B. 1114, that was signed into law by the Governor earlier this year and became effective September 24, 2022. This change is anticipated to be non-controversial but will have a significant impact on members of the Arizona community in need of emergency evaluation for mental/behavioral health conditions.

The second phase, which will be initiated at a later date, is intended to address more substantive changes as well as consideration of best practices for the treatment and support of persons designated to be SMI, with particular emphasis on patient outcomes. In addition, the follow up rulemaking will include changes to Article 3, which was not included in this rulemaking.

**a. The conduct and its frequency of occurrence that the rule is designed to change:**

The majority of the proposed changes are for clarification and do not change the current process, in addition all changes comply with existing statutory authority or agency practice, therefore it will not change the conduct or its frequency.

**b. The harm resulting from the conduct the rule is designed to change and the likelihood it will continue to occur if the rule is not changed:**

Currently the rules do not reflect the language found in their implementation statutes, therefore the rules will remain out of compliance with legal authority if the text of the rules is not updated.

**c. The estimated change in frequency of the targeted conduct expected from the rule change:**

The Administration does not expect a change in frequency of any conduct.

**A brief summary of the information included in the economic, small business, and consumer impact statement.**

The Administration does not anticipate an economic impact on small businesses, the public or the implementing agencies since this rulemaking only contains technical and conforming changes.

**2. Identification of the persons who will be directly affected by, bear the costs of, or directly benefit from the rule making.**

Members and providers will be most directly affected by changes to the rules, although they are likely already aware of the statutory and agency processes that require these rules updates.

**3. Cost benefit analysis.**

**a. Probable costs and benefits to implementing agency and other agencies directly affected by the implementation and enforcement of the proposed rulemaking. The probable costs to the implementing agency shall include the number of new full-time employees necessary to implement and enforce the proposed rule. The preparer of the economic, small business and consumer impact statement shall notify the Joint Legislative Budget Committee (JLBC) of the number of new full-time employees necessary to implement and enforce the rule before the rule is approved by the council:**

**i. Cost:**

The Administration does not anticipate any costs will be associated to the Administration or the public with this rulemaking.

**ii. Benefit:**

The clarifications made to the rule language assists AHCCCS, members, and providers to more easily understand and comply with the rules.

**iii. Do any Full-time Employees need to be hired?**

The Administration does not anticipate the need to hire full-time employees as a result of the proposed rule changes.

**b. Probable costs and benefits to political subdivision of this state directly affected by the implementation and enforcement of the proposed rulemaking.**

This proposed rule revision does not directly affect political subdivisions.

**c. Probable costs and benefits to businesses directly affected by the proposed rulemaking, including any anticipated effect on the revenues or payroll expenditures of employers who are subject to the proposed rulemaking.**

The Administration does not anticipate an impact to businesses by these changes. The Administration anticipates that adding the clarifications permits entities to more easily understand and comply with the requirements.

**4. General description of the probable impact on private and public employment in businesses, agencies, and political subdivisions of this state directly affected by the rulemaking.**

The Administration does not anticipate an impact to public and private employment by these changes. The Administration anticipates that adding the clarifications to the rule language permits the Administration, members, and providers to more easily understand and comply with rules.

**5. Statement of probable impact of the proposed rule on small businesses. The statement shall include:**

**a. Identification of the small businesses subject to the proposed rulemaking.**

The Administration does not anticipate a fiscal impact on small businesses.

**b. Administrative and other costs required for compliance with the proposed rulemaking.**

The Administration does not anticipate an impact upon the administrative expenses of the small business community.

**c. Description of methods prescribed in section A.R.S. § 41-1035 that the agency may use to reduce the impact on small businesses, with reasons for the agency's decision to use or not use each method:**

**i. Establishing less stringent compliance or reporting requirements in the rule for small businesses:**

The Administration did not identify a less stringent compliance or reporting requirement for small businesses since this rulemaking was only intended for technical and conforming changes.

**ii. Establishing less stringent schedules deadlines in the rule for compliance or reporting requirements for small businesses;**

The Administration did not identify a less stringent schedule deadline for the compliance or reporting requirement for small businesses since this rulemaking was only intended to implement technical and conforming changes.

**iii. Consolidate or simplify the rule's compliance or reporting requirements for small businesses;**

The Administration did not consolidate or simplify the rule's compliance or reporting requirement for small businesses since this rulemaking was only intended to implement technical and conforming changes.

**iv. Establish performance standards for small businesses to replace design or operational standards in the rule; and**

The Administration did not establish performance standards for small businesses since this rulemaking was only intended to implement technical and conforming changes.

**v. Exempting small businesses from any or all requirements of the rule.**

The Administration cannot exempt small businesses from any rule requirements for health purposes, however there are no new requirements in this rulemaking.

**d. The probable cost and benefit to private persons and consumers who are directly affected by the proposed rulemaking.**

Private persons, consumers, and AHCCCS members are impacted and benefit by the clarifications, which provide additional clarity and conciseness to rule language enabling persons to more easily understand and comply with rules.

**6. Statement of the probable effect on state revenues.**

The Administration does not anticipate a fiscal impact upon state revenues. The clarifications are designed to deliver health care in the most cost-effective and efficient manner while complying with the state and federal requirements.

**7. Description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed rulemaking, including the monetizing of the costs and benefits for each option and providing the rationale for not using nonselected alternatives.**

The Administration did not consider other alternatives because the changes are the most cost effective and efficient method of complying with federal law and state statute.

**8. A description of any data on which a rule is based with a detailed explanation of how the data was obtained and why the data is acceptable data. An agency advocating that any data is acceptable data has the burden of proving that the data is acceptable. For the purposes of this paragraph, "acceptable data" means empirical, replicable and testable data as evidenced in supporting documentation, statistics, reports, studies or research.**

The Administration did not consider any data to base the rule upon. This rulemaking was made to implement technical and conforming changes.



## **Replacement Check List**

For rules filed within the

4th Quarter

October 1 – December 31, 2016

# THE ARIZONA ADMINISTRATIVE CODE

Within the stated calendar quarter, this Chapter contains all rules made, amended, repealed, renumbered, and recodified; or rules that have expired or were terminated due to an agency being eliminated under sunset law.

These rules were either certified by the Governor's Regulatory Review Council or the Attorney General's Office; or exempt from the rulemaking process, and filed with the Office of the Secretary of State. Refer to the historical notes for more information.

Please note that some rules you are about to remove may still be in effect after the publication date of this Supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

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## **Title 9. Health Services**

### **Chapter 21. Arizona Health Care Cost Containment System - Behavioral Health Services for Persons with Serious Mental Illness**

#### **Supplement 16-4**

#### **Sections, Parts, Exhibits, Tables or Appendices modified**

R9-21-101, R9-21-102 through R9-21-106, R9-21-201, R9-21-203 through R9-21-206.01, R9-21-208, R9-21-209, Exhibit A, R9-21-301, R9-21-303, R9-21-307, R9-21-309 through R9-21-311, R9-21-401 through R9-21-410

REMOVE Supp. 03-2  
Pages: 1 - 57

REPLACE with Supp. 16-4  
Pages: 1 - 61

*The agency's contact person who can answer questions about rules in Supp. 16-4:*

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*Disclaimer: Please be advised the person listed is the contact of record as submitted in the rulemaking package for this supplement. The contact and other information may change and is provided as a public courtesy.*

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## **PUBLISHER**

**Arizona Department of State**

**Office of the Secretary of State, Public Services Division**

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), accepts state agency rule filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the Administrative Code. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
PUBLIC SERVICES DIVISION  
December 31, 2016

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### **RULES**

A.R.S. § 41-1001(17) states: “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### **THE ADMINISTRATIVE CODE**

The Arizona Administrative Code is where the official rules of the state of Arizona are published. The Code is the official codification of rules that govern state agencies, boards, and commissions. Virtually everything in your life is affected in some way by rules published in the Arizona Administrative Code, from the quality of air you breathe to the licensing of your dentist. This chapter is one of more than 230 in the Code compiled in 21 Titles.

### **ADMINISTRATIVE CODE SUPPLEMENTS**

Rules filed by an agency to be published in the Administrative Code are updated quarterly. Supplement release dates are printed on the footers of each chapter:

First Quarter: January 1 - March 31  
Second Quarter: April 1 - June 30  
Third Quarter: July 1 - September 30  
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2016 is cited as Supp. 16-1.

### **HOW TO USE THE CODE**

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the Arizona Administrative Register for recent updates to rule Sections.

### **ARTICLES AND SECTIONS**

Rules in chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering system separated into subsections.

### **HISTORICAL NOTES AND EFFECTIVE DATES**

Historical notes inform the user when the last time a Section was updated in the Administrative Code. Be aware, since the Office publishes each quarter by entire chapters, not all Sections are updated by an agency in a supplement release. Many times just one Section or a few Sections may be updated in the entire chapter.

### **ARIZONA REVISED STATUTE REFERENCES**

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### **SESSION LAW REFERENCES**

Arizona Session Law references in the introduction of a chapter can be found at the Secretary of State’s website, [www.azsos.gov/services/legislative-filings](http://www.azsos.gov/services/legislative-filings).

### **EXEMPTIONS FROM THE APA**

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the Arizona Administrative Register online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the Administrative Register link.

In the Administrative Code the Office includes editor’s notes at the beginning of a chapter indicating that certain rulemaking Sections were made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

### **EXEMPTIONS AND PAPER COLOR**

If you are researching rules and come across rescinded chapters on a different paper color, this is because the agency filed a Notice of Exempt Rulemaking. At one time the office published exempt rules on either blue or green paper. Blue meant the authority of the exemption was given by the Legislature; green meant the authority was determined by a court order. In 2001 the Office discontinued publishing rules using these paper colors.

### **PERSONAL USE/COMMERCIAL USE**

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*Public Services managing rules editor, Rhonda Paschal, assisted with the editing of this chapter.*

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

Editor's Note: Laws 2015, Ch. 195 provided for the statutory transfer of behavioral health responsibilities from the Arizona Department of Health Services to the Arizona Health Care Cost Containment System (AHCCCS). Therefore the Chapter name has been amended from Department of Health Services to the Arizona Health Care Cost Containment System at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

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

Editor's Note: Title 9, Chapter 21 was adopted and amended by the Department of Health Services under the provisions of Laws 1992, Ch. 301, § 61, which provided for an exemption from the rulemaking process as specified in the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6, § 41-1001 et seq.). Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules. Because this Chapter contains rules which are exempt from the provisions of the Arizona Administrative Procedure Act, the Chapter is printed on blue paper.

Former Title 9, Chapter 21 renumbered to Title 18, Chapter 11.

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**ARTICLE 1. GENERAL PROVISIONS**

**R9-21-101. Definitions and Location of Definitions**

A. Location of definitions. Unless the context otherwise requires, terms used in this Chapter that are defined in A.R.S. § 36-501 shall have the same meaning as in A.R.S. § 36-501. In addition, the following definitions applicable to this Chapter are found in the following Section or Citation:

“Abuse”	R9-21-101
“ADHS”	R9-22-101
“Administration”	A.R.S. § 36-2901
“Agency director”	R9-21-101
“AHCCCS”	R9-22-101
“Applicant”	R9-21-101
“ASH”	R9-21-101
“Authorization”	R9-21-101
“Behavioral health issue”	R9-21-101
“Burden of proof”	R9-21-101
“Case manager”	R9-21-101
“Client”	R9-21-101
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“Client who needs special assistance”	R9-21-101
“Clinical team”	R9-21-101
“Community services”	R9-21-101
“Condition requiring investigation”	R9-21-101
“County Annex”	R9-21-101
“Court”	A.R.S. § 36-501
“Court-ordered treatment”	R9-21-101
“Crisis services” or “emergency services”	R9-21-101
“Danger to others”	A.R.S. § 36-501
“Dangerous”	R9-21-101
“Department”	R9-21-101, A.R.S. § 36-501
“Designated representative”	R9-21-101
“Director”	A.R.S. § 36-501
“Discharge plan”	R9-21-101
“Division”	R9-21-101
“Drug used as a restraint”	R9-21-101
“DSM” or “Diagnostic and Statistical Manual of Mental Disorders”	R9-21-101
“Emergency safety situation”	R9-21-101
“Enrolled Children”	R9-21-101
“Evaluation”	A.R.S. § 36-501
“Exploitation”	R9-21-101
“Family member”	A.R.S. § 36-501
“Frivolous”	R9-21-101
“Generic services”	R9-21-101
“Grievance”	R9-21-101
“Guardian”	R9-21-101
“Hearing officer”	R9-21-101
“Human rights advocate”	R9-21-101
“Human rights committee”	R9-21-101
“Illegal”	R9-21-101
“Individual service plan” or “ISP”	R9-21-101
“Informed consent”	A.R.S. § 36-501
“Inhumane”	R9-21-101
“Inpatient facility”	R9-21-101
“Inpatient treatment and discharge plan” or “ITDP”	R9-21-101
“Licensed physician”	A.R.S. § 36-501
“Long-term view”	R9-21-101
“Mechanical restraint”	R9-21-101
“Medical practitioner”	R9-21-101
“Meeting”	R9-21-101
“Mental disorder”	A.R.S. § 36-501
“Mental health agency”	R9-21-101
“Mental health provider”	A.R.S. § 36-501
“Nurse”	R9-21-101
“Outpatient treatment”	A.R.S. § 36-501

“Party” or “parties”	R9-21-101
“Persistent or acute disability”	A.R.S. § 36-501
“Personal restraint”	R9-21-101
“PRN order” or “Pro re rata medication”	R9-21-101
“Professional”	A.R.S. § 36-501
“Program director”	R9-21-101
“Proposed patient”	A.R.S. § 36-501
“Psychiatrist”	A.R.S. § 36-501
“Psychologist”	A.R.S. § 36-501
“Qualified clinician”	R9-21-101
“Records”	A.R.S. § 36-501
“Region”	R9-21-101
“Regional authority”	R9-21-101
“Regional Behavioral Health Authority (RBHA)”	A.R.S. § 36-3401
“Restraint”	R9-21-101
“Seclusion”	R9-21-101
“Seriously Mentally Ill (SMI)”	A.R.S. § 36-550
“Service provider”	R9-21-101
“Social worker”	A.R.S. § 36-501
“State Protection and Advocacy System”	R9-21-101
“Title XIX”	R9-21-101
“Treatment team”	R9-21-101

B. In this Chapter, unless the context otherwise requires:

“Abuse” means, with respect to a client, the infliction of, or allowing another person to inflict or cause, physical pain or injury, impairment of bodily function, disfigurement or serious emotional damage which may be evidenced by severe anxiety, depression, withdrawal or untoward aggressive behavior. Such abuse may be caused by acts or omissions of an individual having responsibility for the care, custody or control of a client receiving behavioral health services or community services under this Chapter. Abuse shall also include sexual misconduct, assault, molestation, incest, or prostitution of, or with, a client under the care of personnel of a mental health agency.

“Agency director” means the person primarily responsible for the management of an outpatient or inpatient mental health agency, service provider, regional authority or the Administration, or their designees.

“AHCCCS” means the Arizona Health Care Cost Containment System.

“Applicant” means an individual who:

- a. Submits to a regional authority an application for behavioral health services under this Chapter or on whose behalf an application has been submitted; or
- b. Is referred to a regional authority for a determination of eligibility for behavioral health services according to this Chapter.

“ASH” means the Arizona State Hospital.

“Authorization” means written permission for a mental health agency to release or disclose a client’s record or information, containing:

- a. The name of the mental health agency releasing or disclosing the client’s record or information;
- b. The purpose of the release or disclosure;
- c. The individual, mental health agency, or entity requesting or receiving the client’s record or information;
- d. A description of the client’s record or information to be released or disclosed;
- e. A statement:

- i. Of permission for the mental health agency to release or disclose the client's record or information; and
- ii. That permission may be revoked at any time;
- f. The date when or conditions under which the permission expires;
- g. The date the document is signed; and
- h. The signature of the client or, if applicable, the client's guardian.

"Behavioral health issue" means an individual's condition related to a mental disorder, personality disorder, substance abuse, or a significant psychological or behavioral response to an identifiable stressor or stressors.

"Behavioral health service" means the assessment, diagnosis, or treatment of an individual's behavioral health issue.

"Burden of proof" means the necessity or obligation of affirmatively proving the fact or facts in dispute.

"Case manager" means the person responsible for locating, accessing and monitoring the provision of services to clients in conjunction with a clinical team.

"Client" means an individual who is seriously mentally ill and is being evaluated or treated for a mental disorder by or through a regional authority.

"Client record" means the written compilation of information that describes and documents the evaluation, diagnosis or treatment of a client.

"Client who needs special assistance" means a client who has been:

- a. Deemed by a qualified clinician, case manager, clinical team, or regional authority to need special assistance in participating in the ISP or ITDP process, which may include, but is not limited to:
  - i. A client who requires 24-hour supervision;
  - ii. A client who is, in fact, incapable of making or communicating needs but is without a court-appointed fiduciary; or
  - iii. A client with physical disabilities or language difficulties impacting the client's ability to make or communicate decisions or to prepare or participate in meetings; or
- b. Otherwise deemed by a program director, the Administration, or an Administrative Law Judge to need special assistance to effectively file a written grievance, to understand the grievance and investigation procedure, or to otherwise effectively participate in the grievance process under this Chapter.

"Clinical team" refers to the interdisciplinary team of persons who are responsible for providing continuous treatment and support to a client and for locating, accessing and monitoring the provision of behavioral health services or community services. A clinical team consists of a psychiatrist, case manager, vocational specialist, psychiatric nurse, and other professionals or paraprofessionals, such as a psychologist, social worker, consumer case management aide, or rehabilitation specialist, as needed, based on the client's needs. The team shall also include a team leader who is a certified behavioral health supervisor.

"Community services" means services such as clinical case management, outreach, housing and residential services, crisis intervention and resolution services, mobile

crisis teams, day treatment, vocational training and opportunities, rehabilitation services, peer support, social support, recreation services, advocacy, family support services, outpatient counseling and treatment, transportation, and medication evaluation and maintenance.

"Condition requiring investigation" means, within the context of the grievance and investigation procedure set forth in Article 4 of this Chapter, an incident or condition which appears to be dangerous, illegal, or inhumane, including a client death.

"County Annex" means the Maricopa County Psychiatric Annex of the Maricopa Medical Center.

"Court-ordered treatment" means treatment ordered by the court.

"Court-ordered evaluation" means evaluation ordered by the court.

"Crisis services" or "emergency services" means immediate and intensive, time-limited, crisis intervention and resolution services which are available on a 24-hour basis and may include information and referral, evaluation and counseling to stabilize the situation, triage to an inpatient setting, clinical crisis intervention services, mobile crisis services, emergency crisis shelter services, and follow-up counseling for clients who are experiencing a psychiatric emergency.

"Dangerous" as used in Article 4 of this Chapter means a condition that poses or posed a danger or the potential of danger to the health or safety of any client.

"Department" means the Arizona Department of Health Services.

"Designated representative" means a parent, guardian, relative, advocate, friend, or other person, designated in writing by a client or guardian who, upon the request of the client or guardian, assists the client in protecting the client's rights and voicing the client's service needs.

"Discharge plan" means a hospital or community treatment and discharge plan prepared according to Article 3 of these rules.

"Drug used as a restraint" means a pharmacological restraint as used in A.R.S. § 36-513 that is not standard treatment for a client's medical condition or behavioral health issue and is administered to:

- a. Manage the client's behavior in a way that reduces the safety risk to the client or others,
- b. Temporarily restrict the client's freedom of movement.

"DSM" means the latest edition of the "Diagnostic and Statistical Manual of Mental Disorders," edited by the American Psychiatric Association.

"Emergency safety situation" means unanticipated client behavior that creates a substantial and imminent risk that the client may inflict injury, and has the ability to inflict injury, upon:

- a. The client, as evidenced by threats or attempts to commit suicide or to inflict injury on the client; or
- b. Another individual, as evidenced by threats or attempts to inflict injury on another individual or individuals, previous behavior that has caused injury to another individual or individuals, or behavior that

places another individual or individuals in reasonable fear of sustaining injury.

“Enrolled Children” means persons under the age of 18 who receive behavioral health services by or through a regional authority.

“Exploitation” means the illegal or improper use of a client or a client’s resources for another’s profit or advantage.

“Frivolous” as used in this Chapter, means a grievance that is devoid of merit. Grievances are presumed not to be frivolous unless the grievance:

- a. Involves conduct that is not within the scope of this Chapter,
- b. Is impossible on its face, or
- c. Is substantially similar to conduct alleged in two previous grievances within the past year that have been determined to be unsubstantiated as provided in this Chapter.

“Generic services” means services other than behavioral health services or community services for which clients may have a need and include, but are not limited to, health, dental, vision care, housing arrangements, social organizations, recreational facilities, jobs, and educational institutions.

“Grievance” means a complaint regarding an act, omission or condition, as provided in this Chapter.

“Guardian” means an individual appointed by court order according to A.R.S. Title 14, Chapter 5, or similar proceedings in another state or jurisdiction where said guardianship has been properly domesticated under Arizona law.

“Hearing officer” refers to an impartial person designated by the Office of Administrative Hearing to hear a dispute and render a written decision.

“Human rights advocate” means the human rights advocates appointed by the Administration under R9-21-105.

“Human rights committee” means the human rights committee established under A.R.S. § 41-3803.

“Illegal” means, within the context of the grievance and investigation procedure set forth in Article 4 of this Chapter, an incident or occurrence which is or was likely to constitute a violation of a state or federal statute, regulation, court decision or other law, including the provisions of these Articles.

“Individual service plan” or “ISP” means the written plan for services to a client, prepared in accordance with Article 3 of this Chapter.

“Inhumane” as used in Article 4 of this Chapter means an incident, condition or occurrence that is demeaning to a client, or which is inconsistent with the proper regard for the right of the client to humane treatment.

“Inpatient facility” means the Arizona State Hospital, the County Annex, or any other inpatient treatment facility registered with or funded by or through the Administration to provide behavioral health services, including psychiatric health facilities, psychiatric hospitals, and psychiatric units in general hospitals.

“Inpatient treatment and discharge plan” or “ITDP” means the written plan for services to a client prepared

and implemented by an inpatient facility in accordance with Article 3 of this Chapter.

“Long-term view” means a planning statement that identifies, from the client’s perspective, what the client would like to be doing for work, education, and leisure and where the client would like to be living for up to a three-year period. The long-term view is based on the client’s unique interests, strengths, and personal desires. It includes predicted times for achievement.

“Mechanical restraint” means any, device, article, or garment attached or adjacent to a client’s body that the client cannot easily remove and that restricts the client’s freedom of movement or normal access to the client’s body, but does not include a device, article, or garment:

- a. Used for orthopedic or surgical reasons, or
- b. Necessary to allow a client to heal from a medical condition or to participate in a treatment program for a medical condition.

“Medical practitioner” means a

- a. Physician,
- b. Physician assistant, or
- c. Nurse practitioner.

“Meeting” means an encounter or assembly of individuals which may be conducted in person or by telephone or by video-conferencing.

“Mental health agency” includes a regional authority, service provider, inpatient facility, or an entity that conducts screening and evaluation under Article 5.

“Nurse” means an individual licensed as a registered nurse or a practical nurse according to A.R.S. Title 32, Chapter 15.

“Party” or “parties” as used in Articles 3 and 4 of these rules means the person filing a grievance under this Chapter, the agency director who issued any final resolution or decision of such a grievance, the person whose conduct is complained of in the grievance, any client or applicant who is the subject of the request or grievance, the legal guardian of client or applicant, and, in selected cases, the appropriate human rights committee.

“Personal restraint” means the application of physical force without the use of any device, for the purpose of restricting the free movement of a client’s body, but for a behavioral health agency licensed as a level 1 Residential Treatment Center RTC or a Level I sub-acute agency does not include:

- a. Holding a client for no longer than five minutes, without undue force, in order to calm or comfort the client; or
- b. Holding a client’s hand to escort the client from one area to another.

“PRN order” or “Pro re nata medication” means medication given as needed.

“Program director” means the person with the day-to-day responsibility for the operation of a programmatic component of a service provider, such as a specific residential, vocational, or case management program.

“Qualified clinician” means a behavioral health professional who is licensed or certified under A.R.S. Title 32, or a behavioral health technician who is supervised by a licensed or certified behavioral health professional.

“Region” means the geographical region designated by the Administration in its contract with the regional authority.

“Regional authority” means the Regional Behavioral Health Authority (RBHA) under contract with the Administration to organize and administer the delivery of behavioral health services or community services to clients and enrolled children within a defined geographic area.

“Restraint” means personal restraint, mechanical restraint, or drug used as a restraint.

“Seclusion” means restricting a client to a room or area through the use of locked doors or any other device or method which precludes a client from freely exiting the room or area or which a client reasonably believes precludes his unrestricted exit. In the case of an inpatient facility, confining a client to the facility, the grounds of the facility, or a ward of the facility does not constitute seclusion. In the case of a community residence, restricting a client to the residential site, according to specific provisions of an individual service plan or court order, does not constitute seclusion.

“Seriously mentally ill” means a person 18 years of age or older as defined in A.R.S. § 36-550.

“Service provider” means an agency, inpatient facility or other mental health provider funded by or through, under contract or subcontract with, certified by, approved by, registered with, or supervised by the Administration or receiving funds under Title XIX, to provide behavioral health services or community services.

“State Protection and Advocacy System” means the agency designated as the Protection and Advocacy System for individuals with mental illness, according to 42 U.S.C. 10801-10851.

“Title XIX” means Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq.

“Treatment team” means the multidisciplinary team of persons who are responsible for providing continuous treatment and support to a client who is in an inpatient facility.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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 by exempt rulemaking at 7 A.A.R. 3469, effective July 17, 2001 (Supp. 01-3). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

#### R9-21-102. Applicability

With regard to the provision of behavioral health services or community services to clients under A.R.S. Title 36 Chapter 5, this Chapter shall apply to the Administration and to all mental health agencies. This Chapter shall not apply to the Arizona Department of Corrections.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

#### R9-21-103. Computation of Time

For any period of time prescribed or allowed by this Chapter, the time shall be calculated as follows:

1. The period of time shall not include the day of the act, event or default from which the designated period of time begins to run;
2. If the period of time prescribed or allowed is less than 11 days, the period of time shall not include intermediate Saturdays, Sundays and legal holidays;
3. If the period of time is 11 days or more, the period of time shall include intermediate Saturdays, Sundays and legal holidays;
4. If the last day of the period of time is a Saturday, Sunday, or legal holiday, the period of time shall extend until the end of the next day that is not a Saturday, Sunday or legal holiday.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Section repealed; new Section R9-21-103 renumbered from R9-21-104 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

#### R9-21-104. Office of Human Rights; Human Rights Advocates

- A. An Office of Human Rights shall be established within the Administration. The office shall have its own chief officer who shall be responsible for the management and control of the office, as well as the hiring, training, supervision, and coordination of human rights advocates.
- B. The chief officer shall appoint at least one human rights advocate for each 2,500 clients in each region. Each region shall have at least one human rights advocate. The chief officer shall appoint at least one human rights advocate for ASH. All clients shall have the right of access to a human rights advocate in order to understand, exercise, and protect their rights. The human rights advocate shall advocate on behalf of clients and shall assist clients in understanding and protecting their rights and obtaining needed services. The human rights advocate shall also assist clients in resolving appeals and grievances under Article 4 of this Chapter and shall coordinate and assist the human rights committees in performing their duties.
- C. The human rights advocates shall be given access to all:
  1. Clients; and
  2. Client records from a service provider, regional authority, or the Administration, except as prohibited by federal or state law.
- D. Staff of inpatient facilities, regional authorities, and service providers shall cooperate with the advocate by providing relevant information, reports, investigations, and access to meetings, staff persons, and facilities except as prohibited by federal or state law and the client’s right to privacy.

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- E. An agency director shall notify the Office of Human Rights and the applicable human rights committee of each client who needs special assistance.
- F. The Office of Human Rights shall:
1. Maintain a list that contains the names of each client who needs special assistance and, if applicable, the name and address of the residential program providing behavioral services to the client; and
  2. Provide each human rights committee with a list of all clients who need special assistance who reside in the respective jurisdiction of the human rights committee.
- G. The Office of Human Rights shall promptly distribute to all appropriate human rights committees copies of all reports received according to this Chapter (e.g., reports regarding clients who need special assistance, allegations of mistreatment, denial of rights, restraint, and seclusion).
- Historical Note**
- Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-104 renumbered to R9-21-103; new Section R9-21-104 renumbered from R9-21-105 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).
- R9-21-105. Human Rights Committees**
- A. According to A.R.S. §§ 41-3803 and 41-3804, the Administration shall establish human rights committees to provide independent oversight to ensure that the rights of clients and enrolled children are protected. The Administration shall establish at least one human rights committee for each region and the Arizona State Hospital. Upon the establishment of a human rights committee, if more than 2,500 clients reside within a region, the Administration shall establish additional human rights committees until there is one human rights committee for each 2,500 clients in a region.
- B. Each human rights committee shall be composed of at least seven and not more than 15 members. At least two members of the committee shall be clients or former clients, at least two members shall be relatives of clients, two members shall be parents of enrolled children and at least three members shall have expertise in one of the following areas: psychology, law, medicine, education, special education, social work, or behavioral health services.
- C. The Administration shall appoint the initial members to each regional committee and the human rights committee for the Arizona State Hospital. Members shall be appointed to fill vacancies on a human rights committee, subject to the approval of the committee.
- D. Each committee shall meet at least four times each year. Within three months of its formation, each committee shall establish written guidelines governing the committee's operations. These guidelines shall be consistent with A.R.S. §§ 41-3803 and 41-3804. The adoption and amendment of the committee's guidelines shall be by a majority vote of the committee and shall be submitted to the Administration for approval.
- E. No employee or individual under contract with the Administration, regional authority, or service provider may be a voting member of a committee.
- F. If a member of a human rights committee or the human rights committee determines that a member has a conflict of interest regarding an agenda item, the member shall refrain from:
1. Participating in a discussion regarding the agenda item, and
  2. Voting on the agenda item.
- G. Each committee shall, within its respective jurisdiction, provide independent oversight and review of:
1. Allegations of illegal, dangerous, or inhumane treatment of clients and enrolled children;
  2. Reports filed with the committee under R9-21-203 and R9-21-204 concerning the use of seclusion, restraint, abuse, neglect, exploitation, mistreatment, accidents, or injuries;
  3. The provision of services to clients identified under R9-21-301 in need of special assistance
  4. Violations of rights of clients and enrolled children and conditions requiring investigation under Article 4 of this Chapter;
  5. Research in the field of mental health according to A.R.S. § 41-3804(E)(2); and
  6. Any other issue affecting the human rights of clients and enrolled children.
- H. Within its jurisdiction, each human rights committee shall, for a client who needs special assistance, and may, for other clients and enrolled children:
1. Make regular site visits to residential environments;
  2. Meet with the client, including a client who needs special assistance, in residential environments to determine satisfaction of the clients with the residential environments; and
  3. Inspect client records, including client records for clients who need special assistance, except as prohibited by federal or state law and a client's right to privacy.
- I. A committee may request the services of a consultant or staff person to advise the committee on specific issues. The cost of the consultant or staff person shall be assumed by the Administration or regional authority subject to the availability of funds specifically allocated for that purpose. A consultant or staff person may, in the sole discretion of the committee, be a member of another committee or an employee of the Administration, regional authority, or service provider. No committee consultant or staff person shall vote or otherwise direct the committee's decisions.
- J. Committee members and committee consultants and staff persons shall have access to client records according to A.R.S. §§ 36-509(A)(11) and 41-3804(I). If a human rights committee's request for information or records is denied, the committee may request a review of the decision to deny the request according to A.R.S. § 41-3804(J). Nothing in this rule shall be construed to require the disclosure of records or information to the extent that such information is protected by A.R.S. § 36-445 et seq.
- K. On the first day of the months of January, April, July, and October of each year, each committee shall issue a quarterly report summarizing its activities for the prior quarter, including any written objections to the Administration according to A.R.S. § 41-3804(F), and make any recommendations for changes it believes the Administration or regional authorities should implement. In addition, the committee may, as it deems appropriate, issue reports on specific problems or violations of client's rights. The report of a regional committee shall be delivered to the regional authority and the Administration.
- L. The Administration shall provide training and support to human rights committees.
- M. A human rights committee may request:
1. An investigation for a client according to Article 4 of this Chapter, or
  2. A regional authority or the Arizona State Hospital, as applicable, to conduct an investigation for an enrolled child.

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- N. The regional authority or the Arizona State Hospital, as applicable, when requested by a human rights committee, shall conduct an investigation concerning:
1. A client as provided in Article 4 of this Chapter, and
  2. An enrolled child.
- O. A human rights committee shall submit an annual report of the human rights committee's activities and recommendations to the Director at the end of each calendar year according to A.R.S. § 41-3804(G).

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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). Former Section R9-21-105 renumbered to R9-21-104; new Section R9-21-105 renumbered from R9-21-106 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

**R9-21-106. State Protection and Advocacy System**

Staff of mental health agencies shall cooperate with the State Protection and Advocacy System in its investigations and advocacy for clients and shall provide the System access to clients, records and facilities to the extent permitted and required by federal law, 42 U.S.C. 10801-10851. Nothing in this rule shall be construed to create an independent cause of action that does not already exist for the State Protection and Advocacy System either in state court or any administrative proceeding provided by these rules.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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 by exempt rulemaking at 7 A.A.R. 3469, effective July 17, 2001 (Supp. 01-3). Former Section R9-21-106 renumbered to R9-21-105; new Section R9-21-106 renumbered from R9-21-107 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

**R9-21-107. Renumbered****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Renumbered to R9-21-106 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

**ARTICLE 2. RIGHTS OF PERSONS WITH SERIOUS MENTAL ILLNESS****R9-21-201. Civil and Other Legal Rights**

- A. Clients shall have all rights accorded by applicable law, including but not limited to those prescribed in A.R.S. §§ 36-504 through 36-517.02. Any individual or agency providing behavioral health services or community services as defined in R9-21-101 shall not abridge these rights, including the following:
1. Those civil rights set forth in A.R.S. § 36-506;
  2. The right to acquire and dispose of property, to execute instruments, to enter into contractual relationships, to hold professional or occupational or vehicle operator's licenses, unless the client has been adjudicated incompetent or there has been a judicial order or finding that such client is unable to exercise the specific right or category of rights. In the case of a client adjudicated incompetent, these rights may be exercised by the client's guardian, in accordance with applicable law;
  3. The right to be free from unlawful discrimination by the Administration or by any mental health agency on the basis of race, creed, religion, sex, sexual preference, age, physical or mental handicap or degree of handicap; provided, however, classifications based on age, sex, category or degree of handicap shall not be considered discriminatory, if based on written criteria of client selection developed by a mental health agency and approved by the Administration as necessary to the safe operation of the mental health agency and in the best interests of the clients involved;
  4. The right to equal access to all existing behavioral health services, community services, and generic services provided by or through the state of Arizona;
  5. The right to religious freedom and practice, without compulsion and according to the preference of the client;
  6. The right to vote, unless under guardianship, including reasonable assistance when desired in registering and voting in a nonpartisan and noncoercive manner;
  7. The right to communicate including:
    - a. The right to have reasonable access to a telephone and reasonable opportunities to make and receive confidential calls and to have assistance when desired and necessary to implement this right;
    - b. The unrestricted right to send and receive uncensored and unopened mail, to be provided with stationery and postage in reasonable amounts, and to receive assistance when desired and necessary to implement this right;
  8. The right to be visited and visit with others, provided that reasonable restrictions may be placed on the time and place of the visit but only to protect the privacy of other clients or to avoid serious disruptions in the normal functioning of the mental health agency;
  9. The right to associate with anyone of the client's choosing, to form associations, and to discuss as a group, with those responsible for the program, matters of general interest to the client, provided that these do not result in serious disruptions in the normal functioning of the mental health agency. Clients shall receive cooperation from the mental health agency if they desire to publicize and hold meetings and clients shall be entitled to invite visitors to attend and participate in such meetings, provided that they do not result in serious disruptions in the normal functioning of the mental health agency;
  10. The right to privacy, including the right not to be fingerprinted and photographed without authorization, except as provided by A.R.S. § 36-507(2);
  11. The right to be informed, in appropriate language and terms, of client rights;
  12. The right to assert grievances with respect to infringement of these rights, including the right to have such grievances considered in a fair, timely, and impartial procedure, as set forth in Article 4 of these rules, and the right not to be retaliated against for filing a grievance;
  13. The right of access to a human rights advocate in order to understand, exercise, and protect a client's rights;

14. The right to be assisted by an attorney or designated representative of the client's own choice, including the right to meet in a private area at the program or facility with an attorney or designated representative. Nothing in this Chapter shall be construed to require the Administration or any mental health agency to pay for the services of an attorney who consults with or represents a client;
  15. The right to exercise all other rights, entitlements, privileges, immunities provided by law, and specifically those rights of consumers of behavioral health services or community services set forth in A.R.S. §§ 36-504 through 36-517.02;
  16. The same civil rights as all other citizens of Arizona, including the right to marry and to obtain a divorce, to have a family, and to live in the community of their choice without constraints upon their independence, except those constraints to which all citizens are subject.
- B.** Nothing in this Article shall be interpreted to:
1. Give the power, right, or authority to any person or mental health agency to authorize sterilization, abortion, or psychosurgery with respect to any client, except as may otherwise be provided by law; or
  2. Restrict the right of physicians, nurses, and emergency medical technicians to render emergency care or treatment in accordance with A.R.S. § 36-512; or
  3. Construe this rule to confer constitutional or statutory rights not already present.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

#### R9-21-202. Right to Support and Treatment

- A.** A client has the following rights with respect to the client's support and treatment:
1. The right to behavioral health services or community services:
    - a. Under conditions that support the client's personal liberty and restrict personal liberty only as provided by law or in this Chapter;
    - b. From a flexible service system that responds to the client's needs by increasing, decreasing and changing services as needs change;
    - c. Provided in a way that:
      - i. Preserves the client's human dignity;
      - ii. Respects the client's individuality, abilities, needs, and aspirations without regard to the client's psychiatric condition;
      - iii. Encourages the client's self-determination, freedom of choice, and participation in treatment to the client's fullest capacity;
      - iv. Ensures the client's freedom from the discomfort, distress and deprivation that arise from an unresponsive and inhumane environment;
      - v. Protects and promotes the client's privacy, including an opportunity whenever possible to be provided clearly defined private living, sleeping and personal care spaces; and
  2. Maximizes integration of the client into the client's community through housing and residential services which are located in residential neighborhoods, rely as much as possible on generic support services to provide training and assistance in ordinary community experiences, and utilize specialized mental health programs that are situated in or near generic community services;
  3. Offers the client humane and adequate support and treatment that is responsive to the client's needs, recognizes that the client's needs may vary, and is capable of adjusting to the client's changing needs; and
  4. That provide the client with an opportunity to:
    - i. Receive services that are adequate, appropriate, consistent with the client's individual needs, and least restrictive of the client's freedom;
    - ii. Receive treatment and services that are culturally sensitive in structure, process and content;
    - iii. Receive services on a voluntary basis to the maximum extent possible and entirely if possible;
    - iv. Live in the client's own home;
    - v. Undergo normal experiences, even though the experiences may entail an element of risk, unless the client's safety or well-being or that of others is unreasonably jeopardized; and
    - vi. Engage in activities and styles of living, consistent with the client's interests, which encourage and maintain the integration of the client into the community.
  5. The right to ongoing participation in the planning of services as well as participation in the development and periodic revision of the individual service plan;
  6. The right to be provided with a reasonable explanation of all aspects of one's condition and treatment;
  7. The right to give informed consent to all behavioral health services and the right to refuse behavioral health services in accordance with A.R.S. §§ 36-512 and 36-513, except as provided for in A.R.S. §§ 36-520 through 36-544 and 13-3994;
  8. The right not to participate in experimental treatment without voluntary, written informed consent; the right to appropriate protection associated with such participation; and the right and opportunity to revoke such consent;
  9. The right to a humane treatment environment that affords protection from harm, appropriate privacy, and freedom from verbal or physical abuse;
  10. The right to enjoy basic goods and services without threat of denial or delay. For residential service providers, these basic goods and services include at least the following:
    - a. A nutritionally sound diet of wholesome and tasteful food available at appropriate times and in as normal a manner as possible;
    - b. Arrangements for or provision of an adequate allowance of neat, clean, appropriate, and seasonable clothing that is individually chosen and owned;
    - c. Assistance in securing prompt and adequate medical care, including family planning services, through community medical facilities;
    - d. Opportunities for social contact in the client's home, work or schooling environments;
    - e. Opportunities for daily activities, recreation and physical exercise;

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- f. The opportunity to keep and use personal possessions; and
  - g. Access to individual storage space for personal possessions;
  - 8. The right to be informed, in advance, of charges for services;
  - 9. The right to a continuum of care in a unified and cohesive system of community services that is well integrated, facilitates the movement of clients among programs, and ensures continuity of care;
  - 10. The right to a continuum of care that consists of, but is not limited to, clinical case management, outreach, housing and residential services, crisis intervention and resolution services, mobile crisis teams, vocational training and opportunities, day treatment, rehabilitation services, peer support, social support, recreation services, advocacy, family support services, outpatient counseling and treatment, transportation, and medication evaluation and maintenance;
  - 11. The right to a continuum of care with programs that offer different levels of intensity of services in order to meet the individual needs of each client;
  - 12. The right to appropriate mental health treatment, based on each client's individual and unique needs, and to those community services from which the client would reasonably benefit;
  - 13. The right to community services provided in the most normal and least restrictive setting, according to the least restrictive means appropriate to the client's needs;
  - 14. The right to clinical case management services and a case manager. The clinical team negotiates and oversees the provision of services and ensures the client's smooth transition with service providers and among agencies;
  - 15. The right to participate in treatment decisions and in the development and implementation of the client's ISP, and the right to participate in choosing the type and location of services, consistent with the ISP;
  - 16. The right to prompt consideration of discharge from an inpatient facility and the identification of the steps necessary to secure a client's discharge as part of an ISP;
  - 17. The rights prescribed in Articles 3 and 4 of this Chapter, including the right to:
    - a. A written individual service plan;
    - b. Assert grievances; and
    - c. Be represented by a qualified advocate or other designated representative of the client's choosing in the development of the ISP and the inpatient treatment and discharge plan and in the grievance process, in order to understand, exercise and protect the client's rights.
- B.** Subsection (A) shall not be construed to confer constitutional or statutory rights not already present.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

**R9-21-203. Protection from Abuse, Neglect, Exploitation, and Mistreatment**

- A.** No mental health agency shall mistreat a client or permit the mistreatment of a client by staff subject to its direction. Mistreatment includes any intentional, reckless or negligent action

or omission which exposes a client to a serious risk of physical or emotional harm. Mistreatment includes but is not limited to:

1. Abuse, neglect, or exploitation;
  2. Corporal punishment;
  3. Any other unreasonable use or degree of force or threat of force not necessary to protect the client or another person from bodily harm;
  4. Infliction of mental or verbal abuse, such as screaming, ridicule, or name calling;
  5. Incitement or encouragement of clients or others to mistreat a client;
  6. Transfer or the threat of transfer of a client for punitive reasons;
  7. Restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
  8. Any act in retaliation against a client for reporting any violation of the provisions of this Chapter to the Administration; or
  9. Commercial exploitation.
- B.** The following special sanctions shall be available to the Department and/or the Administration, in addition to those set forth in 9 A.A.C. 10, Article 10 of the Department's rules, to protect the interests of the client involved as well as other current and former clients of the mental health agency.
1. Mistreatment of a client by staff or persons subject to the direction of a mental health agency may be grounds for suspension or revocation of the license of the mental health agency or the provision of financial assistance, and, with respect to employees of the mental health agency, grounds for disciplinary action, which may include dismissal.
  2. Failure of an employee of the Administration to report any instance of mistreatment within any mental health agency subject to this Chapter shall be grounds for disciplinary action, which may include dismissal.
  3. Failure of a mental health agency to report client deaths and allegations of sexual and physical abuse to the Administration and to comply with the procedures described in Article 4 of this Chapter for the processing and investigation of grievances and reports shall be grounds for suspension of the license of the mental health agency or the provision of financial assistance, and, with respect to a service provider directly operated by the Department, grounds for disciplinary action, which may include dismissal.
  4. A mental health agency shall report all allegations of mistreatment and denial of rights to the Office of Human Rights and the regional authority for review and monitoring in accordance with R9-21-105.
- C.** A mental health agency shall report all incidents of abuse, neglect, or exploitation to the appropriate authorities as required by A.R.S. § 46-454 and shall document all such reports in the mental health agency's records.
- D.** If a mental health agency has reasonable cause to believe that a felony relevant to the functioning of the program has been committed by staff persons subject to the agency's direction, a report shall be filed with the county attorney.
- E.** The identity of persons making reports of abuse, neglect, exploitation, or mistreatment shall not be disclosed by the mental health agency or by the Administration, except as necessary to investigate the subject matter of the report.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under

## Arizona Health Care Cost Containment System (AHCCCS) - Behavioral Health Services for Persons with Serious Mental Illness

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 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

**R9-21-204. Restraint and Seclusion**

- A.** A mental health agency shall only use restraint or seclusion to the extent permitted by and in compliance with this Chapter, and other applicable federal or state law.
- B.** A mental health agency shall only use restraint or seclusion:
1. To ensure the safety of the client or another individual in an emergency safety situation;
  2. After other available less restrictive methods to control the client's behavior have been tried and were unsuccessful;
  3. Until the emergency safety situation ceases and the client's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired; and
  4. In a manner that:
    - a. Prevents physical injury to the client,
    - b. Minimizes the client's physical discomfort and mental distress, and
    - c. Complies with the mental health agency's policies and procedures required in subsection (E) and with this Section.
- C.** A mental health agency shall not use restraint or seclusion as a means of coercion, discipline, convenience, or retaliation.
- D.** A service provider shall at all times have staff qualified on duty to provide:
1. Restraint and seclusion according to this Section, and
  2. The behavioral health services the mental health agency is authorized to provide.
- E.** A mental health agency shall develop and implement written policies and procedures for the use of restraint and seclusion that are consistent with this Section and other applicable federal or state law and include:
1. Methods of controlling behavior that may prevent the need for restraint or seclusion,
  2. Appropriate techniques for placing a client in each type of restraint or seclusion; used at the mental health agency, and
  3. Immediate release of a client during an emergency.
- F.** A mental health agency shall develop and implement a training program on the policies and procedures in subsection (E).
- G.** A mental health agency shall only use restraint or seclusion according to:
1. A written order given:
    - a. By a physician providing treatment to a client; or
    - b. If a physician providing treatment to a client is not present on the premises or on-call:
      - i. If the agency is licensed as a level 1 psychiatric acute hospital, by a physician or a nurse practitioner; or
      - ii. If the agency is licensed as a level 1 subacute agency or a level 1 RTC, by a medical practitioner.
  2. An oral order given to a nurse by:
    - a. A physician providing treatment to a client, or
    - b. If a physician providing treatment to a client is not present on the premises or on-call:
      - i. If the agency is licensed as a level 1 psychiatric acute hospital, by a physician or a nurse practitioner; or
      - ii. If the agency is licensed as a level 1 sub-acute agency or a level 1 RTC, by a medical practitioner.
- H.** If a restraint or seclusion is used according to subsection (G)(2), the individual giving the order shall, at the time of the oral order in consultation with the nurse, determine whether, based upon the client's current and past medical, physical and psychiatric condition, it is clinically necessary for:
1. If the agency is licensed as a level 1 psychiatric acute hospital, a physician to examine the client as soon as possible and, if applicable, the physician shall examine the client as soon as possible; or
  2. If the agency is licensed as a level 1 sub-acute agency or a level 1 RTC, a medical practitioner to examine the client as soon as possible and, if applicable, the medical practitioner shall examine the client as soon as possible.
- I.** An individual who gives an order for restraint or seclusion shall:
1. Order the least restrictive restraint or seclusion that may resolve the client's behavior that is creating the emergency safety situation, based upon consultation with a staff member at the agency;
  2. Be available to the agency for consultation, at least by telephone, throughout the period of the restraint or seclusion;
  3. Include the following information on the order:
    - a. The name of the individual ordering the restraint or seclusion,
    - b. The date and time that the restraint or seclusion was ordered,
    - c. The restraint or seclusion ordered,
    - d. The criteria for release from restraint or seclusion without an additional order, and
    - e. The maximum duration for the restraint or seclusion;
  4. If the order is for mechanical restraint or seclusion, limit the order to a period of time not to exceed three hours.
  5. If the order is for a drug used as a restraint, limit the:
    - a. Dosage to that necessary to achieve the desired effect, and
    - b. Drug ordered to a drug other than a time-released drug designed to be effective for more than three hours; and
  6. If the individual ordering the use of restraint or seclusion is not a physician providing treatment to the client:
    - a. After ordering the restraint or seclusion, consult with the physician providing treatment as soon as possible, and
    - b. Inform the physician providing treatment of the client's behavior that created the emergency safety situation and required the client to be restrained or placed in seclusion.
- J.** PRN orders shall not be used for any form of restraint or seclusion.
- K.** If an individual has not examined the client according to subsection (H), the following individual shall conduct a face-to-face assessment of a client's physical and psychological well-being within one hour after the initiation of restraint or seclusion:
1. For a behavioral health agency licensed as a level 1 psychiatric acute hospital, a physician or nurse practitioner who is either on-site or on-call at the time the mental health agency initiates the restraint or seclusion; or
  2. For a behavioral health agency licensed as a level 1 RTC or a level 1 sub-acute agency a medical practitioner or a registered nurse with at least one year of full time behavioral health work experience, who is either on-site or on-

- call at the time the mental health agency initiates the restraint or seclusion.
- L.** A face-to-face assessment of a client according to subsection (K) shall include a determination of:
1. The client's physical and psychological status,
  2. The client's behavior,
  3. The appropriateness of the restraint or seclusion used,
  4. Whether the emergency safety situation has passed, and
  5. Any complication resulting from the restraint or seclusion used.
- M.** For each restraint or seclusion of a client, a mental health agency shall include in the client's record the order and any renewal order for the restraint or seclusion, and shall document in the client's record:
1. The nature of the restraint or seclusion;
  2. The reason for the restraint or seclusion, including the facts and behaviors justifying it;
  3. The types of less restrictive alternatives that were attempted and the reasons for the failure of the less restrictive alternatives;
  4. The name of each individual authorizing the use of restraint or seclusion and each individual restraining or secluding a client or monitoring a client who is in restraint or seclusion;
  5. The evaluation and assessment of the need for seclusion or restraint conducted by the individual who ordered the restraint or seclusion;
  6. The determination and the reasons for the determination made according to subsection (H);
  7. The specific and measurable criteria for client release from mechanical restraint or seclusion with documentation to support that the client was notified of the release criteria and the client's response;
  8. The date and times the restraint or seclusion actually began and ended;
  9. The time and results of the face-to-face assessment required in subsection (L);
  10. For the monitoring of a client in restraint or seclusion required by subsection (P):
    - a. The time of the monitoring,
    - b. The name of the staff member who conducted the monitoring, and
    - c. The observations made by the staff member during the monitoring; and
  11. The outcome of the restraint or seclusion.
- N.** If, at any time during a seclusion or restraint, a medical practitioner or registered nurse determines that the emergency which justified the seclusion or restraint has subsided, or if the required documentation reflects that the criteria for release have been met, the client shall be released and the order terminated. The client shall be released no later than the end of the period of time ordered for the restraint or seclusion, unless a the order for restraint or seclusion is renewed according to subsection (Q).
- O.** For any client in restraint, the individual ordering the restraint shall determine whether one-to-one supervision is clinically necessary and shall document the determination and the reasons for the determination in the client's record.
- P.** A mental health agency shall monitor a client in restraint or seclusion as follows:
1. The client shall be personally examined at least every 15 minutes for the purpose of ensuring the client's general comfort and safety and determining the client's need for food, fluid, bathing, and access to the toilet. Personal examinations shall be conducted by staff members with documented training in the appropriate use of restraint and seclusion and who are working under the supervision of a licensed physician, nurse practitioner or registered nurse.
  2. A registered nurse shall personally examine the client every hour to assess the status of the client's mental and physical condition and to ensure the client's continued well-being.
  3. If the client has any medical condition that may be adversely affected by the restraint or seclusion, the client shall be monitored every five minutes, until the medical condition resolves, if applicable.
  4. If other clients have access to a client being restrained or secluded or, if the individual ordering the restraint or seclusion determines that one-to-one supervision is clinically necessary according to subsection (O), a staff member shall continuously supervise the client on a one-to-one basis.
  5. If a mental health agency maintains a client in a mechanical restraint, a staff member shall loosen the mechanical restraints every 15 minutes.
  6. Nutritious meals shall not be withheld from a client who is restrained or secluded, if mealtimes fall during the period of restraint. Staff shall supervise all meals provided to the client while in restraint or seclusion.
  7. At least once every two hours, a client who is restrained or secluded shall be given the opportunity to use a toilet.
- Q.** An order for restraint or seclusion may be renewed as follows:
1. For the first renewal order, the order shall meet the requirements of subsection (G)(1) or (G)(2); and
  2. For a renewal order subsequent to the first renewal order:
    - a. The individual in (G)(1) or (G)(2) shall personally examine the client before giving the renewal order, and
    - b. The order shall not permit the continuation of the restraint or seclusion for more than 12 consecutive hours unless the requirements of subsection (P) are met.
- R.** No restraint or seclusion shall continue for more than 12 consecutive hours without the review and approval by the medical director or designee of the mental health agency in consultation with the client and relevant staff to discuss and evaluate the needs of the client. The review and approval, if any, and the reasons justifying any continued restraint or seclusion shall be documented in the client's record.
- S.** If a client requires the repeated or continuous use of restraint or seclusion during a 24-hour period, a review process shall be initiated immediately and shall include the client and all relevant staff persons and clinical consultants who are available to evaluate the need for an alternative treatment setting and the needs of the client. The review and its findings and recommendations shall be documented in the client's record.
- T.** Whenever a client is subjected to extended or repeated orders for restraint or seclusion during a 30-day period, the medical director shall require a special meeting of the client's clinical team according to R9-21-314 to determine whether other treatment interventions would be useful and whether modifications of the ISP or ITDP are required.
- U.** As part of a mental health agency's quality assurance program, an audit will be conducted and a report filed with the agency's medical director within 24 hours, or the first working day, for every episode of the use of restraint or seclusion to ensure that the agency's use of seclusion or restraint is in full compliance with the rules set forth in this Article.
- V.** Not later than the tenth day of every month, the program director shall prepare and file with the Administration and the Office of Human Rights a written report describing the use of

any form of restraint or seclusion during the preceding month in the mental health agency or by any employees of the agency. In the case of an inpatient facility, the report shall also be filed with any patient or human rights committee for that facility.

- W. The Office of Human Rights, and any applicable human rights committee shall review such reports to determine if there has been any inappropriate or unlawful use of restraint or seclusion and to determine if restraint or seclusion may be used in a more effective or appropriate fashion.
- X. If any human rights committee or the Office of Human Rights determines that restraint or seclusion has been used in violation of any applicable law or rule, the committee or Office may take whatever action is appropriate, including investigating the matter itself or referring the matter to the Administration for remedial action.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

#### R9-21-205. Labor

- A. No client shall be required to perform labor which involves the essential operation and maintenance of the service provider or the regular care, treatment or supervision of other clients, provided however, that:
  1. Only a residential service provider may require clients to perform activities related to maintaining their bedrooms, other personal areas, and their clothing and personal possessions in a neat and clean manner.
  2. Clients may perform labor in accordance with a planned and supervised program of vocational and rehabilitation training as set forth in an ISP or ITDP developed according to Article 3 of this Chapter.
- B. Any client may voluntarily perform any labor available.
- C. The requirements of federal and state laws relating to wages, hours of work, workers' compensation and other labor standards shall be met with respect to all labor.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

#### R9-21-206. Competency and Consent

- A. A client shall not be deemed incompetent to manage the client's affairs, to contract, to hold professional, occupational or vehicle operator's licenses, to make wills, to vote or to exercise any other civil or legal right solely by reason of admission to a mental health agency.
- B. An applicant or client is presumed to be legally competent to conduct the client's personal and financial affairs, unless otherwise determined by a court in a guardianship or conservatorship proceeding.
- C. Only an applicant or client who is competent may provide informed consent, authorization, or permission as required in this Chapter. A mental health agency shall use the following

criteria to determine if an applicant or client is competent and the appropriateness of establishing or removing a guardianship, temporary guardianship, conservatorship, or guardianship ad litem for the client:

1. An applicant or client shall be determined to be in need of guardianship or conservatorship only if the applicant's or client's ability to make important decisions concerning the applicant or client or the applicant's or client's property is so limited that the absence of a person with legal authority to make such decisions for the applicant or client creates a serious risk to the applicant's or client's health, welfare or safety.
  2. Although the capability of the applicant or client to make important decisions is the central factor in determining the need for guardianship, the capabilities of the applicant's or client's family, the applicant's or client's living circumstances, the probability that available treatment will improve the applicant's or client's ability to make decisions on the applicant's or client's behalf, and the availability and utility of nonjudicial alternatives to guardianships such as trusts, representative payees, citizen advocacy programs, or community support services should also be considered.
  3. If the applicant or client has been determined to be incapable of making important decisions with regard to the applicant's or client's personal or financial affairs, and if nonjudicial, less restrictive alternatives such as trusts, representative payees, cosignatory bank accounts, and citizen advocates are inadequate to protect the applicant or client from a substantial and unreasonable risk to the applicant's or client's health, safety, welfare, or property, the applicant's or client's nearest living relatives shall be notified with an accompanying recommendation that a guardian or conservator be appointed.
  4. If the applicant or client is capable of making important decisions concerning the applicant's or client's health, welfare, and property, either independently or through other less restrictive alternatives such as trusts, representative payees, cosignatory bank accounts, and citizen advocates, the applicant's or client's nearest living relative shall be notified with an accompanying recommendation that any existing guardian or conservator be removed.
  5. If the client has been determined to require or no longer require assistance in the management of financial or personal affairs, and the nearest living relative cannot be found or is incapable of or not interested in caring for the client's interest, the mental health agency shall assist in the recruitment or removal of a trustee, representative payee, advocate, conservator, or guardian. Nothing in this Chapter shall be construed to require the Administration or any regional authority or service provider to pay for the recruitment, appointment or removal of a trustee, representative payee, advocate, conservator, or guardian.
  6. The assessment or periodic review shall identify the specific area or areas of the client's functioning that forms the basis of the recommendation for the appointment or removal of a guardian or conservator, such as an inability to respond appropriately to health problems or consent to medical care, or an inability to manage savings or routine expenses.
- D. Mental health agencies shall devise and implement procedures to ensure that suspected improprieties of a guardian, conservator, trustee, representative payee, or other fiduciary are reported to the court or other appropriate authorities.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

**R9-21-206.01. Informed Consent**

- A.** Except in an emergency according to A.R.S. §§ 36-512 or 36-513 or R9-21-204, or a court order according to A.R.S. Title 36, Chapter 5, Articles 4 and 5, a mental health agency shall obtain written informed consent in at least the following circumstances:
1. Before providing a client a treatment with known risks or side effects, including:
    - a. Psychotropic medication,
    - b. Electro-convulsive therapy, or
    - c. Telemedicine;
  2. Before a client participates in research activities; and
  3. Before admitting a client to any medical detoxification, inpatient facility, or residential program operated by a mental health agency.
- B.** The informed consent in subsection (A) shall be voluntary and shall be obtained from:
1. The client, if the client is determined to be competent according to R9-21-206; or
  2. The client's guardian, if a court of competent jurisdiction has adjudicated the client incompetent.
- C.** If informed consent is required according to subsection (A), a medical practitioner or a registered nurse with at least one year of behavioral health experience shall, before obtaining the informed consent, provide a client or, if applicable, the client's guardian with the following information:
1. The client's diagnosis;
  2. The nature of and procedures involved with the proposed treatment, the client's participation in a research activity, or the client's admission to a program operated by a mental health agency;
  3. The intended outcome of the proposed treatment, the client's participation in a research activity, or the client's admission to a program operated by a mental health agency;
  4. The risks, including any side effects, of the proposed treatment, the client's participation in a research activity, or the client's admission to a program operated by a mental health agency;
  5. The risks of not proceeding with the proposed treatment, the client's participation in a research activity, or the client's admission to a program operated by a mental health agency;
  6. The alternatives to the proposed treatment, the client's participation in a research activity, or the client's admission to a program operated by a mental health agency, particularly alternatives offering less risk or other adverse effects;
  7. That any informed consent given may be withheld or revoked orally or in writing at any time, with no punitive action taken against the client;
  8. The potential consequences of revoking the informed consent; and
  9. A description of any clinical indications that might require suspension or termination of the proposed treatment, research activity, or program operated by a mental health agency.

- D.** A client or, if applicable, the client's guardian who gives informed consent for a treatment, participation in a research activity, or admission in a program operated by a mental health agency, shall give the informed consent by:
1. Signing and dating an acknowledgment that the client or, if applicable, the client's guardian has received the information in subsection (C) and gives informed consent to the proposed treatment, participation in a research activity, or admission of the client to the program operated by a mental health agency; or
  2. If the informed consent is for use of psychotropic medication or telemedicine and the client or, if applicable the client's guardian, refuses to sign an acknowledgement according to subsection (D)(1), giving verbal informed consent.
- E.** If a client or, if applicable, a client's guardian gives verbal informed consent according to subsection (D)(2), a medical practitioner shall document in the client's record that:
1. The information in subsection (C) was given to the client or, if applicable, the client's guardian;
  2. The client or, if applicable, the client's guardian refused to sign an acknowledgement according to subsection (D)(1); and
  3. The client or, if applicable, the client's guardian gives informed consent to the use of the psychotropic medication or telemedicine.
- F.** A client or, if applicable, the client's guardian may revoke informed consent at any time orally or by submitting a written statement revoking the informed consent.
- G.** If informed consent is revoked according to subsection (F):
1. The treatment, the client's participation in a research activity, or the applicant's or client's admission to a program operated by a mental health agency shall be immediately discontinued, or
  2. If abrupt discontinuation of a treatment poses an imminent risk to a client, the treatment shall be phased out to avoid any harmful effects.
- H.** If a client or, if applicable, the client's guardian needs assistance with revoking informed consent according to subsection (F), the client or, if applicable, the client's guardian shall receive the assistance.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

**R9-21-207. Medication**

- A.** Medication shall only be administered with the informed consent of the client or Title 36 guardian. Information relating to common risks and side effects of the medication, the procedures to be taken to minimize such risks, and a description of any clinical indications that might require suspension or termination of the drug therapy shall be available to the client, guardian, if any, and the staff in every mental health agency. Such information shall be available to family members in accordance with A.R.S. §§ 36-504, 36-509, and 36-517.01.
- B.** All clients have a right to be free from unnecessary or excessive medication.
- C.** Medication shall not be used as punishment, for the convenience of the staff, or as a substitute for other behavioral health services and shall be given in the least amount medically necessary with particular emphasis placed on minimizing side effects which otherwise would interfere with aspects of treatment.

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- D.** Medication administered by a mental health agency shall be prescribed by a licensed physician, certified physician assistant, or a licensed nurse practitioner.
1. Psychotropic medication shall be prescribed by:
    - a. A psychiatrist who is a licensed physician; or
    - b. A licensed nurse practitioner, certified physician assistant, or physician trained or experienced in the use of psychotropic medication, who has seen the client and is familiar with the client's medical history or, in an emergency, is at least familiar with the client's medical history.
  2. Each client receiving psychotropic medication shall be seen monthly or as indicated in the client's ISP by a licensed nurse practitioner, certified physician's assistant or physician prescribing the medication, who shall note in the client's record:
    - a. The appropriateness of the current dosage,
    - b. All medication being taken by the client and the appropriateness of the mixture of medications,
    - c. Any signs of tardive dyskinesia or other side effects,
    - d. The reason for the use of the medication, and
    - e. The effectiveness of the medication.
  3. When a client on psychotropic medication receives a yearly physical examination, the results of the examination shall be reviewed by the physician prescribing the medication. The physician shall note any adverse effects of the continued use of the prescribed psychotropic medication in the client's record.
  4. Whenever a prescription for medication is written or changed, a notation of the medication, dosage, frequency of administration, and the reason why the medication was ordered or changed shall be entered in the client's record.
- E.** Self-administration of medication by clients shall be permitted unless otherwise restricted by the responsible physician or licensed nurse practitioner. Such clients shall be trained in self-administration of medication and, if necessary, shall be monitored by trained staff.
- F.** Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation and security.
- G.** PRN orders for medication shall not be given for a drug used as a restraint.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

**R9-21-208. Property and Possessions**

- A.** No mental health agency shall interfere with a client's right to acquire, retain and dispose of personal property, including the right to maintain an individual bank account, except where:
1. The client is under guardianship, conservatorship, or has a representative payee;
  2. Otherwise ordered by court; or
  3. A particular object, other than money or personal funds, poses an imminent threat of serious physical harm to the client or others. Any restriction on the client's control of property deemed to pose an imminent threat of serious physical harm shall be recorded in the client's record together with the reasons the particular object poses an imminent threat of serious physical harm to the client or others.
- B.** If a mental health agency, which offers assistance to its clients in managing their funds, takes possession or control of a client's funds at the request of the client, guardian, or by court order, the mental health agency shall issue a receipt to the client or guardian for each transaction involving such funds. If deposited funds in excess of \$250 are held by the mental health agency, where the likelihood of the client's stay will exceed 30 days, an individual bank account or an amalgamated client trust account shall be maintained for the benefit of the client. All interest shall become the property of the client or the fair allocation of the interest in the case of an amalgamated client trust account. The mental health agency shall provide a bond to cover client funds held.
1. Unless a guardian, conservator, or representative payee has been appointed, the client shall have an unrestricted right to manage and spend deposited funds.
  2. The mental health agency shall obtain prior written permission from the client, the guardian or conservator for any arrangement involving shared or delegated management responsibilities. The permission shall set forth the terms and conditions of the arrangement.
  3. Where the mental health agency has shared or delegated management responsibilities, the mental health agency shall meet the following requirements:
    - a. Client funds shall not be applied to goods or services which the mental health agency is obligated by law or funded by contract to provide, except as permitted by a client fee schedule authorized by the Administration;
    - b. The mental health agency and its staff shall have no direct or indirect ownership or survivorship interest in the funds;
    - c. Such arrangements shall be accompanied by a training program, documented in the ISP, to eliminate the need for such assistance;
    - d. Staff shall not participate in arrangements for shared or delegated management of the client's funds except as representatives of the mental health agency;
    - e. Any arrangements made to transfer a client from one mental health agency to another shall include provisions for transferring shared or delegated management responsibilities to the receiving mental health agency;
    - f. The client shall be informed of all proposed expenditures and any expression of preference within reason shall be honored; and
    - g. Expenditures shall be made only for purposes which directly benefit the client in accordance with the client's interests and desires.
  4. A record shall be kept of every transaction involving deposited funds, including the date and amount received or disbursed, and the name of the person to or from whom the funds are received or disbursed. The client, guardian, conservator, mental health agency or regional human rights advocate or other representative may demand an accounting at any reasonable time, including at the time of the client's transfer, discharge or death.
  5. Any funds so deposited shall be treated for the purpose of collecting charges for care the same as any other property held by or on behalf of the client. The client or guardian shall be informed of any possible charges before the onset of services.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

**R9-21-209. Records**

- A.** Records of a client who is currently receiving or has received services from a mental health agency are private and shall be disclosed only to those individuals authorized according to federal and state law.
- B.** Inspection by the client, the client's guardian, attorney, paralegal working under the supervision of an attorney, or any other designated representative shall be permitted as follows:
1. Except as prohibited by federal and state law, the client and, if applicable, the client's guardian shall be permitted to inspect and copy the client's record as soon as possible after a request, and no later than 10 working days after a request. If any portion of the client record is withheld under federal or state law, the mental health agency shall provide written notice to the client or, if applicable, the client's guardian including:
    - a. The reason the mental health agency is withholding a portion of the client's record,
    - b. An explanation of the client's right to a review of the decision to withhold a portion of the client's record, and
    - c. An explanation of the client's right to file a grievance according to Article 4 of this Chapter.
  2. An attorney, paralegal working under the supervision of an attorney, or other designated representative of the client shall be permitted to inspect and copy the record, if such attorney or representative furnishes written authorization from the client or guardian.
  3. When necessary for the understanding of the client or guardian and, if the client or the client's guardian provides authorization, when necessary for the understanding of an attorney, paralegal working under the supervision of an attorney, or designated representative, staff of the mental health agency possessing the records shall read or interpret the record for the client, guardian, attorney, paralegal working under the supervision of an attorney, or designated representative.
- C.** Inspection by specially authorized persons or entities shall be permitted as follows unless otherwise prohibited by federal or state law:
1. Records of a client may be available to those individuals and agencies listed in A.R.S. § 36-509.
  2. Records of a client shall be open to inspection upon proper judicial order, whether or not such order is made in connection with pending judicial proceedings.
  3. Records of a client shall be made available to a physician who requests such records in the treatment of a medical emergency, provided that the client is given notice of such access as soon as possible.
  4. Records of a client shall be made available to staff authorized by the Administration to monitor the quality of services being provided by the mental health agency to the client.
  5. Records of a client shall be made available to guardians and family members actively participating in the client's care, treatment or supervision as provided by A.R.S. §§ 36-504, 36-509(A)(8) and (B). Except when inspection of a client's record is required under a proper judicial order

or by a physician in a medical emergency, a client, guardian or family member may challenge the decision to allow or deny inspection of the record by filing a request for administrative and judicial review in accordance with the provisions of A.R.S. § 36-517.01 or other applicable federal or state law. Once a request is filed, no further disclosure of records shall be made until the review has been completed.

- D.** Unless otherwise permitted by federal or state law, records shall be open to inspection by other third parties only upon the authorization of the client or guardian. Before authorization is given, the client or guardian shall be offered an opportunity to examine the information to be disclosed and be provided with the name of the recipient and uses to be made of the information.
- E.** The fee for copying records obtained under this rule shall be no more than the actual expense of reproducing the record or the requested parts and may be limited further by A.R.S. § 12-2295.
- F.** A client or guardian shall be informed of a court order or subpoena commanding production of a client's record as soon as possible and in any event prior to the date for production and of the client's or guardian's right to request the court to quash or modify the order or subpoena.
- G.** The records maintained by the mental health agency shall contain accurate, complete, timely, pertinent, and relevant information.
  1. If a client or guardian believes that the record contains inaccurate or misleading information, the client or guardian may prepare, with assistance if requested, a statement of disagreement which shall be entered in the record.
  2. If a client or guardian objects to the collection of the information in the record, the client or guardian may file a grievance according to Article 4 of this Chapter.
- H.** A list shall be kept of every person or organization who inspects the client's records, other than the client's clinical team, the uses to be made of that information, and the person authorizing access. A list of such access shall be placed in the client's record and shall be made available to the client or other designated representative.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

**R9-21-210. Policies and Procedures of Service Providers**

- A.** A mental health agency may establish policies and procedures for the provision of behavioral health services or community services that are consistent with Articles 1 through 5 of these rules and with all other requirements of Arizona law. No policy or procedure may restrict any right protected by these rules.
- B.** The mental health agency shall inform all prospective clients of its policies and procedures prior to the client or, if applicable, the client's guardian giving informed consent to the client's admission to the program according to R9-21-206.01(A)(3).
- C.** If a client acts in a manner that is seriously in disregard of a reasonable policy, the agency director shall make all reason-

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able efforts to respond to the situation, including making reasonable accommodation to the program's policy if the client's failure to conform to a reasonable policy is due to the client's disability.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

**R9-21-211. Notice of Rights**

- A.** Every mental health agency shall provide written notice of the civil and legal rights of its clients by posting a copy of ADHS Form MH-211, "Notice of Client's Rights," set forth in Exhibit A, in one or more areas of the agency so that it is readily visible to clients and visitors.
- B.** In addition to posting as required by subsection (A), a copy of ADHS Form MH-211, set forth in Exhibit B, shall be given to each client, or guardian if any, at the time of admission to the agency for evaluation or treatment. The person receiving the notice shall be required to acknowledge in writing receipt of the notice and the acknowledgment shall be retained in the client's record.
- C.** Every mental health agency shall provide written notice of the terms of A.R.S. § 36-506 to each client upon discharge by giving the client a copy of ADHS Form MH-209, "Discrimination Prohibited".
- D.** All notices required by this rule shall be provided and posted in both English and Spanish.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

**Exhibit A. Notice of Legal Rights for Persons with Serious Mental Illness**

If you have a serious or chronic mental illness, you have legal rights under federal and state law. Some of these rights include:

- The right to appropriate mental health services based on your individual needs;
- The right to participate in all phases of your mental health treatment, including individual service plan (ISP) meetings;
- The right to a discharge plan upon discharge from a hospital;
- The right to consent to or refuse treatment (except in an emergency or by court order);
- The right to treatment in the least restrictive setting;
- The right to freedom from unnecessary seclusion or restraint;
- The right not to be physically, sexually, or verbally abused;
- The right to privacy (mail, visits, telephone conversations);
- The right to file an appeal or grievance when you disagree with the services you receive or your rights are violated;
- The right to choose a designated representative(s) to assist you in ISP meetings and in filing grievances;
- The right to a case manager to work with you in obtaining the services you need;
- The right to a written ISP that sets forth the services you will receive;

- The right to associate with others;
- The right to confidentiality of your psychiatric records;
- The right to obtain copies of your own psychiatric records (unless it would not be in your best interests to have them);
- The right to appeal a court-ordered involuntary commitment and to consult with an attorney and to request judicial review of court-ordered commitment every 60 days;
- The right not to be discriminated against in employment or housing.

If you would like information about your rights, you may request a copy of the "Your Rights in Arizona as an Individual with Serious Mental Illness" brochure or you may also call Administration, Office of Human Rights at 1-800-421-2124.

ADHS/BHS Form MH-211 (9/93)

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 21, 1992 (Supp. 92-4). 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 by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

**Exhibit B. Notice of Legal Rights for Persons with Serious Mental Illness****NOTICE****Discrimination Prohibited**

Pursuant to A.R.S. § 36-506 and R9-21-101(B)

- A.** Persons undergoing evaluation or treatment pursuant to this Chapter shall not be denied any civil right, including, but not limited to, the right to dispose of property, sue and be sued, enter into contractual relationships and vote. Court-ordered treatment or evaluation pursuant to this Chapter is not a determination of legal incompetency, except to the extent provided in A.R.S. § 36-512.
- B.** A person who is or has been evaluated or treated in an agency for a mental disorder shall not be discriminated against in any manner, including but not limited to:
1. Seeking employment.
  2. Resuming or continuing professional practice or previous occupation.
  3. Obtaining or retaining housing.
  4. Obtaining or retaining licenses or permits, including but not limited to, motor vehicle licenses, motor vehicle operator's and chauffeur's licenses and professional or occupational licenses.
- C.** "Discrimination" for purposes of this Section means any denial of civil rights on the grounds of hospitalization or outpatient care and treatment unrelated to a person's present capacity to meet the standards applicable to all persons. Applications for positions, licenses and housing shall contain no requests for information which encourage such discrimination.
- D.** Upon discharge from any treatment or evaluation agency, the patient shall be given written notice of the provisions of this Section.

**AVISO****Discriminacion Prohibida**

Conforme a A.R.S. § 36-506 y R9-21-101(B)

- A.** A las personas que estan bajo evaluacion o tratamiento conforme a este capitulo, no se les negara ningun derecho civil, incluyendo pero no limitado a, el derecho a disponer de propiedad, a demandar y ser demandado, a tomar parte en rela-

ciones contractuales y a votar. El tratamiento o evaluacion ordenado por la corte conforme a este capitulo no es una determinacion de incompetencia legal, excepto hasta el punto proveido en la seccion 36-512.

- B.** No se haran discriminaciones de ninguna clase, en contra de una persona que ha sido o esta siendo evaluada o tratada en una agencia debido a un desorden mental, incluyendo pero no limitado a:
1. Buscar trabajo.
  2. Reasumir o continuar una practica profesional u ocupacion previa.
  3. Obtener o retener vivienda.
  4. Obtener o retener licencias o permisos, incluyendo pero no limitado a, licencias para vehiculo de motor, licencias de operador de vehiculo de motor y de chofer, y licencias ocupacionales o profesionales.
- C.** "Discriminacion" para propositos de esta seccion quiere decir cualquier denegacion de derechos civiles por motivos de hospitalizacion o tratamiento externo no relacionado a la capacidad actual de la persona para cumplir con las normas aplicables a toda persona. Las solicitudes para posiciones, licencias y vivienda no contendran peticion de informacion que pueda fomentar tal discriminacion.
- D.** Al ser dado de alta de cualquier agencia de tratamiento o evaluacion, se dara al paciente notificacion por escrito sobre las provisiones de esta seccion.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

### ARTICLE 3. INDIVIDUAL SERVICE PLANNING FOR BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

#### R9-21-301. General Provisions

- A.** Responsibilities of the regional authority, clinical team, and case manager.
1. The regional authority is responsible for providing, purchasing, or arranging for all services identified in ISPs.
    - a. The regional authority shall perform all intake and case management for its region. The regional authority may contract with a mental health agency to perform intake or case management but only with the written approval of the Administration, which may be given in its sole discretion.
    - b. Other services may be provided directly by programs operated by the Administration or by the regional authority through contracts with service providers, or through arrangements with other agencies or generic providers.
  2. The regional authority and the clinical team shall work diligently to ensure equal access to generic services for its clients in order to integrate the client into the mainstream of society.
  3. The initial clinical team shall work to meet the individual's needs from the date of application or referral for services until such time as eligibility is established and an ISP is developed.
  4. The assigned clinical team shall be primarily responsible for providing continuous treatment, outreach and support to a client, for identifying appropriate behavioral health services or community services, and for developing, implementing and monitoring ISPs for clients.
  5. The case manager, in conjunction with the clinical team, shall:
    - a. Locate services identified in the ISP;
    - b. Confirm the selection of service providers and include the names of such providers in the ISP;
    - c. Obtain a written client service agreement from each provider;
    - d. Be responsible for ensuring that services are actually delivered in accordance with the ISP; and
    - e. Monitor the delivery of services rendered to clients. Monitoring shall consider, at a minimum, the consistency of the services with the goals and objectives of the ISP.
  6. The case manager shall also be responsible to:
    - a. Initiate and maintain close contact with clients and service providers;
    - b. Provide support and assistance to a client, with the client's permission and consistent with the client's individual needs;
    - c. Ensure that each service provider participates in the development of the ISP for each client of the service provider;
    - d. Ensure that each inpatient facility, according to R9-21-312, develops an ITDP that is integrated in and consistent with the ISP;
    - e. Assess progress toward, and identify impediments to, the achievement of the client's goals and objectives identified in the ISP;
    - f. Promote client involvement in the development, review, and implementation of the ISP;
    - g. Attempt to resolve problems and disagreements with respect to any component of the ISP;
    - h. Assist in resolving emergencies concerning the implementation of the ISP;
    - i. Attend all periodic reviews of the ISP and ITDP meetings;
    - j. Assist in the exploration of less restrictive alternatives to hospitalization or involuntary commitment; and
    - k. Otherwise coordinate services provided to the client.
  7. If a case manager is assigned to a client who, at any time, is admitted to an inpatient facility, the case manager shall ensure the development, modification or revision of a client's ISP and the integration of the ITDP according to this Article.
    - a. The inpatient facility clinician responsible for coordinating the ITDP shall immediately notify the client's case manager of the time of the admission and ensure that all treatment and discharge planning includes the case manager.
    - b. The case manager shall be provided notice of all treatment and discharge meetings, shall participate as a full member of the inpatient facility treatment team in such meetings, shall receive periodic and other reports concerning the client's treatment, and shall be responsible for identifying and securing appropriate community services to facilitate the client's discharge.
    - c. If no case manager has been assigned, the inpatient facility clinician primarily responsible for the client's inpatient care shall, within three days of admission, make a referral to the appropriate regional authority for the appointment of a case manager.
    - d. Delays in the assignment of a case manager or in the development or modification of an ISP or ITDP shall not be construed to prevent the clinically appropriate discharge of a client from an inpatient facility.

- e. Inpatient facilities shall establish a mechanism for the credentialing of case managers and other members of the clinical team in order that they may participate in ITDP meetings.
- B. Client participation in service planning.**
1. It is the responsibility of the regional authority and its service providers to engage in service planning, including the provision of assessments, case management, ISPs, ITDPs, and service referrals, according to the provisions of these rules for the benefit of clients requesting, receiving or referred for behavioral health services or community services. Clients and the clients' guardians may refuse to participate in or to receive any service planning. In the event of such refusal, service planning shall not be provided unless:
    - a. There is an emergency in which a qualified clinician determines that immediate intervention is necessary to prevent serious harm to the client or others; or
    - b. The client is subject to court-ordered evaluation or treatment.
  2. A client's refusal to accept a particular service, including case management services, or a particular mode or course of treatment, shall not be grounds for refusing a client's access to other services that the client accepts.
  3. A physical examination shall not be conducted over a client's refusal unless the examination is consented to by the client's guardian, or the examination is otherwise required by court order.
  4. A decision to provide services, including assessment, service planning, and case management services, to a client who is refusing such services, or a decision not to provide such services to such an individual, may be appealed according to the provisions of R9-21-401. This subsection does not limit the rights of a client to accept, reject, or appeal particular results of the service planning process as identified in other applicable provisions of these rules.
- C. Clients with special needs.**
1. Whenever, according to an assessment or in the development or review of any plan prepared under this Article, it is determined that a client is a client who needs special assistance or a client who needs counsel or advice in making treatment decisions or in enforcing the client's rights, the case manager shall:
    - a. Notify the regional authority, the Office of Human Rights, and the appropriate human rights committee of the client's need so that the client can be provided special assistance from the human rights advocate or special review by the human rights committee; and
    - b. If the client does not have a guardian, identify a friend, relative, or other person who is willing to serve as a designated representative of the client.
  2. The clinical team shall make arrangements to have qualified interpreters or other reasonable accommodations, including qualified interpreters for the deaf, present at any assessment, meeting, service delivery, notice, review, or grievance for clients who cannot converse adequately in spoken English.
  3. Clients who are incarcerated in jails shall receive ISPs in accordance with R9-21-307. If legitimate security requirements of any jail in which a client is incarcerated require a reasonable modification of a specific procedure set forth in this rule, the clinical team may modify the method for preparing the ISP only to the extent necessary to accommodate the legitimate security concerns.
    - a. No modification may unreasonably restrict the client's right to participate in the ISP process;
    - b. No modification may alter the standards for developing an ISP, the client's right to obtain services identified in the ISP, as provided in this Article, or the client's right to appeal any aspect of treatment planning according to R9-21-401, including the decision to modify the process for security reasons.
- D. Notices to the individual.**
1. Any individual or mental health agency required to give notice to an individual of any documents, including eligibility determinations, assessment reports, ISPs, and ITDPs according to this rule shall do so by:
    - a. Providing a copy of the document to the individual;
    - b. Providing copies to any designated representative and guardian;
    - c. Personally explaining to the individual and designated representative and/or guardian any right to accept, reject, or appeal the contents of the document and the procedures for doing so under this Article.
  2. Individuals requesting or receiving behavioral health services or community services shall be informed:
    - a. Of the right to request an assessment;
    - b. Of the right to have a designated representative assist the client at any stage of the service planning process;
    - c. Of the right to participate in the development of any plan prepared under this Article, including the right to attend all planning meetings;
    - d. Of the right to appeal any portion of any assessment, plan, or modification to an assessment or plan, according to R9-21-401;
    - e. Of the Administration's authority to require necessary and relevant information about the individual's needs, income, and resources;
    - f. Of the availability of assistance from the regional authority in obtaining information necessary to determine the need for behavioral health services or community services;
    - g. Of the Administration's or mental health agency's authority to charge for services and assessments;
    - h. That if the individual declines the services of a case manager or an ISP, the individual has the right to apply for services at a subsequent time; and
    - i. That if the individual declines any particular service or treatment modality, it will not jeopardize other accepted services.
- E. Extensions of time.**
1. The time to initiate or complete eligibility determinations, assessments, ISPs, and other actions according to this Chapter may be extended if:
    - a. There is substantial difficulty in scheduling a meeting at which all necessary participants can attend;
    - b. The client fails to keep an appointment for assessment, evaluation, or any other necessary meeting;
    - c. The client is capable of but temporarily refuses to cooperate in the preparation of the plan or completion of an assessment or evaluation;
    - d. The client or the client's guardian and/or designated representative requests an extension of time or
    - e. Additional documentation has been requested but has not yet been received.
  2. An extension under this rule shall not exceed the number of days incurred by the delay and in no event may exceed

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20 days, unless the whereabouts of the client are unknown.

3. For an SMI eligibility determination, an extension of time shall only apply if an applicant agrees to the extension.

**F.** Meeting attendance through telecommunications link. Attendance by any person at any meeting that is required or recommended according to this Article may be accomplished through a telecommunications link that is contemporaneous with the meeting.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

#### R9-21-302. Identification, Application, and Referral for Services of Persons with Serious Mental Illness

- A.** Each regional authority shall develop and implement outreach programs that identify individuals within the authority's geographic area, including persons who reside in jails, homeless shelters, or other settings, who are seriously mentally ill.
1. Inpatient facilities shall identify individuals in their respective facilities who are seriously mentally ill.
  2. An individual identified under this subsection shall be referred in writing to the appropriate regional authority for a determination of eligibility as provided in this Article.
- B.** An individual desiring behavioral health services or community services under this Article may apply to the appropriate regional authority for a determination of eligibility. Application may be made by the individual or on the individual's behalf by the person's guardian, designated representative, or other appropriate individuals such as a family member or staff of a mental health agency. Individuals may apply for behavioral health services or community services regardless of whether they reside in the community, an inpatient facility, a county jail, a homeless shelter, or any other location within the state of Arizona.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

#### R9-21-303. Eligibility Determination and Initial Assessment

- A.** Upon receipt of a request or referral for a determination of whether an individual is eligible for services under this Chapter, a regional authority shall schedule an appointment for an initial meeting with the applicant by a qualified clinician, to occur no later than seven days after the regional authority receives the request or referral.
- B.** During the initial meeting with an applicant by a qualified clinician, the qualified clinician shall:
1. Obtain consent to an assessment of the applicant from the applicant or, if applicable, the applicant's guardian;
  2. Provide to the applicant and, if applicable, the applicant's guardian, the information required in R9-21-301(D)(2), a

client rights brochure, and the notice required by R9-21-401(B);

3. Determine whether the applicant is competent, according to R9-21-206;
  4. If, during the initial meeting with an applicant by a qualified clinician, the qualified clinician is unable to obtain sufficient information to determine whether the applicant is eligible for services under this Chapter:
    - a. Obtain authorization from the applicant or, if applicable, the applicant's guardian, for release of information, if applicable;
    - b. Request the additional information the qualified clinician needs in order to make a determination of whether the applicant is eligible for services under this Chapter; and
  5. Initiate an assessment according to R9-21-305.
- C.** The qualified clinician in subsection (B) shall obtain information necessary to make an eligibility determination, including:
1. Identifying data and residence, including a social security number if available;
  2. The reasons for the request or referral for services;
  3. The individual's psychiatric diagnosis;
  4. The individual's present level of functioning, based upon the criteria set forth in the definition of "seriously mentally ill";
  5. The individual's history of mental health treatment;
  6. The individual's abilities, needs, and preferences for services; and
  7. A preliminary determination as to the individual's need for special assistance.
- D.** If at any time during the course of the eligibility process the qualified clinician determines that the individual has a current case manager, a current assessment, or an ISP, the clinician shall notify the client's case manager and terminate the eligibility process.
- E.** To be eligible for behavioral health services or community services according to this Chapter the individual must be:
1. A resident of the state of Arizona, and
  2. Seriously mentally ill.
- F.** The qualified clinician in subsection (B) shall determine whether an applicant is eligible for services under this Chapter and provide written notice of the SMI eligibility determination to the applicant or, if applicable, the applicant's guardian according to the following time-frames:
1. If the qualified clinician obtains sufficient information during the initial meeting with the applicant to determine whether the applicant is eligible for services under this Chapter, within three days of the initial meeting with the applicant by the qualified clinician;
  2. If the qualified clinician does not obtain sufficient information during the initial meeting with the applicant to determine whether the applicant is eligible for services under this Chapter, at the earliest of:
    - a. Within three days of obtaining sufficient information to determine whether the applicant is eligible for services under this Chapter, or
    - b. The time provided according to R9-21-301(E).
- G.** At the time a qualified clinician provides an applicant with written notice of an SMI eligibility determination according to subsection (F), the qualified clinician shall:
1. Provide written notice to the applicant:
    - a. That the applicant has the right to appeal the SMI eligibility determination according to R9-21-401, including the right to an administrative hearing according to A.R.S. § 41-1092.03; and

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- b. That, if the applicant is not eligible for services according to this Chapter, the applicant may reapply at any time; and
- 2. If the applicant is eligible for services under this Chapter:
  - a. Serve as the client's case manager or arrange for the provision of case management services for the client; and
  - b. Initiate with the client the development of a clinical team that may include:
    - i. Behavioral health professionals,
    - ii. Professionals other than behavioral health professionals,
    - iii. Behavioral health technicians,
    - iv. Family members,
    - v. Paraprofessionals, and
    - vi. Any individual whom the qualified clinician and the client deem appropriate and necessary to ensure that the assessment is comprehensive and meets the needs of the client.
- H. Nothing in this rule shall be construed to require the qualified clinician to make the determination of whether the applicant is eligible for services under the Arizona Health Care Cost Containment System Administration (AHCCCSA) according to A.R.S. Title 36, Chapter 29.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

**R9-21-304. Interim and Emergency Services**

- A. At an applicant's first visit with a qualified clinician and after a determination of eligibility the qualified clinician shall:
  - 1. Determine whether the applicant or client needs interim services prior to the development and acceptance of the ISP;
  - 2. If the applicant or client needs interim services, identify the interim services that are consistent with the applicant's or client's preferences and needs and the findings in the assessment;
  - 3. Arrange for the provision of the interim services identified by the qualified clinician; and
  - 4. Document in the client's record the interim services that shall be provided to the applicant or client.
- B. If a qualified clinician determines that an emergency exists necessitating immediate intervention, emergency or crisis services shall be provided immediately.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

**R9-21-305. Assessments**

- A. The following individuals may participate in and contribute to the assessment of a client:
  - 1. The client;
  - 2. The qualified clinician in R9-21-303(B);

- 3. The client's case manager;
- 4. Each individual on the client's clinical team, including:
  - a. Behavioral health professionals,
  - b. Professionals other than behavioral health professionals,
  - c. Behavioral health technicians,
  - d. Family members,
  - e. Paraprofessionals, and
  - f. Any individual whom the qualified clinician and the client deem appropriate and necessary to ensure that the assessment is comprehensive and meets the needs of the client.
- B. The individuals contributing to the assessment of a client shall not consider the availability of services, but shall consider the client's circumstances and evaluate all available information including:
  - 1. The information obtained during the initial meeting with the client by a qualified clinician according to R9-21-303(B);
  - 2. Written information such as the client's clinical history, records, tests, and other evaluations;
  - 3. Information from family, friends, and other individuals.
- C. An assessment shall include:
  - 1. An evaluation of the client's:
    - a. Presenting concerns;
    - b. Behavioral health treatment;
    - c. Medical conditions and treatment;
    - d. Sexual behavior and, if applicable, sexual abuse;
    - e. Substance abuse, if applicable;
    - f. Living environment;
    - g. Educational and vocational training;
    - h. Employment;
    - i. Interpersonal, social, and cultural skills;
    - j. Developmental history;
    - k. Criminal justice history;
    - l. Public and private resources;
    - m. Legal status and apparent capacity;
    - n. Need for special assistance; and
    - o. Language and communication capabilities;
  - 2. A risk assessment of the client;
  - 3. A mental status examination of the client;
  - 4. A summary, impressions, and observations;
  - 5. Recommendations for next steps;
  - 6. Diagnostic impressions of the qualified clinician; and
  - 7. Other information determined to be relevant.
- D. Within 45 days of a request or referral for an SMI eligibility determination, a qualified clinician shall prepare an assessment report based on the information obtained according to R9-21-303 and this Section, including:
  - 1. The development of a long-term view by the client with assistance from the clinical team that establishes a method of integration for living, employment and social conditions that the client wishes to achieve over the next three years;
  - 2. A summary of the information gathered during the eligibility and assessment processes;
  - 3. An identification of the client's legal status, resources, and assessed strengths and actual needs, regardless of the availability of services to meet that need, in each area of assessment identified in subsection (C) above;
  - 4. An analysis of the major findings of the mental health assessment, including a description of the nature and severity of any illness and a diagnosis in terms set forth in the DSM;
  - 5. The client's preferences regarding services to be provided;

6. A description of any additional interim services which are required and plans for the referral of the client to additional interim services or the continuation of interim services already provided;
  7. An identification of further evaluations which the clinical team deem necessary to determine the services appropriate to the client's needs;
  8. An identification of information that could not be obtained due to the client's circumstances or unavailability; and
  9. A functional assessment of the client's current status in terms of independent living, employment (or retirement), and social integration and analysis of the support or skills, if any, necessary to achieve the client's long-term view.
- E.** The qualified clinician shall arrange for any further evaluations recommended by the clinical team. If the client needs assessment in an area beyond the ability or expertise of the clinical team, such assessment shall be conducted by professionals with appropriate credentials, with the client's consent. The need for further evaluations shall not unreasonably delay the preparation of the ISP.
- F.** If a qualified clinician determines that the client is a client who needs special assistance, the case manager shall:
1. Notify the regional authority, the Office of Human Rights, and the appropriate human rights committees of the client's need so that the client can be provided special assistance from the human rights advocate or special review by the human rights committee; and
  2. If the client does not have a guardian, identify a friend, relative or other person who is willing to serve as a designated representative of the client.
- G.** Upon completion of the assessment report, copies shall be sent to the client, the designated representative, if any, the guardian, and all service providers who have been identified by the case manager or regional authority to serve the client.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

#### R9-21-306. Identification of Potential Service Providers

- A.** As soon as needs of the client for particular services are identified through the eligibility determination, assessment, or further evaluation processes, the clinical team in conjunction with the client shall begin considering and choosing potential service providers to participate in the development of the client's ISP.
1. Within five days of the completion of the assessment report, the clinical team and the client shall complete the identification of service providers most appropriate to meet the client's needs.
  2. The case manager shall promptly contact the identified providers to determine their ability to serve the client.
  3. Within 10 days of the completion of the assessment report, the case manager shall request identified providers able to serve the client to participate in the development of the client's Individual Service Plan. All identified providers shall be provided notice of the time and place of the ISP meeting.
- B.** The clinical team, in conjunction with the client, shall determine which provider(s) are the most appropriate to serve the client. The determination of appropriateness shall consider:
1. The client's preferences for the type, intensity, and location of services;
  2. The capacity and experience of the provider in meeting the client's assessed needs;
  3. The proximity of the provider to the client's family and home community;
  4. The availability and quality of services offered by the provider; and
  5. Other factors deemed relevant by the case manager and clinical team.
- C.** The clinical team shall provide sufficient information to the identified service providers to allow them to understand the client's long-term view, strengths, needs, and required services and to take an active role in the ISP meeting.
- D.** All mental health agencies currently providing services to the client shall bring to the ISP meeting a written description of the nature, type, and frequency of services provided or to be provided by the agency.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

#### R9-21-307. The Individual Service Plan

- A.** General provisions.
1. An individual service plan (ISP) shall be developed by the clinical team and each client.
  2. The ISP shall include the most appropriate and least restrictive services, consistent with the client's needs and preferences, as identified in the assessment conducted according to R9-21-305, and without regard to the availability of services or resources.
  3. The ISP shall identify those services which maximize the client's strengths, independence, and integration into the community.
  4. Generic services available to the general public should be utilized, to the maximum extent possible, when adequate to meet the client's needs and if access can be arranged by the case manager or client.
  5. If all needed services are not available, a plan for alternative services shall detail those services which are, to the maximum extent possible, adequate, appropriate, consistent with the client's needs, and least restrictive of the client's freedom.
  6. The clinical team shall solicit and actively encourage the participation of the client and guardian.
  7. The clinical team shall inform the client of the right to have a designated representative throughout the ISP process and to invite family members or other persons who could contribute to the development of the ISP. The case manager shall seek to obtain a representative for clients who need special assistance or otherwise have limited capacity to articulate their own preferences and to protect their own interests in the ISP process and shall advise the relevant human rights committee that the client has been determined to need special assistance.

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8. The ISP shall contain goals and objectives which are measurable and which facilitate meaningful evaluation of the progress toward attaining those goals and objectives.
  9. The ISP shall incorporate a specific description of the client objectives, services, and interventions for each mental health agency which will provide services to the client. Each existing service provider will bring to the ISP meeting a detailed written description of the objectives and services currently in effect for the client.
  10. For residents of an inpatient facility, the facility's treatment and discharge plan shall be developed according to R9-21-312 and shall be incorporated in the ISP.
  11. Prior to the planned discharge of a new client from an inpatient facility, the clinical team shall develop an ISP which describes the community services, including alternative housing and residential supports, that will be provided when the client leaves the facility.
  12. The ISP shall be written in language which can be easily understood by a lay person.
  13. In developing the ISP, the case manager shall facilitate resolution of differences among service providers and, if resolution is not achieved, shall refer the matter to the regional authority, which shall resolve the matter in accordance with the Administration's policy.
- B. The individual service plan meeting.**
1. Within 20 days of the completion of the assessment report, the case manager shall convene an ISP meeting at a convenient time and place for the client, guardian, clinical team, and potential service providers.
  2. The case manager shall arrange for the client's transportation, if needed, to the ISP meeting.
  3. The case manager shall notify in writing the following persons of the time, date and location of the ISP meeting at least 10 days prior:
    - a. The client, any designated representative and guardian, including an invitation to submit relevant information in writing if their attendance is impossible;
    - b. Clinicians involved in the assessment or further evaluation;
    - c. All current and potential service providers;
    - d. All members of the client's clinical team;
    - e. Family members, with the client's permission;
    - f. Other persons familiar with the client whose presence at the meeting is requested by the client;
    - g. Any other person whose participation is not objected to by the client and who, in the judgment of the case manager, will contribute to the ISP.
  4. The case manager shall chair the ISP meeting which shall include a discussion of:
    - a. The client's supports or skills necessary to achieve the client's long-term view in each of the areas listed in R9-21-305(B);
    - b. The findings and conclusions obtained during the assessment, further evaluations, including a list of further evaluations to be completed, and any interim services provided;
    - c. Any existing ITDP according to R9-21-312;
    - d. The client's preferences regarding services;
    - e. Recommended long-term or alternative services;
    - f. Current or proposed service providers, including the need to have service providers with staff who have language and communications skills other than English if necessary to communicate with the client;
    - g. Recommended dates for commencement of each service or date each service commenced;
- h. The methods and persons to ensure that services are provided as set forth in the ISP, adequately coordinated, and regularly monitored for effectiveness;
  - i. The procedure for completion and implementation of the ISP process, including the procedures for accepting, rejecting, or appealing the ISP; and
  - j. The procedure for clients or service providers to request changes in the ISP.
- C. The individual service plan shall include:**
1. A description of the client's long-term view and the client's preferences, strengths, and needs in all relevant areas listed in R9-21-305(C), including present functioning level and medical condition, with documentation of any chronic medical condition which requires regular monitoring or intervention.
  2. A description of the most appropriate and least restrictive services consistent with the client's needs and without reference to existing resources.
  3. A statement of whether the client requires service providers with staff who are competent in any language other than English in order to communicate with the client.
  4. Target dates for commencement of each service or date each service commenced and their anticipated duration.
  5. Long range goals for each service which will assist the client in attaining the most self-fulfilling, age-appropriate, and independent style of living possible for the client, consistent with the client's preference, stated in terms which allow objective measurement of progress and which the client, to the maximum extent possible, both understands and adopts.
  6. Short-term objectives that lead to attainment of overall goals stated in terms which allow objective measurement of progress and which the client, to the maximum extent possible, both understands and accepts.
  7. Expected dates of completion for each objective;
  8. Persons and service providers responsible for each objective.
  9. Identification of each generic or service provider responsible for providing the specific service required to meet each of the client's needs, including the name and address and telephone number of the provider and the location where the service will be provided.
  10. A detailed description of the client objectives and services for each mental health agency which will provide services to the client.
  11. Identification of any need for alternative housing or residential setting, including the support and monitoring to be provided after any change in housing or residential setting as provided in R9-21-310(D).
  12. Based upon assessments and other available information, a determination of:
    - a. The client's capacity to:
      - i. Make competent decisions on matters such as medical and mental health treatment, finances, and releasing confidential information;
      - ii. Participate in the development of the ISP; and
      - iii. Independently exercise the client's rights under this Chapter.
    - b. The client's need for guardianship or other protective services or assistance.
    - c. The client's need for special assistance.
  13. A list of the assessments which were not completed due to the client's current mental or physical condition or due to the clinical team's inability to access records together with a statement of the causes and plans to obtain these assessments.

14. A description of the methods and persons responsible for ensuring that services are:
    - a. Provided as set forth in the ISP;
    - b. Adequately coordinated; and
    - c. Regularly monitored for effectiveness.
  15. A statement of the right of the client, designated representative, or guardian to accept or reject the ISP, request other services, or appeal the ISP or any aspect of the ISP.
  16. A statement that the client's acceptance of the ISP constitutes consent to the services enumerated in the ISP.
- D. Preparation and distribution of the individual service plan.**
1. Within seven days of the ISP meeting, but no later than 90 days from the date of a referral or request for an SMI eligibility determination, the case manager shall prepare and distribute the ISP as provided herein.
  2. The case manager or other clinical team member shall personally deliver to and review the ISP with the client.
  3. The ISP shall be mailed or otherwise distributed to the following persons:
    - a. The client's designated representative and/or guardian;
    - b. The members of the clinical team; and
    - c. All existing or potential service providers.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

#### R9-21-308. Acceptance or Rejection of the Individual Service Plan

- A.** Within seven days of the distribution of the ISP, the case manager shall contact the client concerning acceptance or rejection of all or any portion of the ISP, or request for other services, if there has not been acceptance, rejection or a request prior to that date.
- B.** If the client or guardian does not object to the ISP within 30 days of receipt of the plan, the client shall be deemed to have accepted the ISP.
- C.** If the client or guardian rejects some or all of the services identified in the ISP, or requests other services, the case manager shall provide written notice to the client or guardian of the right to immediately appeal the ISP according to R9-21-401 or to meet with the clinical team within seven days of the rejection to discuss the plan and suggest modifications. The case manager shall arrange the meeting at a convenient time and place for the client, any designated representative and/or guardian, and the clinical team.
- D.** If the client's proposed modifications are adopted by the clinical team, the case manager shall arrange for approval of the modifications by all service providers.
- E.** If the matter is not resolved to the client's or guardian's satisfaction, the case manager shall again inform the client or guardian of the right to appeal the ISP.
- F.** A client or guardian who rejects the ISP may accept some or all of the identified services pending the outcome of the meeting with the clinical team or an appeal.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective

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#### R9-21-309. Selection of Service Providers

- A.** Within seven days of the distribution of the ISP to the service providers identified in the ISP, the case manager, after consultation with the clinical team and the provider, shall determine whether each of these providers are capable of serving the client.
  1. A contracted service provider shall not refuse to serve a client except for good cause related to the inability of the service provider to safely and professionally meet the client's needs as identified in the ISP.
  2. If a contracted service provider believes it is incapable of meeting the client's needs or of implementing the ISP, the provider shall inform the case manager in writing within five days of receipt of the ISP. A contracted service provider shall specify the reasons for its conclusion.
- B.** If the clinical team determines that a housing, residential or vocational service provider identified in the ISP is not capable of serving the client, the case manager shall, with the approval of the clinical team, identify another provider who is qualified to provide the services identified in the client's ISP, introduce the client to the new service provider, and modify the ISP as needed.
- C.** If the clinical team determines that an identified provider, other than a housing, residential or vocational service provider, is not capable of serving a client, the case manager shall, with the approval of the clinical team, identify another provider that is qualified to provide the services identified in the client's ISP. The case manager shall promptly distribute the ISP to the alternative service provider.
- D.** All selected service providers shall sign the ISP and implement the identified services.

#### Historical Note

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#### R9-21-310. Implementation of the Individual Service Plan

- A.** Upon acceptance of the ISP by the client or as defined in a court order, services shall be initiated in accordance with the timetable identified in the ISP.
- B.** If all or a portion of the ISP is rejected by the client or guardian, the plan shall not be implemented and services shall not be provided unless the client or guardian consents to specific services.
- C.** For each client who is identified as needing alternative housing, a new residential setting, or a residential support service, the case manager shall inform the client of the need for an alternative living arrangement and shall use the case manager's best efforts to obtain appropriate housing or residential supports. These efforts may include showing the client the house or apartment in which the client could reside, introducing the client to other residents of the residential setting, as appropriate, and permitting the client to live in the alternative setting on a trial basis. All clients shall be informed that they may elect to move at any time in the future subject to the terms

- of any lease, mortgage, contract, or other legal agreement between the client and the housing provider.
- D.** For at least the first two months after a client moves to a new residential setting, the case manager shall coordinate and monitor support services, as identified in the client's ISP, in order to foster the maintenance of the client's key relationships with others, to provide necessary orientation, and to ensure a smooth and successful transition into the new setting.
- E.** All contracts with service providers shall include:
1. A provision that the service provider shall abide by the rules contained in this Chapter and shall not alter, terminate, or otherwise interrupt services required under the ISP except parts of the ISP that have been modified according to R9-21-314;
  2. A provision that the service provider shall cooperate with the Administration in collecting data necessary to determine if the Administration is meeting its obligations under this Chapter and A.R.S. Title 36, Chapter 5, Article 10; and
  3. A provision that the service provider agrees to maintain current client records that document progress toward achievement of ISP goals and objectives and that meet applicable requirements of law, contract, and professional standards.
- F.** Forward a description of the unmet service need to the Administration, if the appropriate service cannot be located or developed through existing services or reallocated resources; and
- G.** Nothing in this rule shall effect or modify any provision of Arizona law with respect to a client's right to appropriate services.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

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#### R9-21-311. Alternative Services

- A.** If the services identified in the ISP are not currently available, the clinical team shall develop an alternative plan for alternative services, based upon the client's strengths, needs, and preferences as set forth in the assessment conducted according to R9-21-305. The plan for alternative services shall be developed after the preparation of the ISP.
- B.** The plan for alternative services shall be developed according to the same procedures for the preparation of an ISP and may be developed at the same meeting with the ISP if the clinical team is aware that appropriate services are not currently available. If at an ISP meeting the clinical team does not know whether the appropriate services are available, the clinical team shall use diligent efforts to locate the identified services. If appropriate services are determined to be unavailable, the ISP meeting shall be reconvened to develop an ISP for alternative services.
- C.** The plan for alternative services shall identify those available mental health and generic services which are, to the maximum extent possible, adequate, appropriate, consistent with the client's needs and least restrictive of the client's freedom.
- D.** The plan for alternative services shall contain a list of appropriate but unavailable services and the projected date for the initiation of each service.
- E.** If the clinical team determines that a recommended service is unavailable or does not exist, it shall forward a description of that service to the director of the regional authority. The director shall:
1. Use best efforts to locate the needed service through existing services or reallocated resources;

#### R9-21-312. Inpatient Treatment and Discharge Plan

- A.** General provisions.
1. Every client of an inpatient facility shall have an Inpatient Treatment and Discharge Plan (ITDP).
  2. An ITDP shall be developed by the inpatient facility's treatment team, the case manager and other members of the clinical team, as appropriate.
  3. The ITDP shall include the most appropriate and least restrictive services available at the inpatient facility, as well as a plan for the client's discharge to the community.
  4. The ITDP shall identify those treatment interventions and services which maximize the client's strengths, independence, and integration into the community.
  5. The ITDP shall be developed with the fullest possible participation of the client and any designated representative and/or guardian.
  6. The ITDP shall contain goals and objectives which are measurable and which facilitate meaningful evaluation of the progress toward attaining those goals and objectives.
  7. The ITDP shall be written in language which can be easily understood by a lay person.
  8. Delays in the assignment of a case manager or in the development or modification of an ISP or ITDP shall not be construed to prevent the appropriate discharge of a client from an inpatient facility.
- B.** The individual treatment and discharge plan meeting.
1. The case manager shall encourage the client to have a designated representative assist the client at the meeting and to have other persons, including family members, attend the meeting. The case manager shall ensure that the human rights advocate is notified of the time and date of the ITDP for clients who need special assistance.
  2. The following persons shall be invited to attend the ITDP meeting:
    - a. The client;
    - b. Any designated representative and/or guardian;
    - c. Family members, with the client's permission;
    - d. Members of the client's inpatient facility treatment team;
    - e. The case manager and other members of the clinical team, as appropriate;

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- f. Other persons familiar with the client whose presence at the meeting is requested by the client; and
  - g. Any other person whose participation is not objected to by the client and who will, in the judgment of the case manager, contribute to the ITDP meeting.
3. The ITDP meeting shall include a discussion of:
- a. A review of the ISP's long-term view;
  - b. If necessary, a new functional assessment of the supports or skills necessary to achieve the client's long-term view;
  - c. The client's needs in terms of assessed strengths and needs;
  - d. The client's preferences regarding services;
  - e. Existing services if any;
  - f. The procedure for completion and implementation of the ITDP process, including the procedures for accepting, rejecting, or appealing the ITDP;
  - g. The procedure for clients or the inpatient facility to request changes in the ITDP; and
  - h. The methods to ensure that services are provided as set forth in the ITDP and regularly monitored for effectiveness.
- C. Inpatient treatment and discharge plan.**
1. The facility treatment team, the case manager, and other representatives of the clinical team, as appropriate, shall develop a preliminary ITDP within three days, and a full ITDP within seven days thereafter, of the client's admission. Where a client's anticipated stay is less than seven days, an acute inpatient facility shall develop a preliminary ITDP within one day and a full ITDP within three days of a client's admission.
  2. The ITDP shall be consistent with the goals, objectives, and services set forth in the client's ISP and shall be incorporated into the ISP.
  3. The ITDP shall include:
    - a. The client's preferences, strengths, and needs;
    - b. A description of appropriate services to meet the client's needs;
    - c. For non-acute facilities, long-range goals which will assist the client in attaining the most self-fulfilling, age-appropriate, and independent style of living possible, stated in terms which allow objective measurement of progress and which the client, to the maximum extent possible, both understands and accepts;
    - d. Short-term objectives that lead to attainment of overall goals stated in terms which allow objective measurement of progress and which the client, to the maximum extent possible, both understands and accepts;
    - e. Expected dates of completion for each objective;
    - f. Persons responsible for each objective;
    - g. The person responsible for ensuring that services are actually provided and are regularly monitored; and
    - h. The right of the client or guardian to accept or reject the ITDP, request other services, or appeal the ITDP or any aspect of the ITDP.
- D. Preparation and distribution of the ITDP.**
1. Within three days of the ITDP meeting, the treatment team coordinator shall prepare and distribute the ITDP.
  2. The ITDP shall be personally presented and explained to the client by the case manager.
  3. The ITDP shall be mailed or otherwise distributed to the following persons:
    - a. The client's designated representative and guardian, if any;
    - b. The case manager and members of the clinical team; and
    - c. The members of the inpatient facility's treatment team.
- E. Acceptance or rejection of the ITDP.**
1. Within two days of the date when the ITDP was distributed, the client shall be contacted by the case manager concerning acceptance or rejection of the ITDP, if there has not been acceptance or rejection prior to that date.
  2. If the client or guardian does not object to the ITDP within 10 days of the date when the ITDP was distributed, the client shall be deemed to have accepted the ITDP.
  3. If the client or guardian rejects some or all of the treatment interventions or services identified in the ITDP or requests other services, the case manager shall provide written notice to the client of the right to meet with the treatment team coordinator within five days of the rejection to discuss the plan and to suggest modifications, or to immediately appeal the plan according to R9-21-401.
  4. If modifications are agreed to by the treatment team coordinator and the client or guardian, the treatment team coordinator shall arrange for approval of the modifications by all members of the inpatient facility's treatment team, the case manager, and members of the clinical team, as appropriate.
  5. If the matter is not resolved to the client's or guardian's satisfaction, the case manager shall again inform the client and guardian of the right to appeal according to R9-21-401. The client or guardian may appeal findings or recommendations in the ITDP within 30 days of receipt of the plan.
  6. A client or guardian who rejects the ITDP may accept some or all of the identified treatment interventions or services pending the outcome of the meeting with the treatment team coordinator or an appeal.
- F. The updated ITDP.** The facility treatment team, the case manager, and other representatives of the clinical team, as appropriate, shall review the ITDP as frequently as necessary, but at least once within the first 30 days of completing the plan, every 60 days thereafter during the first year, and every 90 days thereafter during any subsequent years that the client remains a resident of the facility.
- G. Incorporation into the individual service plan.**
1. If the clinical team determines that the ITDP is appropriate to meet the client's needs, least restrictive of the client's freedom, and consistent with the ISP, it shall approve the ITDP by incorporating it into the ISP. If the clinical team disapproves the ITDP, it shall convene an ISP meeting, which includes the inpatient facility treatment team, to prepare a revised ITDP.
  2. The clinical team, with the assistance of the inpatient facility's treatment team, shall be responsible for implementing the plan for the client's discharge.
  3. The case manager will provide notice to those providers identified in the client's ISP three days prior to the client's actual discharge, except that the failure to provide such notice shall not delay discharge.
  4. The case manager shall meet with the client within five days of the client's discharge to ensure that the ISP is being implemented.
  5. The case manager shall review the ISP with the clinical team within 30 days of the discharge to determine whether any modifications are appropriate, consistent with the standards and requirements set forth in R9-21-314.

**Historical Note**

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**R9-21-313. Periodic Review of Individual Service Plans****A. General provisions.**

1. Where an ISP includes residential, vocational, or other primary service providers that do not currently serve the client, the first ISP review shall be held within 30 days from the date on which all such providers have initiated services to client. Each service provider shall bring to the review a detailed description of the objectives and services currently in effect for the client.
2. Where the ISP includes only primary service providers that currently serve the client, the first ISP review shall be held within six months of the date the ISP is accepted by the client or the date on which any appeal is concluded.
3. Thereafter, ISP reviews shall be conducted at least every six months and more frequently as needed. The ISP review shall be chaired by the case manager.
4. The purpose of the ISP review is to ensure that services continue to be, to the maximum extent possible, appropriate to the client's needs and least restrictive of the client's freedom.
5. The review shall be conducted with the fullest possible participation of the client and any designated representative and/or guardian.

**B. The ISP review.**

1. At least 10 days prior to the ISP review meeting, the case manager shall invite, in writing, the following persons to attend the meeting:
  - a. The client and any designated representative and/or guardian;
  - b. Family members, with the permission of the client;
  - c. Members of the client's clinical team;
  - d. Representatives of each of the client's service providers;
  - e. Any other person familiar with the client whose participation is requested by the client; and
  - f. Any other person whose participation is not refused by the client and who, in the judgment of the case manager, will contribute to the ISP review.
2. The ISP review shall, to the extent possible given the circumstances of the client and the availability of information, consider:
  - a. Whether there has been any change in the clinical, social, training, medical, vocational, educational and personal needs of the client;
  - b. Whether the client needs any further assessment or evaluations;
  - c. Whether the services being provided to the client continue to be appropriate to meet the client's needs, least restrictive of the client's freedom, consistent with the client's preferences, and as integrated as possible in the client's home community;
  - d. Whether there has been progress towards attainment of the long-term view, and each of the goals and objectives stated in the ISP;
  - e. Whether to reaffirm, modify or delete each goal and objective, together with the reasons for these actions;

- f. Whether there has been any change in the legal status of the client, in the necessity or advisability of having a guardian or conservator appointed or removed, or in the client's need for special assistance;
- g. Whether any change in the client's circumstances should result in a modification of the client's priority of need for services not currently provided; and
- h. Whether there has been any change in the availability of services formerly determined to be needed but not then available.

3. The client, any designated representative and/or guardian, and clinical team will review each service provider's detailed description of current objectives and services to determine whether it is consistent with client's needs, least restrictive of the client's freedom, and designed to maximize the client's independence and integration into the community.
  - a. If the detailed description is approved and accepted by the client, any designated representative and/or guardian, and the clinical team, it shall be incorporated into the updated ISP.
  - b. If the description of services is rejected, it shall be revised with the assistance of the service provider and, as revised, incorporated into the updated ISP.

**C. The updated ISP.**

1. Within seven days of the ISP review meeting, the case manager shall prepare an updated ISP which includes all of the elements set forth in R9-21-307(C).
2. The case manager shall personally meet with the client or guardian to explain the updated ISP. The updated ISP shall be mailed or otherwise distributed to the other participants of the review meeting.
3. The updated ISP is subject to the client acceptance, rejection, and requests for other service provisions of R9-21-308 and the appeal provisions of R9-21-401.
4. The updated ISP shall be implemented consistent with the provisions of R9-21-310.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

**R9-21-314. Modification or Termination of Plans**

- A.** Requests for modifications or termination of an ISP or any portion of an ISP may be initiated at the ISP review or at any other time by:
  1. The client;
  2. Any designated representative and/or guardian;
  3. A service provider; or
  4. Any member of the clinical team.
- B.** A request for modification or termination of an ISP shall be directed to the case manager.
- C.** The case manager shall give the client, the client's guardian and designated representative, appropriate service providers, and the client's clinical team written notice of any request for modification or termination of the ISP.
- D.** An ISP may be modified in order to more appropriately meet the client's needs, goals, and objectives. An ISP shall be modified where:

1. The client withdraws consent to the ISP or any portion of the ISP;
  2. The client consents to services recommended as more suitable but previously refused by the client;
  3. The needs of the client have changed due to progress or lack of progress in meeting the client's goals and objectives;
  4. The proposed change will permit the client to receive services which are more consistent with the client's needs, less restrictive of the client's freedom, more integrated in the community, or more likely to maximize the client's ability to live independently;
  5. The client wants to change the long-term view and the focus of the ISP or no longer needs a service or services; or
  6. The client is no longer eligible for services according to R9-21-303.
- E.** The clinical team shall:
1. Be notified by a service provider of any proposed termination or modification of services in the ISP as soon as possible and always prior to its implementation;
  2. Promptly inform the client and any designated representative and/or guardian of the requested modification and seek the client's consent to implement such modification or termination; and
  3. Within 20 days of any request for modification or termination of an ISP, approve the request only if the request meets the requirements of subsection (D).
  4. Provide written notice of the right to appeal to the client and any designated representative and guardian in accordance with R9-21-401(B) whenever service to the client is to be terminated, suspended or reduced.
- F.** The case manager shall:
1. Incorporate the approved modification in the current ISP or prepare a revised ISP, as appropriate.
  2. Within five days of any approval by the clinical team, distribute the modified or revised ISP to the client, any designated representative and/or guardian, the members of the clinical team, and all service providers.
  3. Meet with the client or guardian to explain the modification or revision and the client's right to appeal according to R9-21-401.
- G.** If the client or any designated representative and/or guardian does not reject or appeal the termination or modification within 30 days of the date the modified ISP is distributed, the client shall be deemed to have accepted the termination or modification.
- H.** The client for whom a modification or termination is proposed or any designated representative and/or guardian may appeal a modification or termination according to R9-21-401.
- I.** If the clinical team denies the client's or guardian's request to modify or terminate an ISP, the client or the designated representative and/or guardian may appeal the denial according to R9-21-401.
- J.** No modification or termination of an ISP shall be made without the acceptance of the client or any designated representative and/or guardian, unless a qualified clinician determines that the modification or termination is required to avoid a serious or immediate threat to the health or safety of the client or others.
1. Except in an emergency, no requested termination of a client from a particular service or provider may be considered unless the standards and procedures set forth in R9-21-210 and the provisions of this rule are satisfied.
  2. The client may not be transferred from one program or location to another while an appeal is pending.
- K.** If a qualified clinician determines that the client is no longer eligible for services according to R9-21-303, the qualified clinician shall make a determination of non-eligibility, move to terminate services under the ISP and this rule, and notify in writing the client of the non-eligibility determination and of the right to appeal such determination, in accordance with R9-21-401. When appropriate, referral and provision for further treatment shall be made by the case manager or clinical team.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

**R9-21-315. Renumbered****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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). Renumbered to R9-21-401 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

**ARTICLE 4. APPEALS, GRIEVANCES, AND REQUESTS FOR INVESTIGATION FOR PERSONS WITH SERIOUS MENTAL ILLNESS**

**R9-21-401. Appeals**

- A.** A client or an applicant may file an appeal concerning decisions regarding eligibility for behavioral health services, including Title XIX services, fees and waivers; assessments and further evaluations; service and treatment plans and planning decisions; and the implementation of those decisions. Appeals regarding a determination of categorical ineligibility for Title XIX shall be directed to the agency that made the determination.
1. Disagreements among employees of the Administration, the regional authority, clinical teams, and service providers concerning services, placement, or other issues are to be resolved using the Administration's guidelines, rather than this Article.
  2. The case manager shall attempt to resolve disagreements prior to utilizing this appeal procedure; however, the client's right to file an appeal shall not be interfered with by any mental health agency or the Administration.
  3. The Office of Human Rights shall assist clients in resolving appeals according to R9-21-104.
  4. If a client or, if applicable, an individual on behalf of the client, files an appeal of a modification to or termination of a behavioral health service according to this Section, the client's service shall continue while the appeal is pending unless:
    - a. A qualified clinician determines that the modification or termination is necessary to avoid a serious or immediate threat to the health or safety of the client or another individual; or
    - b. The client or, if applicable, the client's guardian agrees in writing to the modification or termination.
- B.** Applicants and clients shall be informed of their right to appeal at the time an application for services is made, when an

eligibility determination is made, when a decision regarding fees or the waiver of fees is made, upon receipt of the assessment report, during the ISP, ITDP, and review meetings, at the time an ISP, ITDP, and any modification to the ISP or ITDP is distributed, when any service is suspended or terminated, and at any other time provided by this Chapter. The notice shall be in writing in English and Spanish and shall include:

1. The client's right to appeal and to an administrative hearing according to A.R.S. § 41-1092.03;
  2. The method by which an appeal and an administrative hearing may be obtained;
  3. That the client may represent himself or use legal counsel or other appropriate representative;
  4. The services available to assist the client from the Office of Human Rights, Human Rights Committees, State Protection and Advocacy System, and other peer support and advocacy services;
  5. What action the mental health agency or regional authority intends to take;
  6. The reasons for the intended action;
  7. The specific rules or laws that support such action; and
  8. An explanation of the circumstances under which services will continue if an appeal or an administrative hearing is requested.
- C. The right to appeal in this Section does not include the right to appeal a court order entered according to A.R.S. Title 36, Chapter 5, Articles 4 and 5. The following issues may be appealed:
1. Decisions regarding the individual's eligibility for behavioral health services;
  2. The sufficiency or appropriateness of the assessment or any further evaluation;
  3. The long-term view, service goals, objectives, or timelines stated in the ISP or ITDP;
  4. The recommended services identified in the assessment report, ISP, or ITDP;
  5. The actual services to be provided, as described in the ISP, plan for interim services, or ITDP;
  6. The access to or prompt provision of services provided under Title XIX;
  7. The findings of the clinical team with regard to the client's competency, capacity to make decisions, need for guardianship or other protective services, or need for special assistance;
  8. A denial of a request for a review of, the outcome of a review of, a modification to or failure to modify, or a termination of an ISP, ITDP, or portion of an ISP or ITDP;
  9. The application of the procedures and timetables as set forth in this Chapter for developing the ISP or ITDP;
  10. The implementation of the ISP or ITDP;
  11. The decision to provide service planning, including the provision of assessment or case management services, to a client who is refusing such services, or a decision not to provide such services to such a client; or
  12. Decisions regarding a client's fee assessment or the denial of a request for a waiver of fees;
  13. Denial of payment for a client; and
  14. Failure of the regional authority or the Administration to act within the time frames for appeal established in this Chapter.
- D. Initiation of the appeal.
1. An appeal may be initiated by the client or by any of the following persons on behalf of a client or applicant requesting behavioral health services or community services:
    - a. The client's or applicant's guardian,
    - b. The client's or applicant's designated representative, or
    - c. A service provider of the client, if the client or, if applicable, the client's guardian gives permission to the service provider;
  2. An appeal is initiated by notifying the director of the regional authority or the director designee orally or in writing of the decision, report, plan or action being appealed, including a brief statement of the reasons for the appeal and the current address and telephone number, if available, of the applicant or client and designated representative.
  3. An appeal shall be initiated within 60 days of the decision, report, plan, or action being appealed. However, the director of the regional authority or the director designee shall accept a late appeal for good cause. If the regional authority director or the director designee refuses to accept a late appeal, the director or director designee shall notify the individual or client in writing, with a statement of reasons for the decision. Within 10 days of the notification, the client or applicant may request review of that decision by the Administration, who shall act within 15 days of receipt of the request for review. The decision of the Administration shall be final.
  4. Within five days of receipt of an appeal, the director of the regional authority shall inform the client in writing that the appeal has been received and of the procedures that shall be followed during the appeal.
- E. Informal conference with the regional authority.
1. Within seven days of receipt of the notice of appeal, the director of the regional authority or the director designee shall hold an informal conference with the client, any designated representative and/or guardian, the case manager and representatives of the clinical team, and a representative of the service provider, if appropriate.
    - a. The regional authority director or the director's designee shall schedule the conference at a convenient time and place and shall inform all participants in writing of the time, date, and location two days before the conference.
    - b. Individuals may participate in the conference by telephone.
  2. The director of the regional authority or the director's designee shall chair the informal conference and shall seek to mediate and resolve the issues in dispute. To the extent that resolution satisfactory to the client or guardian is not achieved, the regional authority director or director's designee shall clarify issues for further appeal and shall determine the agreement, if any, of the participants as to the material facts of the case.
  3. Except to the extent that statements of the participants are reduced to an agreed statement of facts, all statements made during the informal conference shall be considered as offers in compromise and shall be inadmissible in any subsequent hearing or court proceedings under this rule.
  4. If the informal conference with the director of the regional authority or the director's designee does not resolve the issues in dispute to the satisfaction of the client or, if applicable, the client's guardian, and the issues in dispute are not related to the client's eligibility for behavioral health services, the client or, if applicable, the client's guardian shall be informed that the matter may be further appealed to the Administration, and of the procedure for requesting a waiver of the informal conference with the Administration.

5. If a client or, if applicable, the client's guardian waives the right to an informal conference with the Administration according to subsection (E)(4) or, if the informal conference with the director of the regional authority or the director designee does not resolve the issues in dispute to the satisfaction of the client or, if applicable, the client's guardian, and the issues in dispute are related to the client's eligibility for behavioral health services, the regional authority shall, at the informal conference:
    - a. Provide written notice to the client or, if applicable, the client's guardian according to A.R.S. § 41-1092.03, and
    - b. Ask the client or, if applicable, the client's guardian whether the client or, if applicable, the client's guardian would like the regional authority to request an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client.
    - c. For a client who needs special assistance, send a copy of the notice in subsection (5)(a) to the appropriate human rights committee.
  6. If, at the informal conference, a client or, if applicable, the client's guardian requests that the regional authority file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client, the regional authority shall file the request within three days of the informal conference.
  7. If resolution satisfactory to the client or guardian is achieved, the director of the regional authority or the director designee shall issue a dated written notice to all parties which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved and the date by which the resolution will be implemented.
- F. Informal conference with the Administration.**
1. Within three days of the conclusion of an informal conference with the regional authority according to subsection (E)(4), the director of the regional authority or the director designee shall notify the Administration and shall immediately forward the client's notice of appeal, all documents relevant to the resolution of the appeal and any agreed statements of fact.
  2. Within 15 days of the notification from the regional authority director or the director designee, the Administration shall hold an informal conference with the client, any designated representative and/or guardian, the case manager, and representatives of the clinical team, the service provider, if appropriate, for the purpose of mediating and resolving the issues being appealed.
    - a. The Administration shall schedule the conference at a convenient time and place and shall inform the participants in writing of the time, date, and location five days prior to the conference.
    - b. Individuals may participate in the conference by telephone.
    - c. If a client is unrepresented at the conference but needs assistance, or if for any other reason the Administration determines the appointment of a representative to be in the client's best interest, the Administration may designate a human rights advocate or other person to assist the client in the appeal.
  3. To the extent that resolution satisfactory to the client or guardian is not achieved, the Administration shall clarify issues for further appeal and shall determine the agreement, if any, of the participants as to the material facts of the case.
  4. If resolution satisfactory to the client or guardian is achieved, the Administration shall issue a dated written notice to all parties which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved, and the date by which the resolution will be implemented.
  5. Except to the extent that statements of the participants are reduced to an agreed statement of facts, all statements made during the informal conference shall be considered as offers in compromise and shall be inadmissible in any subsequent hearing or court proceedings under this rule.
  6. If all issues in dispute are not resolved to the satisfaction of the client or guardian at the informal conference with the Administration, the Administration shall, at the informal conference:
    - a. Provide written notice to the client or, if applicable, the client's guardian according to A.R.S. § 41-1092.03, and
    - b. Ask the client or, if applicable, the client's guardian whether the client or, if applicable, the client's guardian would like the Administration to file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client.
    - c. For all clients including clients who needs special assistance, send a copy of the notice in subsection (6)(a) to the Office of Human Rights and the appropriate human rights committee.
  7. If, at the informal conference, a client or, if applicable, the client's guardian requests that the Administration file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client, the Administration shall file the request within three days of the informal conference according to subsection (G).
- G. The fair hearing.**
1. Within three days of the informal conference with the Administration, if the conference failed to resolve the appeal, or within five days of the date the conference was waived, the Administration shall forward a request to schedule a fair hearing.
  2. Within five days of the notification, the Administration shall send a written notice of fair hearing to all parties, informing them of the time and place of the hearing, the name, address, and telephone number of the Administrative Law Judge, and the issues to be resolved. The notice shall also be sent to the appropriate human rights committee and the Office of Human Rights for all clients, including clients who need special assistance.
  3. A fair hearing shall be held on the appeal in a manner consistent with A.R.S. § 41-1092 et seq., and those portions of 9 A.A.C. 1 which are consistent with this Article.
  4. During the pendency of the appeal, the client, any designated representative and/or guardian, the clinical team, and representatives of any service providers may agree to implement any part of the ISP or ITDP or other matter under appeal without prejudice to the appeal.
  5. The client or applicant shall have the right to be represented at the hearing by a person chosen by the client or applicant at the client's or applicant's own expense, in accordance with Rule 31, Rules of the Supreme Court.
  6. The client, any designated representative and/or guardian, and the opposing party shall have the right to present any evidence relevant to the issues under appeal and to call and examine witnesses. The Administration shall have the right to appear to present legal argument.

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7. The client and any designated representative and/or guardian shall have the right to examine and copy at a reasonable time prior to the hearing all records held by the Administration, regional authority, or service provider pertaining to the client and the issues under appeal, including all records upon which the ISP or ITDP decisions were based.
8. Any portion of the hearing may be closed to the public if the client requests or if the Administrative Law Judge determines that it is necessary to prevent the unwarranted invasion of a client's privacy or that public disclosure would pose a substantial risk of harm to a client.

**H. Expedited appeal.**

1. At the time an appeal is initiated, the applicant, client, or mental health agency may request orally or in writing an expedited appeal on issues related to crisis or emergency services or for good cause. Any appeal from a decision denying admission to or continued stay at an inpatient psychiatric facility due to lack of medical necessity shall be accompanied by all medical information necessary to resolution of the appeal and shall be expedited.
2. An expedited appeal shall be conducted in accordance with the provisions of this Section, except as provided for in this subsection.
3. Within one day of receipt of an expedited appeal, the director of the regional authority shall inform the client in writing that the appeal has been received.
4. The director of the regional authority shall accept an expedited appeal on issues related to crisis or emergency services. The regional authority shall also accept an expedited appeal for good cause. If the regional authority refuses to expedite the appeal based on a determination that good cause does not exist, the director shall notify the applicant or client in writing within one day of the initiation of the appeal, with a statement of reasons for the decision, and shall proceed with the appeal in accordance with the provisions of this Section. Within three days of the notification of refusal to expedite the appeal for good cause, the client or applicant may request review of the decision by the Administration, who shall act within one day. The decision of the Administration shall be final.
5. If the regional authority accepts the appeal for expedited consideration, the director shall hold the informal conference according to R9-21-401(E) within two days of the initiation of the appeal. The regional authority shall schedule the conference at a convenient time and place and shall inform all participants of the time, date and location prior to the conference.
6. If the informal conference with the director of the regional authority or the director's designee does not resolve the issues in dispute to the satisfaction of the client or, if applicable, the client's guardian, and the issues in dispute are not related to the client's eligibility for behavioral health services, the client or, if applicable, the client's guardian shall be informed that the matter may be further appealed to the Administration, and of the procedure for requesting waiver of the informal conference with the Administration.
7. If a client or, if applicable, the client's guardian waives the right to an informal conference with the Administration or, if the informal conference with the director of the regional authority or the director's designee does not resolve the issues in dispute to the satisfaction of the client or, if applicable, the client's guardian, and the issues in dispute are related to the client's eligibility for behav-

ioral health services, the regional authority shall, at the informal conference:

- a. Provide written notice to the client or, if applicable, the client's guardian according to A.R.S. § 41-1092.03, and
  - b. Ask the client or, if applicable, the client's guardian whether the client or, if applicable, the client's guardian would like the regional authority to request an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client.
  - c. Send a copy of the notice in subsection (H)(7)(a) to the Office of Human Rights and the appropriate human rights committee.
8. If, at the informal conference, a client or, if applicable, the client's guardian requests that the regional authority file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client, the Administration shall file the request within one day of the informal conference.
  9. Within one day of the conclusion of an informal conference with the regional authority, the director of the regional authority shall notify the Administration if the informal conference failed to resolve the appeal and shall immediately forward the client's notice of appeal and any agreed statements of fact unless the client or, if applicable, the client's guardian waived the client's right to an informal conference with the Administration or the issues in dispute are related to the client's eligibility for behavioral health services.
  10. Within two days of the notification from the regional authority, the Administration shall hold the informal conference pursuant to subsection (F).
  11. If all issues in dispute are not resolved to the satisfaction of the client or if applicable, the client's guardian at the informal conference with the Administration, the Administration shall, at the informal conference:
    - a. Provide written notice to the client or, if applicable, the client's guardian according to A.R.S. § 41-1092.03, and
    - b. Ask the client or, if applicable, the client's guardian whether the client or, if applicable, the client's guardian would like the Administration to file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client.
    - c. For a client who needs special assistance, send a copy of the notice in subsection (H)(11)(a) to the Office of Human Rights and the appropriate human rights committee.
  12. If, at the informal conference, a client or, if applicable, the client's guardian requests that the Administration file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client, the Administration shall file the request within one day of the informal conference.
  13. Within one day of the informal conference with the Administration, if the conference failed to resolve the appeal, or within two days of the date the conference was waived, the Administration shall forward a request to schedule a fair hearing.
  14. Within one day of notification, the Administration shall send a written notice of an expedited fair hearing in accordance with subsection (G)(2) and A.R.S. 41-1092, et seq.
  15. An expedited fair hearing shall be held on the appeal in accordance with subsection (G)(3) and A.R.S. 41-1092, et seq.

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- I.** Standard and burden of proof.
1. The standard of proof on all issues shall be by a preponderance of the evidence.
  2. The burden of proof on the issue of the need for or appropriateness of behavioral health services or community services shall be on the person appealing.
  3. The burden of proof on the issue of the sufficiency of the assessment and further evaluation, and the need for guardianship, conservatorship, or special assistance shall be on the agency which made the decision.
  4. The burden of proof on issues relating to services or placements shall be on the party advocating the more restrictive alternative.
- J.** Implementation of final decision. Within five days after a satisfactory resolution is achieved at an informal conference or after the expiration of an appeal period when no appeal is taken, or after the exhaustion of all appeals and subject to the final decision thereon, the regional authority shall implement the final decision and shall notify the client, any designated representative and/or guardian, and Administration of such action.
- K.** Appeal log.
1. The Administration and regional authority shall maintain logs of appeals filed under this Section.
  2. The log maintained by the Administration shall not include personally identifiable information and shall be a public record, available for inspection and copying by any person.
  3. With respect to each entry, the logs shall contain:
    - a. A unique docket number or matter number;
    - b. A substantive but concise description of the appeal including whether the appeal related to the provision of Title XIX services;
    - c. The date of the filing of appeal;
    - d. The date of the initial decision appealed from;
    - e. The date, nature and outcome of all subsequent decisions, appeals, or other relevant events; and
    - f. A substantive but concise description of the final decision and the action taken by the agency director and the date the action was taken.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-401 renumbered to R9-21-402; new Section R9-21-401 renumbered from R9-21-315 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

**R9-21-402. General**

- A.** It is the policy of the Administration to conduct investigations and bring matters to a resolution in four circumstances: first, in the event of a death of a client; second, whenever there is alleged to have occurred a rights violation; third, whenever there is alleged to exist a condition requiring investigation because it is dangerous, illegal or inhumane; and fourth, in any other case where an investigation would be in the public interest, as determined by the Administration. The purpose of R9-21-402 through R9-21-410 is to implement that policy. All investigations according to R9-21-402 through R9-21-410 shall be carried out in a prompt and equitable manner and with due regard for the dignity and rights of all persons involved. R9-21-402 through R9-21-410 do not obviate the need for sys-

tematically reporting, where appropriate, accidents and injuries involving clients.

- B.** This grievance and investigation procedure applies to any allegation that a rights violation or a condition requiring investigation, as defined in R9-21-101, has occurred or currently exists.
1. A grievance may be filed by a client, guardian, human rights advocate, human rights committee, State Protection and Advocacy System, designated representative, or any other concerned person when a violation of the client's rights or of the rights of several clients has occurred.
  2. A request for an investigation may be filed by any person whenever a condition requiring investigation occurs or has occurred.
  3. Allegations about the need for or appropriateness of behavioral health services or community services should generally should be addressed according to the Individual Service Planning Sections R9-21-301 through R9-21-314 and according to R9-21-401, as applicable.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-402 renumbered to R9-21-403; new Section R9-21-402 renumbered from R9-21-401 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

**R9-21-403. Initiating a Grievance or Investigation**

- A.** Any individual may file a grievance regarding an abridgement by a mental health agency of one or more of a client's rights in Article 2 of this Chapter,
- B.** Any individual may request an investigation regarding a condition requiring investigation.
- C.** An employee of or individual under contract with one of the following shall file a grievance if the employee has reason to believe that a mental health agency has abridged one or more of a client's rights in Article 2 of this Chapter or that a condition requiring investigation exists, and shall receive disciplinary action for failure to comply with this subsection:
1. A service provider,
  2. A regional authority,
  3. An inpatient facility, or
  4. The Administration.
- D.** A service provider or regional authority shall file a grievance if it:
1. Receives a non-frivolous allegation that:
    - a. A mental health agency has abridged one or more of a client's rights in Article 2 of this Chapter, or
    - b. A condition requiring investigation exists; or
  2. Has reason to believe that there exists or has occurred a condition requiring investigation in a mental health agency or program.
- E.** The Administration shall request an investigation if:
1. The Administration determines that it would be in the best interests of a client, the Administration, or the public; or
  2. The Administration receives a non-frivolous allegation or has reason to believe that:
    - a. A mental health agency has abridged one or more of a client's rights in Article 2 of this Chapter, or
    - b. A condition requiring investigation exists.
- F.** To file a grievance, an individual shall communicate the grievance orally or submit the grievance in writing to any employee of a mental health agency who shall forward the grievance to

the appropriate person as identified in R9-21-404. If asked to do so by a client, an employee shall assist the client in making an oral or written grievance or shall direct the client to the available supervisory or managerial staff who shall assist the client in making an oral or written grievance.

- G.** Any grievance or request for investigation shall be accurately and completely reduced to writing on an Administration-provided grievance or request for investigation form by:
1. The individual filing the grievance or request for investigation, or
  2. The mental health agency to whom the grievance or request for investigation is made.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-403 renumbered to R9-21-404; new Section R9-21-403 renumbered from R9-21-402 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

**R9-21-404. Persons Responsible for Resolving Grievances and Requests for Investigation**

- A.** Allegations involving rights violations:
1. Of other than physical abuse, sexual abuse, or sexual misconduct that occurred in a mental health agency, or as a result of an action of a person employed by a mental health agency, shall be addressed to and initially decided by:
    - a. The appropriate regional authority; or
    - b. If the mental health agency is operated exclusively by a governmental entity the allegation shall be addressed to and initially decided by that agency; or
  2. Of physical abuse, sexual abuse, or sexual misconduct that occurred in a mental health agency, or as a result of an action of a person employed by a mental health agency, shall be addressed to and decided by the Administration.
- B.** Allegations involving conditions requiring investigation:
1. Of other than a client death, which occurred in a mental health agency, or as a result of a person employed by a mental health agency, shall be addressed to and initially decided by:
    - a. The appropriate regional authority; or
    - b. If the mental health agency is operated exclusively by a governmental entity, the allegation shall be addressed to and initially decided by that agency; or
  2. Of a client death, which occurred in a mental health agency, or as a result of an action of a person employed by a mental health agency, shall be addressed to and decided by the Administration.
- C.** Within five days of receipt by a mental health agency of a grievance or request for investigation:
1. The mental health agency shall inform the person filing the grievance or request, in writing, that the grievance or request has been received;
  2. If the mental health agency is operated exclusively by a governmental entity, the mental health agency shall provide a copy of the grievance to the appropriate regional authority; and
  3. If the client is in need of special assistance, the mental health agency shall immediately send a copy of the grievance or request to the Office of Human Rights and the

human rights committee with jurisdiction over the agency.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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). Former Section R9-21-404 renumbered to R9-21-405; new Section R9-21-404 renumbered from R9-21-403 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

**R9-21-405. Preliminary Disposition**

- A.** The agency director before whom a grievance or request for investigation has been initiated shall immediately take whatever action may be reasonable to protect the health, safety and security of any client, witness, individual filing the grievance or request for investigation, or individual on whose behalf the grievance or request for investigation is filed.
- B.** Summary disposition.
1. A mental health agency or the Administration may summarily dispose of any grievance or a request for an investigation where the alleged rights violation or condition occurred more than one year immediately prior to the date on which the grievance or request is made.
  2. A mental health agency or the Administration who receives a grievance or request which is primarily directed to the level or type of mental health treatment provided to a client, which can be fairly and efficiently addressed within the procedures set forth in Article 3 and in R9-21-401, and which do not directly or indirectly involve any rights set forth in A.R.S. Title 36 or Article 2, may refer the grievance for resolution through the Individual Service Plan process or the appeal process in R9-21-401.
- C.** Disposition without investigation.
1. Within seven days of receipt of a grievance or request for an investigation, a mental health agency or the Administration may promptly resolve a grievance or request without conducting a full investigation, where the matter:
    - a. Involves no dispute as to the facts;
    - b. Is patently frivolous; or
    - c. Is resolved fairly and efficiently within seven days without a formal investigation.
  2. Within seven days of receipt of the grievance or request described in subsection (C)(1), the mental health agency or the Administration shall prepare a written, dated decision.
    - a. The decision shall explain the essential facts, why the mental health agency or the Administration believes that the matter is appropriately resolved without the appointment of an investigator, and the resolution of the matter.
    - b. The mental health agency or the Administration shall send copies of the decision to the parties, together with a notice of appeal rights according to A.R.S. § 41-1092.03, and to anyone else having a direct interest in the matter.
  3. After the expiration of the appeal period without appeal by any party, or after the exhaustion of all appeals and subject to the final decision on the appeal, the mental health agency or the Administration shall promptly take

appropriate action and prepare and add to the case record a written, dated report of the action taken to resolve the grievance or request.

**D. Matters requiring investigation.**

1. If the matter complained of cannot be resolved without a formal investigation according to the criteria set forth in subsection (C)(1), within seven days of receipt of the grievance or request the mental health agency or the Administration shall prepare a written, dated appointment of an impartial investigator who, in the judgment of the mental health agency or the Administration, is capable of proceeding with the investigation in an objective manner but who shall not be:
  - a. Any of the persons directly involved in the rights violation or condition requiring investigation; or
  - b. A staff person who works in the same administrative unit as, except a person with direct line authority over, any person alleged to have been involved in the rights violation or condition requiring investigation.
2. Immediately upon the appointment of an investigator, the mental health agency or the Administration shall notify the person filing the grievance or request for investigation in writing of the appointment. The notice shall contain the name of the investigator, the procedure by which the investigation will be conducted and the method by which the person may obtain assistance or representation.

- E.** If a client is a client who needs special assistance, the mental health agency or the Administration shall immediately send a copy of the grievance or request to the Office of Human Rights and the human rights committee with jurisdiction over the agency and shall send a copy of all decisions required by this Chapter made by the mental health agency or the Administration regarding the grievance or request to the Office of Human Rights and the human rights committee with jurisdiction over the agency.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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). Former Section R9-21-405 renumbered to R9-21-406; new Section R9-21-405 renumbered from R9-21-404 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

**R9-21-406. Conduct of Investigation**

- A.** Within 10 days of the appointment, the investigator shall hold a private, face-to-face conference with the person who filed the grievance or request for investigation to learn the relevant facts that form the grounds for the grievance or request, unless the grievance or request has been initiated by a mental health agency or the Administration according to R9-21-403 (D) or (E).
1. In scheduling such conference, and again at the conference, if the client appears without a designated representative, the investigator shall advise the client that:
    - a. The client may be represented by a designated representative of the client's own choice. The investigator shall also advise the client of the availability of assistance from the State Protection and Advocacy
- System, the Office of Human Rights, and the relevant human rights committee.
- b. The client may make an audio tape of the conference and all future conferences, meetings or hearings to which the client may be a party during the investigation, provided that the client notify all other parties not later than the beginning of the meeting or hearing that the client intends to do so.
  - c. In any case where the person initiating the grievance or request, or the person(s) who is alleged to have been responsible for the rights violation or condition, is a client and is in need of special assistance and is unrepresented, the investigator shall give the Office of Human Rights notice of the need for representation.
2. Where the grievance has been initiated by the mental health agency or the Administration, the investigator shall promptly determine which persons have relevant information concerning the occurrence of the alleged rights violation or condition requiring investigation and proceed to interview such individuals.
- B.** Within 15 days of the appointment, but only after the conference with the person initiating the grievance or request for investigation, the investigator shall hold a private, face-to-face conference with the person(s) complained of or thought to be responsible for the rights violation or condition requiring investigation to discuss the matter and, in scheduling the conference with such person(s) or with any other witness, the investigator shall advise the person(s) or any other witness that:
1. The individual may make a recording of the conference and all future conferences, meetings or hearings during the course of the investigation, provided that the individual must notify all other parties to such meetings or hearings not later than the beginning of the meeting or hearing if the individual intends to so record.
  2. An employee of an inpatient facility, service provider, regional authority or the Administration has an obligation to cooperate in the investigation.
  3. Failure of an employee to cooperate may result in appropriate disciplinary action.
- C.** The investigator shall gather whatever further information may seem relevant and appropriate, including interviewing additional witnesses, requesting and reviewing documents, and examining other evidence or locations.
- D.** Within 10 days of completing all interviews with the parties but not later than 30 days from the date of the appointment, the investigator shall prepare a written, dated report briefly describing the investigation and containing findings of fact, conclusions, and recommendations
- E.** Within five days of receiving the investigator's report, the agency director shall review the report and the case record and prepare a written, dated decision which shall either:
1. Accept the investigator's report in whole or in part, at least with respect to the facts as found, and state a summary of findings and conclusions and the intended action of the agency director; and send:
    - a. A copy of the decision to:
      - i. The investigator;
      - ii. The individual who filed the grievance or request for investigation;
      - iii. The individual who is the subject of the grievance or request for investigation, if applicable;
      - iv. The Office of Human Rights; and
      - v. The appropriate human rights committee.

- b. A notice to the individual who filed the grievance or request for investigation and, if applicable, the client who is the subject of the grievance or request for investigation or, if applicable, the client's guardian, of:
  - i. If the decision is from an agency director, the client's right to appeal to the Administration according to R9-21-406 and to an administrative hearing according to A.R.S. § 41-1092.03; and
  - ii. If the decision is from the Administration, the client's right to an administrative hearing according to A.R.S. § 41-1092.03; or
- 2. Reject the report for insufficiency of facts and return the matter for further investigation. In such event, the investigator shall complete the further investigation and deliver a revised report to the agency director within 10 days. Upon receipt of the report, the agency director shall proceed as provided in subsection (E)(l).
- F. Actions that an agency director may take according to subsection (E)(1) include:
  - 1. Identifying training or supervision for or disciplinary action against an individual responsible for a rights violation or condition requiring investigation identified during the course of investigating a grievance or request for investigation;
  - 2. Developing or modifying a mental health agency's policies and procedures;
  - 3. Notifying the regulatory entity that licensed or certified an individual according to A.R.S. Title 32, Chapter 33 of the findings from the investigation; or
  - 4. Imposing sanctions, including monetary penalties, according to terms of a contract, if applicable.
- G. After the expiration of the appeal period set forth in R9-21-407, or after the exhaustion of all appeals and subject to the final decision on the appeal, the agency director shall promptly take the action set forth in the decision and add to the case record a written, dated report of the action taken. A copy of the report shall be sent to the Office of Human Rights and the human rights committee if the client is in need of special assistance.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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). Former Section R9-21-406 renumbered to R9-21-407; new Section R9-21-406 renumbered from R9-21-405 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

#### R9-21-407. Administrative Appeal

- A. Any grievant or the client who is the subject of the grievance who is dissatisfied with the final decision of the agency director may, within 30 days of receipt of the decision, file a notice of appeal with the Administration. The appealing party shall send copies of the notice to the other parties and their representatives and to the agency director who shall forward the full case record to the Administration.
- B. The Administration shall review the notice of appeal and the case record, and may discuss the matter with any of the persons involved or convene an informal conference. Within 15

days of the filing of the appeal, the Administration shall prepare a written, dated decision which shall either:

1. Accept the investigator's report, in whole or in part, at least with respect to the facts as found, and affirm, modify or reject the decision of the agency director with a statement of reasons; or
2. Reject the investigator's report for insufficiency of facts and return the matter with instructions to the agency director for further investigation and decision. In such event, the further investigation shall be completed and a revised report and decision shall be delivered to the Administration within 10 days. Upon receipt of the report and decision, the Administration shall render a final decision, consistent with the procedures set forth in subsection (B)(1).
3. A designated representative shall be afforded the opportunity to be present at any meeting or conference convened by the Administration to which the represented party is invited.
4. The Administration shall send copies of the decision to:
  - a. The parties, together with a notice of appeal rights according to A.R.S. § 41-1092.03;
  - b. The agency director; and
  - c. The Office of Human Rights and the applicable human rights committee for all clients, including clients who are in need of special assistance.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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). Former Section R9-21-407 renumbered to R9-21-408; new Section R9-21-407 renumbered from R9-21-406 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

#### R9-21-408. Further Appeal to Administrative Hearing

- A. Any grievant or the client who is the subject of the grievance who is dissatisfied with the Director's decision of the Administration may request a fair hearing before an Administrative Law Judge.
  1. Within 30 days of the date of the Director's decision, the appealing party shall file with the Administration a notice requesting a fair hearing.
  2. Upon receipt of the notice, the Administration shall send a copy to the parties, and to the Office of Human Rights and the human rights committee for clients who are in need of special assistance.
- B. The hearing shall be conducted consistent with A.R.S. § 41-1092 et seq., and those portions of 9 A.A.C. 1 which are consistent with this Article.
  1. The client shall have the right to be represented at the hearing by an individual chosen by the client at the client's own expense, in accordance with Rule 31, Rules of the Supreme Court. If the client has not designated a representative to assist the client at the hearing and is in need of special assistance, the human rights committee, or the human rights advocate unless refused by the client, shall make all reasonable efforts to represent the client.
  2. Any portion of the hearing may be closed to the public if the client requests or if the Administrative Law Judge determines that it is necessary to prevent an unwarranted

invasion of the client's privacy or that public disclosure would pose a substantial risk of harm to the client.

3. The Administration shall explain the Director's decision to the client at the client's request, together with the right to seek rehearing and judicial review.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Section repealed; new Section R9-21-408 renumbered from R9-21-407 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

#### R9-21-409. Notice and Records

- A. Notice to clients. All clients shall be informed of their right to file a grievance or request for investigation under these rules.
  1. Notice of this grievance and investigation process shall be included in the information posted or otherwise provided to every current and new client and employee. Special efforts shall be made to inform current and new residents of mental health facilities of this process and of the right to file a grievance or request for investigation;
  2. A copy of a brief memorandum explaining these rules shall be given to every current and new resident of an inpatient facility;
  3. Such memorandum and blank copies of the forms for filing a grievance, request for investigation, and appeal shall be posted in a prominent place in plain sight on every unit of an inpatient facility or in a program operated by a service provider; and
  4. Such memoranda, forms and copies of these rules shall be available at each inpatient facility, regional authority and service provider upon request by any person at any time.
- B. Notice and oversight by the Office of Human Rights and human rights committees.
  1. Upon receipt of any grievance or request for investigation involving a client, including a client who is in need of special assistance, the agency director shall immediately forward a copy of such grievance or request to the Office of Human Rights and the appropriate regional human rights committee.
  2. Upon receipt of such a grievance from the agency director, at the request of a client, or on its own initiative, the Office of Human Rights and/or the appropriate human rights committee shall assist a client in filing a grievance or request, if necessary. The Office and/or committee shall use its best efforts to see that such client is represented by an attorney, human rights advocate, committee member, or other person to protect the individual's interests and present information on the client's behalf. The Office and/or committee shall maintain a list of attorneys and other representatives, including the state protection and advocacy system, available to assist clients.
  3. Whenever the human rights committee has reason to believe that a rights violation involving abuse or a dangerous condition requiring investigation, including a client death, has occurred or currently exists, or that any rights violation or condition requiring investigation occurred or exists which involves a client who is in need of special assistance, it may, upon written notice to the official before whom the matter is pending, become a party to the grievance or request. As a party it shall receive copies of all reports, plans, appeals, notices and

other significant documents relevant to the resolution of the grievance or request and be able to appeal any finding or decision.

4. The Office of Human Rights shall assist clients in resolving grievances according to R9-21-104.
- C. Notification of other persons.
  1. Whenever any rule, regulation, statute, or other law requires notification of a law enforcement officer, public official, medical examiner, or other person that an incident involving the death, abuse, neglect, or threat to a client has occurred, or that there exists a dangerous condition or event, such notice shall be given as required by law.
  2. A mental health agency shall immediately notify the Administration when:
    - a. A client brings criminal charges against an employee;
    - b. An employee brings criminal charges against a client;
    - c. An employee or client is indicted or convicted because of any action required to be investigated by this Article;
    - d. A client of an inpatient facility, a mental health agency, or a service provider dies. The agency director shall report such death according to the Administration's policy on the reporting and investigation of deaths.
    - e. A client of an inpatient facility, a mental health agency, or a service provider allegedly is physically or sexually abused.
  3. The investigation by the Administration provided for by this Article is independent of any investigation conducted by police, the county attorney, or other authority.
- D. Case records.
  1. A file, known as the case record, shall be kept for each grievance or request for investigation which is received by the Administration, ASH, regional authority or service provider under contract or subcontract with the Administration. The record shall include the grievance or request, the docket number or matter number assigned, the names of all persons interviewed and the dates of those interviews, either a taped or written summary of those interviews, a summary of documents reviewed, copies of memoranda generated by the investigation, the investigator's report, the agency director's decision, and all documents relating to any appeal.
  2. The investigator shall maintain possession of the case record until the investigation report is submitted. Thereafter, the agency director shall maintain control over the case record, except when the matter is on appeal. During any appeal, the record will be in the custody of the official who hears or decides the appeal.
- E. Public logs.
  1. The Administration and regional authority shall maintain logs of deaths and non-frivolous grievances or requests for investigation for inpatient facilities, agencies, service providers, and mental health agencies which it operates, funds, or supervises.
  2. The log maintained by the Administration shall not include personally identifiable information and shall be a public record, available for inspection and copying by any person.
  3. With respect to each grievance or request for investigation, the Administration's log shall contain:
    - a. A unique docket number or matter number;

- b. A substantive but concise description of the grievance or request for investigation;
- c. The date of the filing of grievance;
- d. The date of the initial decision or appointment of investigator;
- e. The date of the filing of the investigator's final report;
- f. A substantive but concise description of the investigator's final report;
- g. The date of all subsequent decisions, appeals, or other relevant events; and
- h. A substantive but concise description of the final decision and the action taken by the mental health agency or the Administration.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

#### R9-21-410. Miscellaneous

- A. Disqualification of official. The agency director, investigator, or any other official with authority to act on a grievance or request for investigation shall disqualify himself from acting, if such official cannot act on the matter impartially and objectively, in fact or in appearance. In the event of such disqualification, the official shall forthwith prepare and forward a written memorandum explaining the reasons for the decision to the Administration, as appropriate, who shall, within 10 days of receipt of the memorandum, take such steps as are necessary to resolve the grievance in an impartial, objective manner.
- B. Request for extension of time.
  - 1. The investigator or any other official of a mental health agency acting according to this Article may secure an extension of any time limit provided in this Article with the permission of the regional authority.
  - 2. The investigator or any other official of an inpatient facility operated exclusively by a governmental entity acting according to this Article may secure an extension of any time limit provided in this Article with the permission of the CEO of the entity or his designee.
  - 3. The investigator or any other official of the Administration acting according to this Article may secure an extension of any time limit provided in this Article with the permission of the Administration or designee.
  - 4. An extension of time may only be granted upon a showing of necessity and a showing that the delay will not pose a threat to the safety or security of the client.
  - 5. A request for extension shall be in writing, with copies to all parties. The request shall explain why an extension is needed and propose a new time limit which does not unreasonably postpone a final resolution of the matter.
  - 6. Such request shall be submitted to and acted upon prior to the expiration of the original time limit. Failure of the rel-

evant official to act within the time allowed shall constitute a denial of the request for an extension.

- C. Procedural irregularities.
  - 1. Any party may protest the failure or refusal of any official with responsibility to take action in accord with the procedural requirements of this Article, including the time limits, by filing a written protest with the Administration.
  - 2. Within 10 days of the filing of such a protest, the Administration shall take appropriate action to ensure that if there is or was a violation of a procedure or timeline, it is promptly corrected, including, if appropriate, disciplinary action against the official responsible for the violation or by removal of an investigator and the appointment of a substitute.
- D. Special Investigation.
  - 1. The Administration may at any time order that a special investigator review and report the facts of a grievance or condition requiring investigation, including a death or other matter.
  - 2. The special investigator and the Administration shall comply with the time limits and other procedures for an investigation set forth in this Article.
  - 3. Any final decision issued by the Administration based on such an investigation under this rule is appealable as provided in R9-21-408.
  - 4. Nothing in this Article shall prevent the Administration from conducting an investigation independent of these rules.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

### ARTICLE 5. COURT-ORDERED EVALUATION AND TREATMENT

#### R9-21-501. Court-ordered Evaluation

- A. An application for court-ordered evaluation shall, according to A.R.S. § 36-521, be made on Department form MH-100, Titled "Application for Involuntary Evaluation," set forth in Exhibit A.
- B. Any mental health agency or service provider that receives an application for court-ordered evaluation shall immediately refer the applicant for pre-petition screening and petitioning for court-ordered evaluation, provided for in A.R.S. Title 36, Chapter 5, Article 4, to:
  - 1. A regional authority; or
  - 2. If a county has not contracted with a regional authority for pre-petition screening and petitioning for court-ordered evaluation, the county.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Section repealed; new Section R9-21-501 renumbered from R9-21-502 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

Exhibit A. Application for Involuntary Evaluation

APPLICATION FOR INVOLUNTARY EVALUATION
(Pursuant to A.R.S. § 36-520)

STATE OF ARIZONA )
COUNTY OF )

To the (Regional or Screening Authority)

- 1. The undersigned applicant requests that the above agency conduct a pre-petition screening of the person named herein.
2. The undersigned applicant alleges that there is now in the County a person whose name and address are:

(Name) (Address)

and that s/he believes that the person has a mental disorder and as a result of said mental disorder, is:

- a danger to self; a danger to others;
gravely disabled; persistently or acutely disabled

and is:

- unwilling to undergo voluntary evaluation, as evidenced by the following facts:
unable to undergo voluntary evaluation, as demonstrated by the following facts:

and who is believed to be in need of supervision, care, and treatment because of the following facts:

- 3. The conclusion that the person has a mental disorder is based on the following facts:
4. The conclusion that the person is dangerous or disabled is based on the following facts:

PERSONAL DATA OF PROPOSED PATIENT:

Age Date of Birth Sex Race
Weight Height Hair Color Eye Color
Marital Status Number of Children
Social Security No. Religion
Distinguishing Marks
Occupation
Present Location
Dates and Places of Previous Hospitalization
How Long in Arizona State Last From
Veteran? C-No. Education

NAME, ADDRESS AND TELEPHONE NUMBER OF:

- 1) Guardian \_\_\_\_\_
- 2) Spouse \_\_\_\_\_
- 3) Next of Kin \_\_\_\_\_
- 4) Significant Other Persons \_\_\_\_\_

\_\_\_\_\_ DATE \_\_\_\_\_ SIGNATURE OF APPLICANT \_\_\_\_\_

Printed or Typed Name of Applicant \_\_\_\_\_

Relationship to Proposed Patient \_\_\_\_\_

Applicant's Address \_\_\_\_\_

Applicant's Telephone \_\_\_\_\_

SUBSCRIBED AND SWORN to before me this \_\_\_\_\_ day of \_\_\_\_\_, 19 \_\_\_\_\_

\_\_\_\_\_  
Notary Public

My Commission Expires:  
\_\_\_\_\_

ADHS/BHS Form MH-100 (9/93)

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit A repealed, new Exhibit A adopted 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). Renumbered from a position after R9-21-502 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

Exhibit B. Petition for Court-ordered Evaluation

PETITION FOR COURT-ORDERED EVALUATION
IN THE SUPERIOR COURT OF THE STATE OF ARIZONA
IN AND FOR THE COUNTY OF \_\_\_\_\_

In the Matter of )
) MH
)
) PETITION FOR COURT-
) ORDERED EVALUATION
) (Pursuant to A.R.S. § 36-523)
)
re: Mental Health Services)
\_\_\_\_\_ )

STATE OF ARIZONA )
)
COUNTY OF )

Petitioner, \_\_\_\_\_
(Medical Director)

being first duly sworn/affirmed, alleges that:

- 1. There is now in this County a person whose name and address are as follows:
(Name) (Address)
2. The person may presently be found at:
3. There is reasonable cause to believe that the person has a mental disorder and is as a result:
A danger to self; A danger to others;
Gravely disabled; Persistently or acutely disabled and is:
4. The person is unwilling to undergo voluntary evaluation, as evidenced by the following facts:
5. The person is unable to undergo voluntary evaluation, as demonstrated by the following reasons:
6. The person is believed to be in need of supervision, care, and treatment because of the following facts:
7. The conclusion that the person has a mental disorder is based on the following facts:
8. The conclusion that the person is dangerous or disabled is based on the following facts:
9. The conclusion that all available alternatives have been investigated and deemed inappropriate is based on the following facts:
10. Applicant information:
Name of Applicant:
Address of Applicant:
Relationship to or Interest in the Proposed Patient:

- 11. In the opinion of the Petitioner, the person is \_\_\_\_\_ is not \_\_\_\_\_ in such a condition that, without immediate or continuing hospitalization, s/he is likely to suffer serious physical harm or inflict serious physical harm upon another person.
- 12. In the opinion of the Petitioner, evaluation should \_\_\_\_\_ should not \_\_\_\_\_ take place on an outpatient basis, based upon the following reasons: \_\_\_\_\_

PETITIONER REQUESTS THAT THE COURT:

Issue an Order requiring the person to be given an \_\_\_\_\_ Inpatient \_\_\_\_\_ Outpatient evaluation.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Signature Of Petitioner

\_\_\_\_\_  
Printed or Typed Name

SUBSCRIBED AND SWORN to before me this \_\_\_\_\_ day of \_\_\_\_\_, 19 \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

My Commission Expires:

\_\_\_\_\_

ADHS/BHS Form MH-105 (9/93)

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit B repealed, new Exhibit B adopted 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). Renumbered from a position after R9-21-502 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

**R9-21-502. Emergency Admission for Evaluation**

- A. An application for emergency evaluation pursuant to A.R.S. § 36-524 may be made to any evaluation agency licensed and approved by the Department to provide such services on Department form MH-104, Titled "Application for Emergency Admission for Evaluation," set forth in Exhibit C.
- B. Prior to admission of an individual under this rule, the evaluation agency shall notify the appropriate regional authority of the potential admission so that the regional authority may first:
  - 1. Provide services or treatment to the individual as an alternative to admission; or
  - 2. Authorize admission of the individual.
- C. If the evaluation agency does not provide notice pursuant to subsection (B) of this rule, the regional authority shall not be obligated to pay for the services provided.

- D. Only a mental health agency licensed by the Department to provide emergency services according to A.R.S. Title 36, Chapter 4 may provide court-ordered emergency admission services under A.R.S. Title 36, Chapter 5, Article 4.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-502 renumbered to R9-21-501; new Section R9-21-502 renumbered from R9-21-503 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

Exhibit C. Application for Emergency Admission for Evaluation

APPLICATION FOR EMERGENCY ADMISSION FOR EVALUATION
(Pursuant to A.R.S. § 36-524)

STATE OF ARIZONA )
)ss
COUNTY OF \_\_\_\_\_ )
\_\_\_\_\_ )

The undersigned applicant, being first duly sworn/affirmed, hereby requests that \_\_\_\_\_
(Evaluation Agency)
admit the person named herein for evaluation.

1. The undersigned applicant alleges that there is now in the County a person whose name and address are:

\_\_\_\_\_ (Name) \_\_\_\_\_ (Address)

and that s/he believes that the person has a mental disorder and, as a result of said mental disorder, is:

[ ] A danger to self; [ ] A danger to others;

and that, during the time necessary to complete pre-petition screening under A.R.S. §§ 36-520 and 36-521, the person is likely without immediate hospitalization to suffer serious physical harm or serious illness or is likely to inflict serious physical harm upon another person.

2. The conclusion that the person has a mental disorder is based on the following facts:

\_\_\_\_\_  
\_\_\_\_\_

3. The specific nature of the danger posed by this person is:

\_\_\_\_\_  
\_\_\_\_\_

4. A summary of the personal observations upon which this statement is based is as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PERSONAL DATA OF PROPOSED PATIENT:

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_
Weight \_\_\_\_\_ Height \_\_\_\_\_ Hair Color \_\_\_\_\_ Eye Color \_\_\_\_\_
Marital Status \_\_\_\_\_ Number of Children \_\_\_\_\_
Social Security No. \_\_\_\_\_ Religion \_\_\_\_\_
Distinguishing Marks \_\_\_\_\_
Occupation \_\_\_\_\_
Present Location \_\_\_\_\_
Dates and Places of Previous Hospitalization \_\_\_\_\_
How Long in Arizona \_\_\_\_\_ State Last From \_\_\_\_\_
Veteran? \_\_\_\_\_ C-No. \_\_\_\_\_ Education \_\_\_\_\_

NAME, ADDRESS AND TELEPHONE NUMBER OF:

- 1) Guardian \_\_\_\_\_
2) Spouse \_\_\_\_\_
3) Next of Kin \_\_\_\_\_
4) Significant Other Persons \_\_\_\_\_

DATE

SIGNATURE OF APPLICANT

Printed or Typed Name of Applicant \_\_\_\_\_

Relationship to Proposed Patient \_\_\_\_\_

Applicant's Address \_\_\_\_\_

Applicant's Telephone \_\_\_\_\_

SUBSCRIBED AND SWORN to before me this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_\_.

Notary Public

My Commission Expires:

\_\_\_\_\_

ADHS/BHS Form MH-104 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit C repealed, new Exhibit C adopted 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). Renumbered from a position after R9-21-503 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

R9-21-503. Voluntary Admission for Evaluation

- A. An application for voluntary evaluation pursuant to A.R.S. § 36-522 shall be submitted on Department form MH-103, Titled "Application for Voluntary Evaluation," set forth in Exhibit D to a mental health agency.
B. If a regional authority receives an application according to subsection (A), the regional authority shall provide for such evaluation under A.R.S. § 36-522 for any individual who:

- 1. Voluntarily makes application as provided in subsection (A);
2. Gives informed consent; and
3. Has not been adjudicated as an incapacitated person pursuant to A.R.S. Title 14, Chapter 5, or Title 36, Chapter 5.
C. Any mental health agency, which is not a regional authority under R9-21-501, that receives an application for voluntary evaluation shall immediately refer the individual to:
1. The county responsible for voluntary evaluations; or

2. If the county has contracted with a regional authority for voluntary evaluations, the appropriate regional authority.
- D.** Any mental health agency providing voluntary evaluation services pursuant to this Article shall place in the medical record of the individual to be evaluated the following:
1. A completed copy of the application for voluntary treatment;
  2. A completed informed consent form pursuant to R9-21-511; and
  3. A written statement of the individual's present mental condition.
- E.** Voluntary evaluation shall proceed only after the individual to be evaluated has given informed consent on Department form MH-103 and received information that the patient-physician

privilege does not apply and that the evaluation may result in a petition for the individual to undergo court-ordered treatment or for guardianship in the method prescribed by A.R.S. § 36-522.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-503 renumbered to R9-21-502; new Section R9-21-503 renumbered from R9-21-504 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

Exhibit D. Application for Voluntary Evaluation

APPLICATION FOR VOLUNTARY EVALUATION

(Pursuant to A.R.S. § 36-522)

The undersigned hereby requests a mental health evaluation to be performed by psychiatrists, psychologists, and social workers at

(Regional Authority)

on the following terms:

INPATIENT. I agree to remain as an inpatient in the above agency for a period of not more than 72 hours. I understand that, at the end of that period, the agency must release me or file a Petition for Court-Ordered Treatment, in which case I may be held until the court holds a hearing, which shall be no longer than six days from the date of filing the petition, excluding weekends and holidays. If such a Petition is filed, I will have the right to representation by a lawyer, and the court will appoint one for me if I cannot afford one.

OUTPATIENT. I agree to keep all scheduled appointments required for a complete evaluation, to the best of my ability. I understand that if I fail to appear, a Petition for Court-Ordered Evaluation or Treatment may be filed, in which case I may be detained and required to undergo involuntary evaluation and treatment. If such a Petition is filed, I will have the right to representation by a lawyer, and the court will appoint one for me if I cannot afford one.

I understand that the physician-patient privilege does not apply, and information I give during this evaluation may be used in court in a civil hearing for court-ordered treatment.

I understand that this evaluation may lead to a court hearing to determine if I need further treatment and that such treatment, or an investigation into the need for a guardianship, may be ordered by a court.

I understand that an application for my examination has been filed and I choose to be evaluated voluntarily rather than by court order.

I understand that my evaluation must take place within five days of my application.

I understand that I have a right to require the person who has applied for my evaluation to present evidence of the need for such evaluation to a court of law for approval or disapproval and I waive my right to require prior court review of the application.

I understand that I have a right, upon written request, to be discharged within 24 hours of that request (excluding weekends and holidays) unless the medical director of the evaluation agency files a petition for court-ordered evaluation.

Presented By

Signature of Applicant

Printed or Typed Name of Applicant

Date

ADHS/BHS Form MH-103 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit D repealed, new Exhibit D adopted 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). Renumbered from a position after R9-21-504 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

R9-21-504. Court-ordered Treatment

- A. The regional authority shall perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5 and this Article. In order to perform these functions, the regional authority or its contractor must be licensed by the Department.
B. A mental health agency may provide court-ordered treatment pursuant to A.R.S. Title 36, Chapter 5, Article 5, other than through contract with the regional authority, provided that:

- 1. The mental health agency is licensed by the Department to provide the court-ordered treatment;
2. The mental health agency complies with all applicable requirements under A.R.S. Title 36, Chapter 5, Article 5; and
3. The individual ordered to undergo treatment is not a client of the regional authority.
C. Upon a determination that an individual is a danger to self or others, gravely disabled, or persistently or acutely disabled,

and if no alternatives to court-ordered treatment exist, the medical director of the agency that provided the court-ordered evaluation shall file the appropriate affidavits on Department form MH-112, set forth in Exhibit E, with the court, together with one of the following petitions:

1. A petition for court-ordered treatment for an individual alleged to be gravely disabled, which shall be filed on Department form MH-110, set forth in Exhibit F.
  2. A petition for court-ordered treatment for an individual alleged to be a danger to self or others, which shall be filed on Department form MH-110, set forth in Exhibit F.
  3. A petition for court-ordered treatment for an individual alleged to be persistently or acutely disabled, which shall be filed on Department form MH-110, set forth in Exhibit F.
- D.** Any mental health agency filing a petition for court-ordered treatment of a client pursuant to subsection (A) above shall do

so in consultation with the client's clinical team prior to filing the petition.

- E.** With respect to inpatient and outpatient treatment, the petition filed with the court shall request that the individual be committed to the care and supervision of the regional authority, if the individual is a client, or to an appropriate mental health treatment agency, if the individual is not a client.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-504 renumbered to R9-21-503; new Section R9-21-504 renumbered from R9-21-505 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).



5. The conclusion that the person is dangerous or disabled is based on the following: \_\_\_\_\_  
\_\_\_\_\_

6. The conclusion that all available alternatives have been investigated and deemed inappropriate is based on the following:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

SUBSCRIBED AND SWORN to before me this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_\_.

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

ADHS/BHS Form MH-112 (9/93)

**PERSISTENTLY OR ACUTELY DISABLED (EXHIBIT E, ADDENDUM NO. 1)**

RE: \_\_\_\_\_

**IF PERSISTENTLY OR ACUTELY DISABLED:**

1. Does the person have a severe mental disorder that, if not treated, has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional, or physical harm that significantly impairs judgment, reason, behavior, or capacity to recognize reality?  
Yes \_\_\_ No \_\_\_

If yes, provide the facts that support this conclusion: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Does the severe mental disorder substantially impair the person's capacity to make an informed decision regarding treatment?  
Yes \_\_\_ No \_\_\_

If yes, provide the facts that support this conclusion: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2a. Does this impairment cause the person to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment, and understanding and expressing an understanding of the alternatives to the particular treatment offered?  
Yes \_\_\_ No \_\_\_

If yes, provide the facts that support this conclusion: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2b. Were the advantages and disadvantages of accepting treatment explained to the person?  
Yes \_\_\_ No \_\_\_

Arizona Health Care Cost Containment System (AHCCCS) - Behavioral Health Services for Persons with Serious Mental Illness

2c. Were the alternatives to treatment and the advantages and disadvantages of such alternatives explained to the person?
Yes \_\_\_ No \_\_\_

2d. Explain the specific reasons why the person is incapable of understanding and expressing an understanding of the explanations described in 2a, 2b, and 2c:
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

3. Is there a reasonable prospect that the severe mental disorder is treatable by outpatient, inpatient, or combined inpatient and outpatient treatment?
Yes \_\_\_ No \_\_\_

If yes, please provide the facts that support this conclusion:
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

ADHS/BHS Form MH-112 Addendum No. 1 (9/93)

GRAVELY DISABLED (EXHIBIT E, ADDENDUM NO. 2)

RE: \_\_\_\_\_

IF GRAVELY DISABLED:

1. Is the person's condition evidenced by behavior in which s/he, as a result of a mental disorder, is likely to come to serious physical harm or serious illness because s/he would be unable to provide for his/her basic physical needs without hospitalization?
Yes \_\_\_ No \_\_\_

2. If Yes, explain how his/her mental disability affects his/her ability to do the following and how any inability might harm him/her. Provide examples, if available, to support your conclusion:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

a. Provide for food: \_\_\_\_\_
\_\_\_\_\_

b. Provide for clothing and maintain hygiene: \_\_\_\_\_
\_\_\_\_\_

c. Provide for shelter: \_\_\_\_\_
\_\_\_\_\_

d. Obtain and maintain steady employment: \_\_\_\_\_
\_\_\_\_\_

e. Respond in an emergency: \_\_\_\_\_
\_\_\_\_\_

f. Care for present or future medical problems: \_\_\_\_\_
\_\_\_\_\_

g. Manage money: \_\_\_\_\_
\_\_\_\_\_

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h. Other:

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ADHS/BHS Form MH-112 Addendum No. 2 (9/93)

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit E repealed, new Exhibit E with Addenda 1 and 2 adopted 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). Renumbered from a position after R9-21-505 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

Exhibit F. Petition for Court-ordered Treatment

PETITION FOR COURT-ORDERED TREATMENT
Gravely Disabled Person

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA IN AND FOR THE COUNTY OF

In the Matter of )
) MH
)
) PETITION FOR COURT-
) ORDERED TREATMENT
) (Pursuant to A.R.S. § 36-533)
re: Mental Health Services ) Danger to Self/Others or
) Persistently or Acutely Disabled or
\_\_\_\_\_ ) Gravely Disabled

STATE OF ARIZONA )
) ss
COUNTY OF \_\_\_\_\_ )
\_\_\_\_\_ )

Petitioner \_\_\_\_\_, being first duly sworn/affirmed, alleges that:
(Medical Director)

- 1. \_\_\_\_\_ is, as a result of a mental disorder:
[ ] danger to self [ ] danger to others
[ ] persistently or acutely disabled
[ ] gravely disabled
and in need of treatment.
2. The court-ordered treatment alternatives that are appropriate and available are:
[ ] outpatient treatment [A.R.S. § 36-540(A)(1)].
[ ] combined inpatient and outpatient treatment [A.R.S. § 36-540(A)(2)].
[ ] inpatient treatment [A.R.S. § 36-540(A)(3)] at.
3. The person is unwilling or is unable to accept treatment voluntarily.
4. A summary of the facts supporting the above allegations is in the attached reports of examining physicians.
5. The person is residing or present in this county, or is admitted to an institution pursuant to an order of a court of competent jurisdiction sitting in this county, or who was committed by an Arizona tribal court, which order of commitment was duly domesticated pursuant to A.R.S. § 12-1702 et seq.
6. The person is entitled to notice of hearing of the petition and may be found at \_\_\_\_\_ (location)
7. Petitioner believes the person requires a:
\_\_\_\_\_ Title 14 guardian; \_\_\_\_\_ Conservator; \_\_\_\_\_ Title 36 guardian
and requests the Court to order an investigation and report to be made to the Court regarding this need. Said need exists because: \_\_\_\_\_
8. Petitioner believes the proposed person needs the immediate services of a temporary \_\_\_\_\_ guardian \_\_\_\_\_ conservator and requests that the Court appoint the same because: \_\_\_\_\_

Arizona Health Care Cost Containment System (AHCCCS) - Behavioral Health Services for Persons with Serious Mental Illness

- 9. Petitioner believes that \_\_\_\_\_ address: \_\_\_\_\_, is the person's guardian/conservator, who should receive notice of any hearing.
- 10. A copy of this Petition has been mailed to the Public Fiduciary of \_\_\_\_\_ County and (other guardian, if any) \_\_\_\_\_

PETITIONER requests that the Court:

- 1. Set a date for a hearing; and
- 2. After notice and hearing find that the person is suffering from a mental disorder the result of which renders him/her dangerous to self or others, persistently or acutely disabled, or gravely disabled and order a period of treatment, all as set forth in paragraphs (1) and (2) above.
- 3. Check if applicable;
  - Order an independent investigation and report to the Court regarding the need for a Title 14 guardian or conservator or Title 36 guardian.
  - Appoint the following-named person as temporary guardian and/or conservator of the person, who Petitioner believes to be a fit and proper person to serve in that capacity:

_____	_____
(Proposed Temporary Guardian/Conservator)	(Relation to Patient)

\_\_\_\_\_  
(Address of Proposed Temporary Guardian/Conservator)

- Impose the duties of a Title 36 guardian upon the person's A.R.S. Title 14 guardian who is \_\_\_\_\_

_____	_____
DATE	Signature of Petitioner Medical Director

SUBSCRIBED AND SWORN to before me this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC OR DEPUTY CLERK OF THE SUPERIOR COURT

My Commission Expires:

\_\_\_\_\_

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit F repealed, new Exhibit F adopted 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). Renumbered from a position after R9-21-505 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

**R9-21-505. Coordination of Court-ordered Treatment Plans with ISPs and ITDPs**

- A.** All inpatient and outpatient treatment plans prepared for clients according to A.R.S. §§ 36-533, 36-540 and 36-540.01, and any modifications to the treatment plans, shall be developed and implemented according to the individual service planning procedures in Article 3 of this Chapter, including the right of the client to request different services and to appeal the treatment plan.
- B.** If a client's ISP or ITDP is inconsistent with an inpatient or outpatient treatment plan ordered by the court, the mental health agency or regional authority, whichever is appropriate, shall recommend to the court that the court-ordered plan be amended so that it is consistent with the client's ISP or ITDP.
- C.** If, during the period a client is on outpatient status, an emergency occurs that satisfies the standards for emergency admission under A.R.S. §§ 36-524 and 36-526, and that requires immediate revocation or modification of an outpatient order, a modification may be submitted to the court in consultation with the client's clinical team without complying with the individual service planning procedures, provided that the client and clinical team subsequently review any such modification according to the individual service planning procedures in Article 3 of this Chapter.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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). Former Section R9-21-505 renumbered to R9-21-504; new Section R9-21-505 renumbered from R9-21-506 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

**R9-21-506. Review of Court-ordered Individual**

- A.** The mental health treatment agency that provides care for an individual ordered by a court to undergo treatment shall:
1. Assure that an examination and review of a court-ordered individual is accomplished in an effective and timely fashion, but not less than 30 days prior to expiration of any treatment portion of the order.
  2. Require written documentation of the examination and review.
  3. Maintain a special record that shall include:
    - a. The expiration date of any treatment portion of the court-ordered treatment; and
    - b. The date by which the review and examination must be initiated.
  4. Establish specific dates by which the review and examination will be accomplished.
  5. Conduct the review and examination by the specified dates.
- B.** In addition to subsection (A), the examination and review process for court-ordered clients shall, at a minimum, include the following:
1. The client's clinical team shall hold an ISP meeting pursuant to R9-21-307, not less than 30 days prior to the expiration of any treatment portion of the court order, which shall include the treatment team of the treatment agency providing behavioral health services under the court order. The ISP meeting shall include a determination by the clinical team of:
    - a. Whether the client continues to be a danger to others, a danger to self, gravely disabled, or persistently or acutely disabled;
    - b. That no alternatives to court-ordered treatment are appropriate; and
    - c. Whether court-ordered treatment should continue.
  2. If, upon conclusion of the ISP meeting, the clinical team determines that the client:
    - a. Continues to be a danger to others, a danger to self, gravely disabled, or persistently or acutely disabled;
    - b. That no alternatives to court-ordered treatment are appropriate; and
    - c. That court-ordered treatment should continue, the medical director of the mental health treatment agency providing care for the client committed by court order shall appoint two physicians (one of whom must be a psychiatrist) and the mental health worker assigned to the case to conduct an examination to determine whether the client continues to be a danger to others, a danger to self, gravely disabled, or persistently or acutely disabled.
  3. After such examination, the examining physicians shall enter a note in the progress sheet of the medical record stating the findings, decision, and the basis for that decision.
  4. If the medical finding is that the client continues to be a danger to self, a danger to others, gravely disabled, or persistently or acutely disabled, and if no alternatives to court-ordered treatment exist, the mental health treatment agency shall file a petition and affidavit(s) as provided in R9-21-505.
- C.** In addition to subsection (A), the examination and review process for non-clients shall, at a minimum, include the following:
1. A person designated by the mental health agency providing treatment shall notify the medical director of the agency in writing of the expiration date 30 days prior to expiration of the court-ordered treatment.
  2. The medical director shall within five days notify one or more physicians (at least one of whom must be a psychiatrist) and the mental health worker assigned to the case of the expiration date of the court-ordered treatment and appoint them to determine whether the non-client continues to be a danger to others, a danger to self, gravely disabled, or persistently or acutely disabled.
  3. After such examination, the examining physician(s) shall enter a note in the progress sheet of the medical record stating the findings, decision, and the basis for that decision.
  4. If the medical finding is that the non-client continues to be a danger to self, a danger to others, gravely disabled, or persistently or acutely disabled, and if no alternatives to court-ordered treatment exist, the mental health treatment agency shall file a petition and affidavits as provided in R9-21-505.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-506 renumbered to R9-21-505; new Section R9-21-506 renumbered from R9-21-507 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

**R9-21-507. Transfers of Court-ordered Persons**

- A.** For the purpose of this Section, “non-client” means an individual who is seriously mentally ill but is not currently being evaluated or treated for a mental disorder by or through a regional authority.
- B.** An individual ordered by the court to undergo treatment and without a guardian may be transferred from a mental health agency to another mental health agency, provided that the medical director of the mental health agency initiating the transfer has established that:
1. There is no reason to believe the individual will suffer more serious physical harm or serious illness as a result of the transfer; and
  2. The individual is being transferred to a level and kind of treatment more appropriate to the individual’s treatment needs and has been accepted for transfer by the medical director of the receiving mental health agency pursuant to subsection (D).
- C.** The medical director of the mental health agency initiating the transfer shall:
1. Be the medical director of the mental health agency to which the court committed the individual; or
  2. Obtain the court’s consent to the transfer as necessary.
- D.** All clients shall be transferred according to the procedures in Article 3 of this Chapter. With regard to non-clients, the medical director of the mental health agency initiating the transfer may not transfer a non-client to, or use the services of, any other mental health agency, unless the medical director of the other mental health agency has agreed to provide such services to a non-client to be transferred, and the Department has licensed and approved the mental health agency to provide those services.
- E.** The medical director of the mental health agency initiating the transfer shall notify the receiving mental health agency in sufficient time for the intended transfer to be accomplished in an orderly fashion, but not less than three days. This notification shall include:
1. A summary of the individual’s needs.
  2. A statement that, in the medical director’s judgment, the receiving mental health agency can adequately meet the individual’s needs.
  3. If the individual is a client, a modification of a client’s ISP according to R9-21-314, when applicable.
  4. Documentation of the court’s consent, when applicable.
- F.** The medical director of the transferring mental health agency shall present a written compilation of the individual’s clinical needs and suggestions for future care to the medical director of the receiving mental health agency, who shall accept and approve it before an individual can be transferred according to subsection (B).
- G.** The transportation of individuals transferred from one mental health agency to another shall be the responsibility of the mental health agency initiating the transfer, irrespective of the allocation of the cost of the transportation defined elsewhere.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-507 renumbered to R9-21-506; new Section R9-21-507 renumbered from R9-21-508 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

#### R9-21-508. Requests for Notification

- A.** At any time during a specified period of court-ordered treatment in which an individual has been found to be a danger to others, a relative or victim wishing to be notified in the event of a individual being released prior to the expiration of the period of court-ordered treatment shall file a demand, according to A.R.S. § 36-541.01(D), on Department form MH-127 in Exhibit G.
- B.** At any time during a specified period of court-ordered treatment in which an individual has been found to be a danger to others, a person other than a relative or victim wishing to be notified in the event of an individual being released prior to the expiration of the period of court-ordered treatment shall file a petition and form of order, to A.R.S. § 36-541.01(D) on Department form MH-128 in Exhibit H.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 530, effective January 29, 2003 (Supp. 03-1). Former Section R9-21-508 renumbered to R9-21-507; new Section R9-21-508 renumbered from R9-21-509 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

Exhibit G Demand for Notice by Relative or Victim

DEMAND FOR NOTICE BY RELATIVE OR VICTIM
(Pursuant to A.R.S. § 36-541.01)

REGARDING: \_\_\_\_\_
(Full Name of Patient)

Pursuant to A.R.S. § 36-541.01, with respect to the above-named patient, a person who was ordered to undergo treatment for a mental disorder as a danger to others pursuant to A.R.S. § 36-540 by a court order of the Superior Court of \_\_\_\_\_ County, Case Number \_\_\_\_\_, or who was committed by an Arizona tribal court, which order of commitment was duly domesticated pursuant to A.R.S. §§ 12-1702 et seq., the undersigned \_\_\_\_\_ relative \_\_\_\_\_ victim does hereby demand that the medical director of \_\_\_\_\_, the mental health treatment agency providing court-ordered treatment for said person, provide the undersigned with written notice of intention to release or discharge said person prior to the expiration of the period for treatment ordered by the Court, as provided for in A.R.S. § 36-541.01(D).

The undersigned person demanding notice hereby agrees to advise the treatment agency in writing, by certified mail, return receipt requested, of any change in the address to which notice is to be mailed.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Printed or Typed Name of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address to Mail Notice

\_\_\_\_\_  
Telephone Number of Applicant

ADHS/BHS Form MH-127 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit G repealed and a new Exhibit G adopted 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). Renumbered from a position after R9-21-509 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

Exhibit H. Petition for Notice

PETITION FOR NOTICE

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA IN AND FOR THE COUNTY OF \_\_\_\_\_

In the matter of )  
 ) MH \_\_\_\_\_  
 )  
 ) PETITION FOR NOTICE  
 )  
 ) (Pursuant to A.R.S. § 36-541.01)  
 re: Mental Health Services )  
 )  
 \_\_\_\_\_ )

REGARDING: \_\_\_\_\_  
(Full Name of Patient)

Pursuant to A.R.S. § 36-541.01, with respect to the above-named patient, a person who was ordered to undergo treatment for a mental disorder as a danger to others pursuant to A.R.S. § 36-540 by a court order of the Superior Court of \_\_\_\_\_ County, Case Number \_\_\_\_\_, the undersigned, a person other than a relative or victim of the person hereby asserting a legitimate reason for receiving such notice, does hereby petition the Court to require that the medical director of \_\_\_\_\_, the mental health treatment agency providing court-ordered treatment for said person, provide the undersigned with written notice of intention to release or discharge said person prior to the expiration of the period for treatment ordered by the Court, as provided for in A.R.S. § 36-541.01, and does hereby provide the following information required by A.R.S. § 36-541.01(D):

Legitimate reason for receiving notice: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The undersigned person demanding notice hereby agrees to advise the treatment agency in writing, by certified mail, return receipt requested, of any change in the address to which notice is to be mailed.

\_\_\_\_\_  
Signature of Person Petitioning

\_\_\_\_\_  
Printed or Typed Name of Petitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address to Send Notice

\_\_\_\_\_  
Telephone Number of Applicant

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA

IN AND FOR THE COUNTY OF \_\_\_\_\_

In the Matter of )  
 ) MH  
 )  
 ) ORDER FOR NOTICE  
 )  
 )  
 re: Mental Health Services )  
 )  
 )  
 )

1. The Court having received a demand by \_\_\_\_\_, a relative or victim of \_\_\_\_\_, a patient ordered by the Court to undergo treatment for a mental disorder as a danger to others, for written notice from the medical director of \_\_\_\_\_, the mental health treatment agency providing court-ordered treatment for said patient, of intention to release or discharge said patient prior to the expiration of the period ordered by the Court, as provided for in A.R.S. § 36-541.01, which demand included all information required by A.R.S. § 36-541.01(D);
2. The Court having received a petition by \_\_\_\_\_, a person other than a relative or victim of \_\_\_\_\_, a patient ordered by this Court to undergo treatment for a mental disorder as a danger to others, asserting that the petitioner has a legitimate reason for receiving such notice and petitioning the Court to require that the medical director of \_\_\_\_\_, the mental health treatment agency providing court-ordered treatment for said patient, provide the petitioner with written notice of intention to release or discharge said patient prior to the expiration of the period for treatment ordered by the Court, as provided for in A.R.S. § 36-541.01, which petition included all information required by A.R.S. § 36-541.01(D); and the Court, after considering said petition, having found that the petitioner has a legitimate reason for receiving prior notice.

THEREFORE IT IS ORDERED that the medical director of \_\_\_\_\_, a mental health treatment agency, shall not release or discharge the above-named patient from court-ordered inpatient treatment without first giving written notice of the intention to do so, in accordance with A.R.S. § 36-541.01(F), to:

- \_\_\_\_\_ The above-named relative of the patient
- \_\_\_\_\_ The above-named victim of the patient
- \_\_\_\_\_ The above-named petitioner found by the Court to have a legitimate reason for receiving prior notice.

IT IS FURTHER ORDERED that a copy of this Order for Notice shall be delivered to the above-named mental health treatment agency and shall be filed with the patient’s clinical record, and if the patient is transferred to another agency or institution, any orders for notice shall be transferred with the patient.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 19 \_\_\_\_\_

\_\_\_\_\_  
 SUPERIOR COURT JUDGE/COMMISSIONER

ADHS/BHS Form MH-128 (9/93)

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit H repealed, new Exhibit H adopted 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). Renumbered from a position after R9-21-509 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

**R9-21-509. Voluntary Admission for Treatment**

- A.** Application for admission for voluntary treatment according to A.R.S. § 36-518 shall be made to a mental health agency on Department form MH-210, Titled "Application for Voluntary Treatment," in Exhibit I, by any individual who:
1. Voluntarily makes application as provided in subsection (A);
  2. Gives informed consent;
  3. Has not been adjudicated as an incapacitated person according to A.R.S. Title 14, Chapter 5, or Title 36, Chapter 5; and
  4. If a minor, is appropriately admitted according to A.R.S. § 36-518.
- B.** Any mental health agency that is not a regional authority under R9-21-501 and that receives an application for voluntary treatment by a client shall immediately refer the client to the appropriate regional authority for treatment as provided under this rule, except that in the case of an emergency, a mental health treatment agency licensed by the Department to provide treatment under A.R.S. § 36-518 may accept an application for voluntary treatment and admit the client for treatment as follows:
1. Prior to admission of a client under this rule, the agency shall notify the appropriate regional authority of the potential admission and treatment so that the regional authority may first:
    - a. Provide other services or treatment to the client as an alternative; or
    - b. Authorize treatment of the client.
2. If the agency does not provide notice according to subsection (B)(1) above, the regional authority shall not be obligated to pay for the treatment provided.
- C.** Any mental health agency providing treatment according to A.R.S. § 36-518 shall place in the medical record of the individual to be treated the following:
1. A completed copy of the application for voluntary treatment;
  2. A completed informed consent form according to R9-21-511; and
  3. A written statement of the individual's present mental condition.
- D.** If the client admitted under this rule does not have an ISP, the regional authority shall prepare one in accordance with Article 3 of this Chapter. If the client already has an ISP, the regional authority shall commence a review of the ISP as provided in R9-21-313 and, if necessary, take steps to modify the ISP in accordance with R9-21-314.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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). Former Section R9-21-509 renumbered to R9-21-508; new Section R9-21-509 renumbered from R9-21-510 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

Exhibit I. Application for Voluntary Treatment

APPLICATION FOR VOLUNTARY TREATMENT

(Pursuant to A.R.S. § 36-518)

I, \_\_\_\_\_, hereby request that the
(Person's Name)
\_\_\_\_\_ place me in a program or agency for mental health treatment.
(Mental Health Agency)

I understand that my capacity to give informed consent to treatment will be determined before I am allowed to voluntarily consent to treatment. My informed consent to treatment will be given on a separate form.

Further, I am aware that I am entitled to:

- 1. Withdraw or modify my consent to treatment at any time.
2. Receive a booklet explaining my rights under Arizona law and assistance from a human rights advocate if I desire.
3. A fair explanation of the treatment I am to receive and the purposes of that treatment.
4. A description of any material and substantial risk reasonably to be expected as a result of the treatment.
5. An answer to my inquiries concerning treatment.
6. Revoke my consent to treatment at any time.
7. Discharge within 24 hours of my written request (excluding weekends and holidays) unless the medical director of the treatment agency files a petition for court-ordered treatment.

Person's Signature

Date

ADHS/BHS Form MH-210 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit I repealed, new Exhibit I adopted 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). Renumbered from a position after R9-21-510 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

**R9-21-510. Informed Consent in Voluntary Application for Admission and Treatment**

- A.** Prior to beginning any course of medication or other treatment for an individual who is subject to voluntary admission under A.R.S. §§ 36-518 and 36-522, a mental health agency shall obtain an informed consent to treatment and enter it in the medical record. For all clients, the informed consent shall be obtained according to R9-21-206.01.
- B.** For clients, the mental health agency shall make reasonable inquiry into an individual's capacity to give informed consent, record these findings, and enter these findings in the client's ISP or record pursuant to Articles 2 and 3 of this Chapter. For non-clients, the agency shall adopt admission procedures that shall include the following:
1. The medical director or the medical director's designee shall make reasonable inquiry into an individual's capacity to give informed consent.
  2. The medical director or the medical director's designee shall record his findings regarding the individual's capacity to give and of having given informed consent.
  3. That the findings of the medical director or the medical director's designee shall be entered into the individual's record.
- C.** Informed consent to treatment may be revoked at any time by a reasonably clear statement in writing.
1. An individual shall receive assistance in writing the revocation as necessary.
  2. If informed consent to treatment is revoked, treatment shall be promptly discontinued, provided that a course of treatment may be concluded or phased out where necessary to avoid the harmful effects of abrupt withdrawal.
- D.** An informed consent form shall be signed by the individual and shall state that the following information was presented to the individual:
1. A fair explanation of the treatments and their purposes.
  2. A description of any material and substantive risk reasonably to be expected.
  3. An offer to answer any inquiries concerning the treatments.
  4. Notice that the individual is free to revoke informed consent to treatment; and
  5. For clients, all information required by R9-21-206.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). 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). Former Section R9-21-510 renumbered to R9-21-509; new Section R9-21-510 renumbered from R9-21-511 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

**Exhibit J. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

**Exhibit K. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective

October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

**R9-21-511. Use of Psychotropic Medication**

- A.** Psychotropic medications may only be ordered for individuals undergoing court-ordered evaluation according to R9-21-204 or R9-21-207.
- B.** Psychotropic medications may not be ordered for and administered to individuals undergoing court-ordered treatment, except as follows:
1. In an emergency involving the safety of the individual or another, as documented in the individual's medical record;
  2. If the individual or guardian gives an informed consent to use the medication;
  3. If provision for use of the medications shall be contained in the individual's treatment plan or ISP. At a minimum, the plan shall specify:
    - a. A description of the circumstances under which the medication may be used.
    - b. A description of the objectives that are expected to be achieved by use of the medication. This description must indicate how the individual's condition would be improved by using the medication and indicate what result would be expected if the medication were not used; or
  4. According to R9-21-204 or R9-21-207.
- C.** The agency shall have the capability to detect drug side effects or toxic reactions that may result from the medications used.
- D.** The agency shall have written policies and procedures governing the use of psychotropic medication. These policies and procedures shall specify:
1. Protective measures that will ensure the individual's safety and promote the avoidance or mitigation of short and long-term deleterious effects on the individual.
  2. Periodic individual care monitoring, i.e., evaluating and updating the treatment plan and reviewing problem areas such as failure of the individual to achieve treatment plan objectives.
  3. Recordkeeping requirements.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-511 renumbered to R9-21-510; new Section R9-21-511 renumbered from R9-21-512 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

**R9-21-512. Seclusion and Restraint**

Individuals undergoing court-ordered evaluation or court-ordered treatment shall not be placed in seclusion or restraint except as permitted by Article 2 of this Chapter, and specifically R9-21-204.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-512 renumbered to R9-21-511; new Section R9-21-512 renumbered from R9-21-513 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

**R9-21-513. Renumbered**

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary

of State October 14, 1992 (Supp. 92-4). Renumbered to R9-21-512 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

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# VIEW DOCUMENT

The Arizona Revised Statutes have been updated to include the revised sections from the 55th Legislature, 2nd Regular Session. Please note that the next update of this compilation will not take place until after the conclusion of the 56th Legislature, 1st Regular Session, which convenes in January 2023.

## DISCLAIMER

This online version of the Arizona Revised Statutes is primarily maintained for legislative drafting purposes and reflects the version of law that is effective on January 1st of the year following the most recent legislative session. The official version of the Arizona Revised Statutes is published by Thomson Reuters.

### 36-502. Powers and duties of the director of AHCCCS; rules; expenditure limitation

A. The director shall make rules that include standards for agencies other than the state hospital when providing services and shall prescribe forms as may be necessary for the proper administration and enforcement of this chapter. The rules shall be applicable to patients admitted to or treated in agencies, other than the state hospital, as set forth in this chapter and shall provide for periodic inspections of such agencies.

B. The director shall make rules concerning the admission of patients and the transfer of patients between mental health treatment agencies other than the state hospital. A patient undergoing court-ordered treatment may be transferred from one mental health treatment agency to another in accordance with the rules of the director, subject to the approval of the court.

C. The director may make rules concerning leaves, visits and absences of patients from evaluation agencies and mental health treatment agencies other than the state hospital.

D. The total amount of state monies that may be spent in any fiscal year by the administration for mental health services pursuant to this chapter may not exceed the amount appropriated or authorized by section 35-173 for that purpose. This chapter does not impose a duty on an officer, agent or employee of this state to discharge a responsibility or create any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose.



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# VIEW DOCUMENT

The Arizona Revised Statutes have been updated to include the revised sections from the 55th Legislature, 2nd Regular Session. Please note that the next update of this compilation will not take place until after the conclusion of the 56th Legislature, 1st Regular Session, which convenes in January 2023.

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41-3803. Independent oversight committee on the mentally ill; membership; community forums; meetings; training plan; Arizona state hospital

A. The independent oversight committee on the mentally ill is established in the department of administration to promote the rights of persons who receive behavioral health services pursuant to:

1. Section 13-3992 or 13-3994.
2. Title 36, chapters 5 and 34.

B. Each region of this state covered by a regional behavioral health authority shall have at least one independent oversight committee with the authority and responsibilities as prescribed by the department of administration pursuant to rules adopted by the department relating to behavioral health services.

C. The director of the department may establish additional committees to serve persons who receive behavioral health services or to oversee the activities of any service provider.

D. Each independent oversight committee shall consist of at least seven and not more than fifteen members appointed by the director of the department with expertise in at least one of the following areas:

1. Psychology.
2. Law.
3. Medicine.
4. Education.
5. Special education.

6. Social work.

7. Mental health.

8. Housing for the mentally ill.

9. Criminal justice.

10. Public safety.

E. Each independent oversight committee, if appropriate, shall include at least two parents of children who receive behavioral health services pursuant to title 36, chapter 34.

F. Each independent oversight committee shall include at least one member who is a current or former client of the behavioral health system.

G. Current or former providers or employees of providers that have contracted with a regional behavioral health authority may serve on an independent oversight committee but may not hold more than two positions on the committee.

H. Each independent oversight committee may hold one or more community forums annually to receive comments regarding the experiences of individuals living with serious mental illness, and their family members and caregivers, across the care continuum.

I. The department shall ensure that each regional behavioral health authority and its providers develop and implement a human rights training plan to ensure that providers are trained regarding clients' human rights and the duties of the independent oversight committees.

J. The independent oversight committee at the Arizona state hospital shall have oversight of patients who have been determined to have a serious mental illness and who are hospitalized and receiving behavioral health services at the civil and forensic hospital pursuant to subsection A of this section. The Arizona state hospital's administration and employees may not retaliate against a patient because the patient or the patient's family participates in the independent oversight committee meetings. A patient or patient's family that alleges retaliation must provide to the independent oversight committee in writing a detailed description of the retaliation and how the retaliation is connected to the patient's or family's participation in the independent oversight committee meetings. This subsection does not preclude the Arizona state hospital's administration from taking action against a patient who violates hospital policies or procedures. The Arizona state hospital shall provide to the committee, subject to state and federal law, information regarding the following:

1. Seclusion of and the use of restraints on patients.

2. Incident accident reports.

3. Allegations of illegal, dangerous or inhumane treatment of patients.

4. Provisions of services to patients in need of special assistance.

5. Allegations of neglect and abuse.

6. Allegations of denial of rights afforded to patients with serious mental illness except if a right may be restricted for the safety of a patient, the state hospital or the public.

K. The Arizona state hospital superintendent and chief medical officer, or their designees, shall attend and participate in scheduled meetings of the independent oversight committee at the Arizona state hospital, except for the public comment period. The superintendent and the chief medical officer, or their designees, shall give a report to and respond to questions from the independent oversight committee members. Questions from the independent oversight committee members to the superintendent and the chief medical officer, or their designees, are limited to subjects specified in subsection J of this section. The superintendent shall ensure that the Arizona state hospital administration:

1. Fully cooperates with the independent oversight committee in all aspects of its work, as outlined in subsection J of this section.

2. Facilitates and supports the independent oversight committee's activities related to the Arizona state hospital and pursuant to the department of administration's rules.

3. Responds to the independent oversight committee with information that is responsive to inquiries made pursuant to this subsection or responds in writing as to why a request was denied.

L. Each committee shall be organized pursuant to this section and the requirements of section 41-3804.

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)**  
Title 9, Chapter 22

**Amend:** R9-22-712.06



# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - REGULAR RULEMAKING

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**MEETING DATE:** March 7, 2023

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** February 17, 2023

**SUBJECT:** Arizona Health Care Cost Containment System (AHCCCS)  
Title 22, Chapter 7

**Amend:** R9-22-712.06

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### **Summary:**

This regular rulemaking from AHCCCS relates to rules in Title 22, Chapter 7 regarding Standards for Payments. AHCCCS is seeking to amend one rule, R9-220712.06 (Supplemental Graduate Medical Education Fund Allocation). A.R.S. § 36-2903.01 requires AHCCCS to describe in rule how Graduate Medical Education (GME) funds are calculated and distributed. Pursuant to Laws 2020, Chapter 58 and Laws 21, Chapter 408 (SFY 2021 and 2002), AHCCCS must prioritize monies appropriated and distributed to programs at hospitals in counties with a higher percentage of persons residing in a health professional shortage area.

Specifically, AHCCCS seeks to implement the SFY 2023 appropriation requirements in Laws 2022, Chapter 313 for two Graduate Medical Education pools. Laws 2022, Chapter 313 established a separate rural pool appropriation for GME hospitals outside of Maricopa and Pima counties, and an urban pool appropriation for GME hospitals inside Maricopa and Pima counties, for the SFY 2023 budget. The proposed amendments will remove prioritization of urban hospitals in counties with a higher percentage of persons residing in health professional shortages areas for purposes of making payments to urban hospitals, reflecting the intention of the legislature.

AHCCCS is requesting an immediate effective date pursuant to A.R.S. § 41-1032(A)(4) “[t]o provide a benefit to the public and a penalty is not associated with a violation of the rule.” Council staff believes the Board has provided sufficient information that demonstrates a need for an immediate effective date.

AHCCCS received approval from the rulemaking moratorium to initiate this rulemaking on October 17, 2022, and final approval to submit to the Council on January 10, 2023.

1. **Are the rules legal, consistent with legislative intent, and within the agency’s statutory authority?**

Yes, AHCCCS cites both general and specific statutory authority for these rules.

2. **Do the rules establish a new fee or contain a fee increase?**

No, the rules do not establish a new fee or contain a fee increase.

3. **Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

AHCCCS did not review or rely on any study for this rulemaking.

4. **Summary of the agency’s economic impact analysis:**

The rulemaking is intended to increase the number of practicing physicians, Doctor of Medicine (MDs) and Doctor of Osteopathic Medicine (DOs), who practice in the State following their residency or fellowship. The payment structure in the rulemaking prioritizes specialties of practice where physicians are in greater need. Although there will be a greater cost to the State General Fund due to these supplemental Graduate Medical Education payments, the legislature determined that was outweighed by the benefit for the patients of Arizona in having a greater supply of MDs and DOs.

5. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Administration did not consider other alternatives because the revisions to the rule are the most cost effective and efficient method of complying with federal law and state law as well as the State’s fiduciary responsibility to Arizona taxpayers. In addition, the rule was developed through a workgroup with impacted hospitals so relevant stakeholders were directly involved with crafting the text of the rule.

**6. What are the economic impacts on stakeholders?**

The Administration anticipates no increase in cost and no specific benefit to the implementing agencies. The Administration does not anticipate the need to hire full-time employees as a result of this rulemaking. This rulemaking does not directly affect political subdivisions. The Administration anticipates that public and private employment will not be directly impacted but will be indirectly impacted in a positive way by this rulemaking. The Administration does not anticipate a fiscal impact on small businesses because the proposed rule language changes are anticipated to only affect hospitals and the Administration. The Administration anticipates no impact on the administrative expenses of small businesses. This rule does not establish performance standards for small businesses beyond those requirements that are necessary to comply with federal law and state statute. The rule will indirectly benefit private persons who received the care of physicians in Arizona.

**7. Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

No changes were made between the proposed and final rulemaking.

**8. Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**

AHCCCS indicates they did not receive any comments on the proposed rules.

**9. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

Not applicable. The rules do not require the issuance of a general permit or license.

**10. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

Not applicable. There are no corresponding federal laws to the rules.

**11. Conclusion**

As mentioned above, AHCCCS is seeking to amend one rule in order to implement the SFY 2023 appropriation requirements in Laws 2022, Chapter 313 for two Graduate Medical Education pools. AHCCCS is requesting an immediate effective date pursuant to A.R.S. § 41-1032(A)(4) “[t]o provide a benefit to the public and a penalty is not associated with a violation of the rule.” Council staff believes the Board has provided sufficient information that demonstrates a need for an immediate effective date.

Council Staff recommends approval of this rulemaking.

January 24, 2023

VIA EMAIL: [grrc@azdoa.gov](mailto:grrc@azdoa.gov)

Nicole Sornsin, Chair

Governor's Regulatory Review Council

100 North 15th Avenue, Suite 305

Phoenix, Arizona 85007

RE: R9-22-712.06 Rulemaking

Dear Ms. Sorenson:

- |    |  |            |
|----|--|------------|
| 1. | The close of record date:  | 12/12/2022 |
| 2. | Does the rulemaking activity relate to a Five Year Review Report:    | No         |
| a. | If yes, the date the Council approved the Five Year Review Report:   | N/A        |
| 3. | Does the rule establish a new fee:                                   | No         |
| a. | If yes, what statute authorizes the fee:                             | N/A        |
| 4. | Does the rule contain a fee increase:                                | No         |
| 5. | Is an immediate effective date requested pursuant to A.R.S. 41-1032: | Yes        |

AHCCCS certifies that the preamble discloses a reference to any study relevant to the rule that the agency reviewed. AHCCCS certifies that the preamble states that it did not rely on any such study in the agency's evaluation of or justification for the rule.

AHCCCS certifies that the preparer of the economic, small business, and consumer impact statement has notified the Joint Legislative Budget Committee of the number of new full-time employees necessary to implement and enforce the rule.

The following documents are enclosed:

1. Notice of Final Rulemaking, including the preamble, table of contents, and text of each rule;
2. An economic, small business, and consumer impact statement that contains the information required by A.R.S. 41-1055;
3. If applicable: The written comments received by the agency concerning the proposed rule and a written record, transcript, or minutes of any testimony received if the agency maintains a written record, transcript or minutes;
4. If applicable: Any analysis submitted to the agency regarding the rule's impact on the competitiveness of businesses in this state as compared to the competitiveness of business in other states;
5. If applicable: Material incorporated by reference;
6. General and specific statutes authorizing the rules, including relevant statutory definitions; and
7. If applicable: If a term is defined in the rule by referring to another rule or a statute other than the general and specific statutes authorizing the rule, the statute or other rule referred to in the definition.

Sincerely,



Kasey Rogg  
Assistant Director

Attachments

**TITLE 9. HEALTH SERVICES**

**CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) -**

**ADMINISTRATION**

**ARTICLE 7. STANDARDS FOR PAYMENTS**

**PREAMBLE**

**1. Article, Part, or Section Affected (as applicable) Rulemaking Action**

R9-22-712.06

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. § 36-2903.01

Implementing statute: A.R.S. §§ 36-2903.01 and Laws 2022, Chapter 313

**3. The effective date of the rule:**

As specified in A.R.S. § 41-1032(A)(4), the agency requests an immediate effective date to provider a benefit to the public and a penalty is not associated with a violation of the rule.

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

Notice of Rulemaking Docket Opening: 28 A.A.R. 3506

Notice of Proposed Rulemaking: 28 A.A.R. 3465

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

Name: Nicole Fries

Address: AHCCCS

Office of the General Counsel

801 E. Jefferson, Mail Drop 6200

Phoenix, AZ 85034

Telephone: (602) 417-4232  
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:**

A.R.S. § 36-2903.01 requires the Administration to describe in rule how Graduate Medical Education (GME) funds are calculated and distributed. Under Laws 2020, Chapter 58 and Laws 2021, Chapter 408 (SFY 2021 and 2022 respectively), AHCCCS must prioritize monies appropriated and distributed to programs at hospitals in counties with a higher percentage of persons residing in a health professional shortage area, as defined in 42 CFR Part 5. The intention of this rulemaking is to implement the SFY 2023 appropriation requirements in Laws 2022, Chapter 313 for two GME pools. Laws 2022, Chapter 313 established a separate rural pool appropriation (for GME hospitals outside of Maricopa and Pima counties) and an urban pool appropriation (for GME hospitals inside Maricopa and Pima counties) for the SFY 2023 budget.

Under Laws 2022, Chapter 313, only monies distributed from the rural pool are to be prioritized to hospitals in counties with a higher percentage of persons residing in health professional shortage areas. The proposed amendments to R9-22-712.06 remove prioritization of urban hospitals in counties with a higher percentage of persons residing in health professional shortages areas for purposes of making payments to urban hospitals, reflecting the intention of the legislature.

**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:**

No study was relied upon.

**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:**

The rulemaking will not diminish a previous grant of authority of a political subdivision.

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

The AHCCCS Administration estimates this amendment will not result in any change in allocation to urban hospitals. All hospitals that received urban pool payments under Laws 2020, Chapter 58 and Laws 2021, Chapter 408 were located in the same county and did not receive funding priority over another hospital based on differences in health professional shortage area designations.

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

There were no changes between the proposed and final rulemakings.

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

There were no public comments about the rulemaking.

**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 have been prescribed.

**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:**

The rules does not require a permit.

**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:**

A federal law is not applicable.

**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:**

No analysis was submitted.

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

No materials incorporated by reference.

**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 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) -**

**ADMINISTRATION**

**ARTICLE 7. STANDARDS FOR PAYMENTS**

**Section**

R9-22-712.06. Supplemental Graduate Medical Education Fund Allocation

## ARTICLE 7. STANDARDS FOR PAYMENTS

### **R9-22-712.06. Supplemental Graduate Medical Education Fund Allocation**

**A.** Gradual Medical Education (GME) reimbursement as of July 1, 2020.

1. In addition to distributions according to Section R9-22-712.05, and subject to the availability of funds and approval by CMS, the Administration shall annually distribute monies appropriated for the GME programs approved by the Administration to hospitals for direct and indirect costs for graduate medical education programs which were established or expanded on or after July 1, 2020. The Administration shall estimate the distributions using information possessed by the Administration as of December 15 of each calendar year. The actual distributions will be made using information possessed by the Administration as of September first of the year in which the new residency or fellowship begins.
2. Eligible Hospitals. A hospital is eligible for distributions under this Section if all of the following apply:
  - a. It is a hospital in Arizona that is the sponsoring institution of, or a participating institution in, one or more of the GME programs in Arizona;
  - b. It incurs direct costs for the training of residents in the GME programs, which costs are or will be reported on the hospital's Medicare Cost Report;
  - c. It is not administered by or does not receive its primary funding from an agency of the federal government;
  - d. It has established a new GME program or expanded the number of residents or fellows in an existing GME program on or after July 1, 2020.
3. Eligible positions. For purposes of determining distributions under this Section the following resident and fellowship positions qualify to the extent that the training takes place in Arizona at an eligible health care facility:
  - a. Filled resident or fellow positions in approved programs which began on or after July 1, 2020;
  - b. Eligible positions do not include residents or fellows that receive payments for services under the Access to Professional Services Initiative (APSI) program established in the

Contractors' prepaid capitation contracts with the Administration.

4. Annual Reporting

- a. By December 15 of each year, a GME program shall provide all of the following information for GME programs and positions which are expected to be eligible for funding under this Section as of the upcoming academic year (i.e., July 1 to June 30 of each year):
  - i. The program name and number assigned by the accrediting organization if available;
  - ii. The original date of accreditation if available;
  - iii. The names of the sponsoring institution and all participating institutions expected as of the date of reporting;
  - iv. The number of anticipated resident and fellowship positions eligible for funding as of the upcoming academic year;
  - v. The number of months or partial months during the upcoming academic year that each resident or fellow is expected to work in each hospital or in a non-hospital setting under agreement between the non-hospital setting and the reporting hospital;
  - vi. The academic year of anticipated resident and fellowship positions;
  - vii. The length of the program; and
  - viii. The names and other information requested by AHCCCS to ensure the total GME distributions for each eligible position are not greater than the costs for each eligible position in the Intern and Resident Information System (IRIS) file.
- b. By December 15 of each year, a GME program located in a county with a population of less than 500,000 persons shall provide the estimated one-time and ongoing costs for each program which it expects to be eligible for funding.
- c. By September 1 of each year, a GME program shall provide the actual name of residents and fellows hired in the current academic year and other information requested by AHCCCS to ensure that total GME distributions for the eligible position are not greater

than the costs for each eligible position in the IRIS file.

**B.** Preliminary allocation of funds for urban hospitals. Annually by January 15, the Administration shall estimate the annual GME distributions under this Section using the funds appropriated for hospitals in counties with a population of 500,000 persons or more based on the number of new residents and fellows in graduate medical education programs in the following manner:

1. Each eligible resident and fellow is placed into tiers with the following priority:
  - a. Returning residents and fellows. A returning resident or fellow is a resident or fellow whose position received funding under this Section for the previous academic year and who is continuing in the same GME program.
  - b. Residents and fellows that are not a returning resident or fellow but are in a GME program for Family Medicine, Internal Medicine, General Pediatrics, Obstetrics and Gynecology, Psychiatry including Subspecialties, General Surgery, and any other program determined as high needs by the AHCCCS Administration.
  - c. Residents or fellows that are not returning residents or fellows and are not described in subsection (1)(b) but are in a GME program that received funding under this Section in a prior year.
  - d. All other residents and fellows.
- ~~2. Residents and fellows in each tier are further divided into four sub-tiers with the following priority based on the location of the sponsoring or participating hospital:~~
  - ~~a. Hospitals in a county designated by the Health Resource and Services Administration of the U.S. Department of Health & Human Services as a health professional shortage area (HPSA) with a greater than 85 percent primary care shortage.~~
  - ~~b. Hospitals in a county designated as a HPSA with a greater than 50 percent to 85 percent primary care shortage.~~
  - ~~c. Hospitals in a county designated as a HPSA with a 25-50 percent primary care shortage.~~
  - ~~d. Hospitals in a county designated as a HPSA with a less than 25 percent primary care shortage.~~
23. The amount of the distribution for each GME program for direct costs is calculated as the product

of:

- a. The number of eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospitals;
- b. The Arizona Medicaid utilization as determined by R9-22-712.05(B)(4)(c)(i) in the previous calendar year; and,
- c. The average direct cost per resident determined under R9-22-712.05(B)(4)(d) in the previous calendar year.

34. If monies are still remaining after direct funding has been allocated, indirect funding shall be allocated based on the priority of each tier and sub-tier. The amount of the distribution for each GME program for indirect costs is calculated as the product of:

- a. The number of allocated eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospital;
- b. The indirect cost per resident per month calculated in R9-22-712.05(D)(4)(b)(vi) in the previous calendar year; and
- c. Twelve months.
- d. Funds shall be allocated based on the priority of each tier and sub-tier. Distributions for eligible positions in a tier or sub-tier with a lower priority will not receive a distribution until distributions are allocated for the costs of all positions in a higher tier or sub-tier. If funding is insufficient to fully fund a tier or sub-tier, the remainder of funds will be prorated for eligible positions in that tier or sub-tier.

45. Payments are made to participating hospitals based on the FTEs who worked at their hospitals per year.

C. Preliminary allocation of funds for rural hospitals. Annually by January 15, the Administration shall estimate the annual GME distributions under this Section using the funds appropriated for rural hospitals based on the number of eligible resident and fellow positions in graduate medical education programs located in a county with a population of less than 500,000 persons in the following manner:

1. Each resident and fellow will then be placed into a tier with the following priority:
  - a. Returning residents and fellows. A returning resident or fellow is a resident or fellow whose position received funding under this Section for the previous academic year and who is continuing in the same GME program.
  - b. Residents and fellows that are not a returning resident or fellow but are in a GME program for Family Medicine, Internal Medicine, General Pediatrics, Obstetrics and Gynecology, Psychiatry including Subspecialties, General Surgery, and any other program determined as high needs by the AHCCCS Administration.
  - c. Residents or fellows that are not returning residents or fellows and are not described in subsection (1)(b) but are in a GME program that received funding under this Section in a prior year.
  - d. All other residents and fellows.
2. Residents and fellows in each tier are further divided into four sub-tiers with the following priority based on the location of the sponsoring or participating hospital:
  - a. Hospitals in a county designated by the Health Resource and Services Administration of the U.S. Department of Health & Human Services as a HPSA with a greater than 85 percent primary care shortage.
  - b. Hospitals in a county designated as a HPSA with a greater than 50 percent to 85 percent primary care shortage.
  - c. Hospitals in a county designated as a HPSA with a 25-50 percent primary care shortage.
  - d. Hospitals in a county designated as a HPSA with a less than 25 percent primary care shortage.
3. Funds shall first be allocated for direct and indirect costs based in order of priority of each tier. If not enough funding is available to fully fund a tier or sub-tier, the remainder of funds will be prorated in a tier or sub-tier.
4. The amount of the distribution for each GME program for direct costs is calculated as the product of:
  - a. The number of eligible residents and fellows adjusted for the number of months or partial

- months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospitals;
- b. The Arizona Medicaid utilization determined under R9-22-712.05(B)(4)(c)(i); and,
  - c. The actual direct cost per resident per year.
5. The amount of the distribution for each GME program for indirect costs is calculated as the product of:
- a. The number of allocated eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospital;
  - b. The indirect cost per resident per month calculated in R9-22-712.05(D)(4)(b)(vi) in the previous calendar year; and
  - c. Twelve months.
6. Payments are made to participating hospitals based on the FTEs who worked at their hospitals per year.
- D.** Final allocation of funds. Annually no sooner than September 1 following the start of the academic year, the Administration will recalculate the allocation for urban and rural hospitals using the same methodology used to estimate distributions, but using the actual residents and fellows as reported in R9-22-712.06(~~B~~A)(~~3~~4)(c).
- F.** Exclusions. To ensure that residents and fellows are not double counted residents/fellows which receive funding through R9-22-712.06 shall not receive funding through R9-22-712.05.

**ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT**

**TITLE 9. HEALTH SERVICES**

**CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**

**ADMINISTRATION**

**ARTICLE 7. STANDARDS FOR PAYMENT**

**Introduction:**

In 2006, the 47th Legislature approved additional funds for distribution to training hospitals for Graduate Medical Education (GME) programs. The funds, which were in addition to the funds allocated yearly to teaching hospitals, are designated to support programs that have expanded and will expand their educational efforts. Prior to September 30, 1997, hospitals were reimbursed for GME costs under the tiered per diem methodology. Beginning September 30, 1997, the Administration was required to establish a separate GME program to reimburse hospitals with approved GME programs, currently funded by Intergovernmental Agreements (IGA's).

**Purpose of Rule:**

A.R.S. § 36-2903.01 requires the Administration to describe in rule how Graduate Medical Education (GME) funds are calculated and distributed. Under Laws 2020, Chapter 58 and Laws 2021, Chapter 408 (SFY 2021 and 2022 respectively), AHCCCS must prioritize monies appropriated and distributed to programs at hospitals in counties with a higher percentage of persons residing in a health professional shortage area, as defined in 42 CFR Part 5. The intention of this rulemaking is to implement the SFY 2023 appropriation requirements in Laws 2022, Chapter 313 for two GME pools. Laws 2022, Chapter 313 established a separate rural pool appropriation (for GME hospitals outside of Maricopa and Pima counties) and an urban pool appropriation (for GME hospitals inside Maricopa and Pima counties) for the SFY 2023 budget.

The Centers for Medicare and Medicaid Services (CMS) require the AHCCCS Administration to annually update the amount allocated to each hospital in the State Plan. Before AHCCCS may make GME payments, a State Plan Amendment (SPA) must be submitted and approved by CMS. Before AHCCCS may make GME payments, a State

Plan Amendment (SPA) must be submitted and approved by CMS. Technical and conforming changes will also be made.

**1. Identification of rulemaking**

Under Laws 2022, Chapter 313, only monies distributed from the rural pool are to be prioritized to hospitals in counties with a higher percentage of persons residing in health professional shortage areas. The proposed amendments to R9-22-712.06 remove prioritization of urban hospitals in counties with a higher percentage of persons residing in health professional shortages areas for purposes of making payments to urban hospitals, reflecting the intention of the legislature.

**a. The conduct and its frequency of occurrence that the rule is designed to change:**

The changes to this rule will not change the conduct and frequency of the conduct.

**b. The harm resulting from the conduct the rule is designed to change and the likelihood it will continue to occur if the rule is not changed:**

The Administration does not anticipate a change in conduct with the rulemaking.

**c. The estimated change in frequency of the targeted conduct expected from the rule change:**

The Administration does not anticipate a change in frequency in conduct.

**2. Identification of the persons who will be directly affected by, bear the costs of, or directly benefit from the rule making.**

The rulemaking is intended to increase the number of practicing physicians, MDs and DOs, who practice in the State following their residency or fellowship. The payment structure in the rulemaking prioritizes specialties of practice where physician are in greater need. Although there will be a greater cost to the State General Fund due to these supplemental Graduate Medical Education payments, the legislature determined that was outweighed by the benefit for the patients of Arizona in having a greater supply of MDs and DOs.

**3. Cost benefit analysis.**

**a. Probable costs and benefits to the implementing agency and other agencies directly affected by the implementation and enforcement of the proposed rulemaking including the number of new full-time employees necessary to implement and enforce the proposed rule:**

**i. Cost:**

The Administration anticipates no increase in cost to the implementing agency.

**ii. Benefit:**

The Administration anticipates no specific benefit to the implementing agencies.

**iii. Need for additional Full-time Employees:**

The Administration does not anticipate the need to hire full-time employees as a result of this rulemaking.

**b. Probable costs and benefits to political subdivision of this state directly affected by the implementation and enforcement of the proposed rulemaking.**

This rulemaking does not directly affect political subdivisions.

**4. General description of the probable impact on private and public employment in businesses, agencies, and political subdivisions of this state directly affected by the rulemaking.**

The Administration anticipates that public and private employment will not be directly impacted but will be indirectly impacted in a positive way by this rulemaking.

**5. Statement of probable impact of the proposed rule on small businesses. The statement shall include:**

**a. Identification of the small businesses subject to the proposed rulemaking.**

The Administration does not anticipate a fiscal impact on small businesses because the proposed rule language changes are anticipated to only affect hospitals and the Administration.

**b. Administrative and other costs required for compliance with the proposed rulemaking.**

The Administration anticipates no impact on the administrative expenses of small businesses.

**c. Description of methods prescribed in section A.R.S. § 41-1035 that the agency may use to reduce the impact on small businesses, with reasons for the agency's decision to use or not use each method:**

**i. Establishing less stringent compliance or reporting requirements in the rule for small businesses;**

This rule does not impose compliance or reporting requirements on small businesses beyond those already necessary to comply with federal law and state statute.

**ii. Establishing less stringent schedules deadlines in the rule for compliance or reporting requirements for small businesses;**

This rule does not impose compliance or reporting requirements on small businesses beyond those requirements that are necessary to comply with federal law and state statute.

**iii. Consolidate or simplify the rule's compliance or reporting requirements for small businesses;**

This rule does not impose compliance or reporting requirements on small businesses beyond those requirements that are necessary to comply with federal law and state statute.

**iv. Establish performance standards for small businesses to replace design or operational standards in the rule; and**

This rule does not establish performance standards for small businesses beyond those requirements that are necessary to comply with federal law and state statute.

**v. Exempting small businesses from any or all requirements of the rule.**

Exempting small businesses is not applicable to this rule.

**d. The probable cost and benefit to private persons and consumers who are directly affected by the proposed rulemaking.**

The rule will indirectly benefit private persons who received the care of a physicians in Arizona.

**6. Statement of the probable effect on state revenues.**

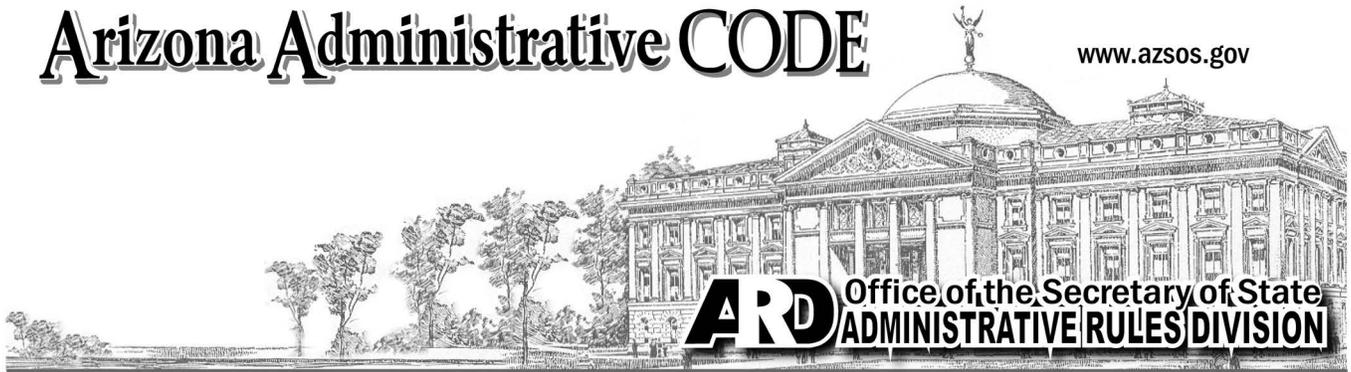
It is anticipated that the rule will not affect state revenues.

**7. Description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed rulemaking, including the monetizing of the costs and benefits for each option and providing the rationale for not using nonselected alternatives.**

The Administration did not consider other alternatives because the revisions to the rule are the most cost effective and efficient method of complying with federal law and state law as well as the State's fiduciary responsibility to Arizona taxpayers. In addition, the rule was developed through a workgroup with impacted hospitals so relevant stakeholders were directly involved with crafting the text of the rule.

**8. A description of any data on which a rule is based with a detailed explanation of how the data was obtained and why the data is acceptable data.**

The Administration did not consider any specific data to base the rule upon.



9 A.A.C. 22

Supp. 22-3

## TITLE 9. HEALTH SERVICES

### CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

The table of contents on page one contains links to the referenced page numbers in this Chapter.  
Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of  
July 1, 2022 through September 30, 2022

<a href="#">R9-22-730.</a>	<a href="#">Hospital Assessment Fund - Hospital Assessment</a>	<a href="#">R9-22-712.61.</a>	<a href="#">DRG Payments: Exceptions</a>	<a href="#">85</a>
	<a href="#">..... 97</a>	<a href="#">R9-22-712.71.</a>	<a href="#">Final DRG Payment</a>	<a href="#">92</a>
<a href="#">R9-22-712.35.</a>	<a href="#">Outpatient Hospital Reimbursement: Adjustments</a>	<a href="#">R9-22-731.</a>	<a href="#">Health Care Investment Fund - Hospital</a>	
	<a href="#">to Fees</a>		<a href="#">Assessment</a>	<a href="#">103</a>
	<a href="#">..... 76</a>			

#### Questions about these rules? Contact:

Office: AHCCCS  
Office of Administrative Legal Services  
Address: 801 E. Jefferson, Mail Drop 6200  
Phoenix, AZ 85034  
[Website:](#) [www.azahcccs.gov](http://www.azahcccs.gov)  
Name: Nicole Fries  
Telephone: (602) 417-4232  
Fax: (602) 253-9115  
[Email:](#) [AHCCCSRules@azahcccs.gov](mailto:AHCCCSRules@azahcccs.gov)

**The release of this Chapter in Supp. 22-3 replaces Supp. 22-2, 1-135 pages.**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31

Second Quarter: April 1 - June 30

Third Quarter: July 1 - September 30

Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, [www.azsos.gov](http://www.azsos.gov) under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

### PERSONAL USE/COMMERCIAL USE

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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**TITLE 9. HEALTH SERVICES**

**CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION**

Authority: A.R.S. § 36-2901.08

**Supp. 22-3**

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*Editor’s Note: Historical notes for Sections made, repealed or amended in Supp. 14-1 were updated to reflect the effective date as immediate per the original notice filed by the agency. A number of other publication errors have been corrected in Supplement 20-4 that should have been made in Supp. 14-1. These include: adding new Sections R9-22-301 and R9-22-302; correcting a punctuation error in R9-22-1401; repealing Sections R9-22-1407 and R9-22-1443; and the amending of R9-22-1501 (Supp. 20-4).*

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

*Editor’s Note: This Chapter contains rules which were adopted or amended under an exemption from the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6), under Laws 1992, Ch. 301, § 61 and Ch. 302, § 13, and Laws 1993, Ch. 6, § 34. 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; the Governor’s Regulatory Review Council did not review these rules; 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.*

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*Former Article 1, consisting of Section R9-22-101, repealed effective December 8, 1997 (Supp. 97-4).*

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*Article 3, consisting of Sections R9-22-301 through R9-22-319 and R9-22-321 through R9-22-344, repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section R9-22-320 repealed December 13, 1993 (Supp. 93-4).*

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*Article 6, consisting of Sections R9-22-601 through R9-22-605, repealed by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1).*

*Article 6, consisting of Sections R9-22-601 through R9-22-604, adopted effective July 16, 1985.*

*Former Article 6, consisting of Sections R9-22-601 through R9-22-603, repealed effective October 1, 1983.*

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Article 13, consisting of Sections R9-22-1301 through R9-22-1306, made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Exemption to promulgate rules repealed under Laws 2012, Chapter 299, Section 7 (Supp. 13-3).

Article 13, consisting of Sections R9-22-1301 through R9-22-1309, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 13 is now in 9 A.A.C. 34 (Supp. 04-1).

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*Article 14, consisting of Sections R9-22-1401 through R9-22-1436, repealed; new Article 14, consisting of Sections R9-22-1401 through R9-22-1433 made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).*

*Article 14, consisting of Sections R9-22-1401 through R9-22-1436, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).*

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*Article 15, consisting of Sections R9-22-1501 through R9-22-1508, repealed; new Article 15, consisting of Sections R9-22-1501 through R9-22-1505 made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).*

*Article 15, consisting of Sections R9-22-1501 through R9-22-1508, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).*

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*Article 16, consisting of Section R9-22-1601 made by final rulemaking at 20 A.A.R. 3436, effective January 1, 2015 (Supp. 14-4).*

*Article 16, consisting of Sections R9-22-1601 through R9-22-1612, R9-22-1614 through R9-22-1616, and R9-22-1618 through R9-22-1619, expired at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).*

*Article 16, consisting of Sections R9-22-1601 through R9-22-1636, repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).*

*Article 16, consisting of Sections R9-22-1601 through R9-22-1613, R9-22-1615 through R9-22-1620, R9-22-1622 through R9-22-1631, R9-22-1633, R9-22-1634, and R9-22-1636, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).*

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## TITLE 9. HEALTH SERVICES

## CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

## ARTICLE 1. DEFINITIONS

**R9-22-101. Location of Definitions**

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

Definition	Section or Citation		
"Accommodation"	R9-22-701	"Copayment"	R9-22-701
"Active treatment"	R9-22-1301	"Cost avoid"	R9-22-1201
"ADHS"	R9-22-101	"Cost-To-Charge Ratio" or "CCR"	R9-22-701 or R9-22-712
"Administration"	A.R.S. § 36-2901	"Court-ordered evaluation"	R9-22-1201
"Adult behavioral health therapeutic home"	9 A.A.C. 10, Article 1	"Court-ordered pre-petition screening"	R9-22-1201
"Adverse action"	R9-22-101	"Court-ordered treatment"	R9-22-1201
"Affiliated corporate organization"	R9-22-101	"Covered charges"	R9-22-701
"Aged"	42 U.S.C. 1382c(a)(1)(A) and R9-22-1501	"Covered services"	R9-22-101
"Agency"	R9-22-1201	"CPT"	R9-22-701
"Aggregate"	R9-22-701	"Creditable coverage"	R9-22-2003 and 42 U.S.C. 300gg(c)
"AHCCCS"	R9-22-101	"Crisis services"	R9-22-1201
"AHCCCS inpatient hospital day or days of care"	R9-22-701	"Critical Access Hospital"	R9-22-701
"AHCCCS registered provider"	R9-22-101	"CRS application"	R9-22-1301
"Ambulance"	A.R.S. § 36-2201	"CRS condition"	R9-22-1301
"Ancillary service"	R9-22-101	"CRS provider"	R9-22-1301
"Anticipatory guidance"	R9-22-201	"Cryotherapy"	R9-22-2001
"Annual enrollment choice"	R9-22-1701	"Customized DME"	R9-22-212
"APC"	R9-22-701	"Day"	R9-22-101 and R9-22-1101
"Applicant"	R9-22-101 or R9-22-301	"Date of the Notice of Adverse Action"	R9-22-1441
"Application"	R9-22-101	"DBHS"	R9-22-101
"Assessment"	R9-22-1101 or R9-22-1201	"DCSS"	R9-22-301
"Assignment"	R9-22-101	"Department"	A.R.S. § 36-2901
"Attending physician"	R9-22-101 or R9-22-202	"Dependent child"	A.R.S. § 46-101 or R9-22-1401
"Authorized representative"	R9-22-101	"DES"	R9-22-101
"Authorization"	R9-22-202	"Diagnostic services"	R9-22-101
"Auto-assignment algorithm"	R9-22-1701	"Direct graduate medical education costs" or "direct program costs"	R9-22-701
"AZ-NBCCEDP"	R9-22-2001	"Direct supervision"	R9-22-1201
"Behavior management services"	R9-22-1201	"Director"	R9-22-101
"Behavioral health therapeutic home care services"	R9-22-1201	"Disabled"	R9-22-1501
"Behavioral health paraprofessional"	R9-22-101	"Discussion"	R9-22-101
"Behavioral health professional"	R9-22-101	"Disenrollment"	R9-22-1701
"Behavioral health recipient"	R9-22-201	"DME"	R9-22-101
"Behavioral health services"	R9-22-1201	"DRI inflation factor"	R9-22-701
"Behavioral health technician"	R9-22-1201	"E.P.S.D.T. services"	42 CFR 440.40(b)
"Benefit year"	R9-22-201	"Eligibility posting"	R9-22-701
"BHS"	R9-22-301	"Eligible person"	A.R.S. § 36-2901
"Billed charges"	R9-22-701	"Emergency behavioral health condition for a non-FES member"	R9-22-201
"Blind"	R9-22-1501	"Emergency behavioral health services for a non-FES member"	R9-22-201
"Burial plot"	R9-22-1401	"Emergency medical condition for a non-FES member"	R9-22-201
"Business agent"	R9-22-701	"Emergency medical services for a non-FES member"	R9-22-201
"Calculated inpatient costs"	R9-22-712.07	"Emergency medical services provider"	R9-22-1201
"Capital costs"	R9-22-701	"Emergency medical or behavioral health condition for a FES member"	R9-22-217
"Capped fee-for-service"	R9-22-101	"Emergency services costs"	A.R.S. § 36-2903.07
"Caretaker relative"	R9-22-1401	"Emergency services for a FES member"	R9-22-217
"Case management"	R9-22-1201	"Encounter"	R9-22-701
"Case record"	R9-22-101	"Enrollment"	R9-22-1701
"Cash assistance"	R9-22-1401	"Equity"	R9-22-101
"Certified psychiatric nurse practitioner"	R9-22-1201	"Experimental services"	R9-22-203
"Charge master"	R9-22-712	"Existing outpatient service"	R9-22-701
"Child"	R9-22-1503	"Expansion funds"	R9-22-701
"Children's Rehabilitative Services" or "CRS"	R9-22-101 or R9-22-301	"FAA"	R9-22-301
"Chronic"	R9-22-1301	"Facility"	R9-22-101
"Claim"	R9-22-1101	"Factor"	R9-22-701 and 42 CFR 447.10
"Claims paid amount"	R9-22-712.07	"FBR"	R9-22-101
"Clean claim"	A.R.S. § 36-2904	"Federal financial participation" or "FFP"	42 CFR 400.203
"Clinical oversight"	9 A.A.C. 10	"Federal poverty level" or "FPL"	A.R.S. § 36-2981
"CMDP"	R9-22-1701	"Fee-For-Service" or "FFS"	R9-22-101
"CMS"	R9-22-101	"FES member"	R9-22-101
"Continuous stay"	R9-22-101	"FESP"	R9-22-101
"Contract"	R9-22-101	"First-party liability"	R9-22-1001
"Contract year"	R9-22-101	"File"	R9-22-1101
"Contractor"	A.R.S. § 36-2901 or R9-22-210.01	"Fiscal agent"	R9-22-210
		"Fiscal intermediary"	R9-22-701
		"Foster care maintenance payment"	42 U.S.C. 675(4)(A)
		"FQHC"	R9-22-101

## TITLE 9. HEALTH SERVICES

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“Freestanding Children’s Hospital”	R9-22-701	“Ownership change”	R9-22-701
“Functionally limiting”	R9-22-1301	“Ownership interest”	42 CFR 455.101
“Fund”	R9-22-712.07	“Partial Care”	R9-22-1201
“Graduate medical education (GME) program”	R9-22-701	“Participating institution”	R9-22-701
“GME program approved by the Administration” or “approved GME program”	R9-22-701	“Peer group”	R9-22-701
“Grievance”	A.A.C. Chapter 34	“Peer-reviewed study”	R9-22-2001
“GSA”	R9-22-101	“Penalty”	R9-22-1101
“HCAC”	R9-22-701	“Person”	R9-22-1101
“HCPCS”	R9-22-701	“Pharmaceutical service”	R9-22-201
“Health care institution”	A.R.S. § 36-401	“Physical therapy”	R9-22-201
“Health care practitioner”	R9-22-1201	“Physician”	R9-22-101
“Hearing aid”	R9-22-201	“Physician assistant”	R9-22-1201
“HIPAA”	R9-22-701	“Post-stabilization services”	R9-22-201 or 42 CFR 422.113
“Home health services”	R9-22-201	“PPS bed”	R9-22-701
“Hospital”	R9-22-101	“Practitioner”	R9-22-101
“ICU”	R9-22-701	“Pre-enrollment process”	R9-22-301
“IHS”	R9-22-101	“Prescription”	R9-22-101
“IHS enrolled” or “enrolled with IHS”	R9-22-708	“Primary care provider” or “PCP”	R9-22-101
“IMD” or “Institution for Mental Diseases”	42 CFR 435.1010 and R9-22-101	“Primary care provider services”	R9-22-201
“Income”	R9-22-301	“Prior authorization”	R9-22-101
“Indirect program costs”	R9-22-701	“Prior period coverage” or “PPC”	R9-22-101
“Individual”	R9-22-211	“Procedure code”	R9-22-701
“In-kind income”	R9-22-1420	“Procurement file”	R9-22-601
“Inmate of a public institution”	42 CFR 435.1010	“Proposal”	R9-22-101
“Inpatient covered charges”	R9-22-712.07	“Prospective rates”	R9-22-701
“Intermediate Care Facility for the Mentally Retarded” or “ICF-MR”	42 U.S.C. 1396d(d)	“Psychiatrist”	R9-22-1201
“Intern and Resident Information System”	R9-22-701	“Psychologist”	R9-22-1201
“LEEP”	R9-22-2001	“Psychosocial rehabilitation services”	R9-22-201
“Legal representative”	R9-22-101	“Public hospital”	R9-22-701
“Level I trauma center”	R9-22-2101	“Qualified alien”	A.R.S. § 36-2903.03
“License” or “licensure”	R9-22-101	“Qualified behavioral health service provider”	R9-22-1201
“Licensee”	R9-22-1201	“Quality management”	R9-22-501
“MAGI-based income”	R9-22-1401	“Radiology”	R9-22-101
“Mailing date”	R9-22-101	“RBHA” or “Regional Behavioral Health Authority”	R9-22-201
“Medical education costs”	R9-22-701	“Reason to know” or “had reason to know”	R9-22-1101
“Medical expense deduction” or “MED”	R9-22-1401	“Rebase”	R9-22-701
“Medical practitioner”	R9-22-1201	“Redetermination”	R9-22-1301
“Medical record”	R9-22-101	“Referral”	R9-22-101
“Medical review”	R9-22-701	“Rehabilitation services”	R9-22-101
“Medical services”	A.R.S. § 36-401	“Reinsurance”	R9-22-701
“Medical supplies”	R9-22-101	“Remittance advice”	R9-22-701
“Medical support”	R9-22-301	“Resident”	R9-22-701
“Medically eligible”	R9-22-1301	“Residual functional deficit”	R9-22-201
“Medically necessary”	R9-22-101	“Resources”	R9-22-301
“Medicare claim”	R9-22-101	“Respiratory therapy”	R9-22-201
“Medicare Urban or Rural Cost-to-Charge Ratio (CCR)”	R9-22-701	“Respite”	R9-22-1201
“Member”	A.R.S. § 36-2901 or R9-22-301	“Responsible offeror”	R9-22-101
“Mental disorder”	A.R.S. § 36-501	“Responsive offeror”	R9-22-101
“Milliman study”	R9-22-712.07	“Revenue Code”	R9-22-701
“Monthly equivalent”	R9-22-1401	“Review”	R9-22-101
“Monthly income”	R9-22-1401	“Review month”	R9-22-101
“National Standard code sets”	R9-22-701	“RFP”	R9-22-101
“New hospital”	R9-22-701	“Rural Contractor”	R9-22-718
“NICU”	R9-22-701	“Rural Hospital”	R9-22-718 R9-22-712.07 and
“Noncontracted Hospital”	R9-22-718	“Scope of services”	R9-22-201
“Noncontracting provider”	A.R.S. § 36-2901	“Section 1115 Waiver”	A.R.S. § 36-2901
“Non-FES member”	R9-22-101	“Service location”	R9-22-101
“Non-IHS Acute Hospital”	R9-22-701	“Service site”	R9-22-101
“Nursing facility” or “NF”	42 U.S.C. 1396r(a)	“SOBRA”	R9-22-101
“Observation day”	R9-22-701	“Specialist”	R9-22-101
“Occupational therapy”	R9-22-201	“Specialty facility”	R9-22-701
“Offeror”	R9-22-101	“Speech therapy”	R9-22-201
“Operating costs”	R9-22-701	“Spendthrift restriction”	R9-22-1401
“OPPC”	R9-22-701	“Sponsor”	R9-22-301
“Organized health care delivery system”	R9-22-701	“Sponsor deemed income”	R9-22-301
“Outlier”	R9-22-701	“Sponsoring institution”	R9-22-701
“Outpatient hospital service”	R9-22-701	“Spouse”	R9-22-101
		“SSA”	42 CFR 1000.10
		“SSI”	42 CFR 435.4
		“SSN”	R9-22-101

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“Stabilize”	42 U.S.C. 1395dd
“Standard of care”	R9-22-101
“Sterilization”	R9-22-201
“Subcontract”	R9-22-101
“Submitted”	A.R.S. § 36-2904
“Substance abuse”	R9-22-201
“SVES”	R9-22-301
“Tax dependent”	42 CFR 435.4
“Taxi”	A.R.S. § 28-101(53)
“Taxpayer”	R9-22-1401
“Third-party”	R9-22-1001
“Third-party liability”	R9-22-1001
“Tier”	R9-22-701
“Tiered per diem”	R9-22-701
“Title IV-D”	R9-22-1401
“Title IV-E”	R9-22-1401
“Total Inpatient payments”	R9-22-712.07
“Trauma and Emergency Services Fund”	A.R.S. § 36-2903.07
“TRBHA” or “Tribal Regional Behavioral Health Authority”	R9-22-1201
“Treatment”	R9-22-2004
“Tribal Facility”	A.R.S. § 36-2981
“Unrecovered trauma center readiness costs”	R9-22-2101
“Urban Contractor”	R9-22-718
“Urban Hospital”	R9-22-718
“USCIS”	R9-22-301
“Utilization management”	R9-22-501
“WWHP”	R9-22-2001

**B. General definitions.** In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“ADHS” means the Arizona Department of Health Services.

“Adverse action” means an action taken by the Department or Administration to deny, discontinue, or reduce medical assistance.

“Affiliated corporate organization” means any organization that has ownership or control interests as defined in 42 CFR 455.101, and includes a parent and subsidiary corporation.

“AHCCCS” means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

“AHCCCS registered provider” means a provider or non-contracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A), and

Meets license or certification requirements to provide covered services.

“Ancillary service” means all hospital services for patient care other than room and board and nursing services, including but not limited to, laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, and occupational).

“Applicant” means a person who submits or whose authorized representative submits a written, signed, and dated application for AHCCCS benefits.

“Application” means an official request for AHCCCS medical coverage made under this Chapter.

“Assignment” means enrollment of a member with a contractor by the Administration.

“Attending physician” means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a Fee-For-Service member.

“Authorized representative” means a person who is authorized to apply for medical assistance or act on behalf of another person.

“Behavioral health paraprofessional” means an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution’s policies and procedures that:

If the behavioral health services were provided in a setting other than a licensed health care institution,

If the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33,

If the behavioral health services were provided in a setting other than a licensed health care institution; and

Are provided under supervision by a behavioral health professional R9-10-101.

“Behavioral Health Professional” has the same meaning as defined A.A.C. R9-10-101 excluding subsection (g).

“Capped fee-for-service” means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific covered service or equipment provided to a member. A payment is made in accordance with an upper or capped limit established by the Director. This capped limit can either be a specific dollar amount or a percentage of billed charges.

“Case record” means an individual or family file retained by the Department that contains all pertinent eligibility information, including electronically stored data.

“Children’s Rehabilitative Services” or “CRS” means the program that provides covered medical services and covered support services in accordance with A.R.S. § 36-261.

“CMS” means the Centers for Medicare and Medicaid Services.

“Continuous stay” means a period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

“Contract” means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and this Chapter.

“Contract year” means the period beginning on October 1 of a year and continuing until September 30 of the following year.

“Covered services” means the health and medical services described in Articles 2 and 12 of this Chapter as being eligible for reimbursement by AHCCCS.

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“Day” means a calendar day unless otherwise specified.

“DBHS” means the Division of Behavioral Health Services within the Arizona Department of Health Services.

“DES” means the Department of Economic Security.

“Diagnostic services” means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.

“Director” means the Director of the Administration or the Director’s designee.

“Discussion” means an oral or written exchange of information or any form of negotiation.

“DME” means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.

“Equity” means the county assessor full cash value or market value of a resource minus valid liens, encumbrances, or both.

“Facility” means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related service.

“FBR” means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.

“Fee-For-Service” or “FFS” means a method of payment by the AHCCCS Administration to a registered provider on an amount-per-service basis for a member not enrolled with a contractor.

“FES member” means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.

“FESP” means the federal emergency services program under R9-22-217 which covers services to treat an emergency medical or behavioral health condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

“FQHC” means federally qualified health center.

“GSA” means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with the contractor.

“Hospital” means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.

“IHS” means Indian Health Service.

“IMD” or “Institution for Mental Diseases” means an Institution for Mental Diseases as described in 42 CFR 435.1010 that is licensed by ADHS.

“Legal representative” means a custodial parent of a child under 18, a guardian, or a conservator.

“License” or “licensure” means a nontransferable authorization that is granted based on established standards in law by a state or a county regulatory agency or board and allows a health care provider to lawfully render a health care service.

“Mailing date” when used in reference to a document sent first class, postage prepaid, through the United States mail, means the date:

Shown on the postmark;

Shown on the postage meter mark of the envelope, if no postmark; or

Entered as the date on the document, if there is no legible postmark or postage meter mark.

“Medical record” means a document that relates to medical or behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that is kept at the site of the provider.

“Medical supplies” means consumable items that are designed specifically to meet a medical purpose.

“Medically necessary” means a covered service is provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or their progression, or to prolong life.

“Medicare claim” means a claim for Medicare-covered services for a member with Medicare coverage.

“Non-FES member” means an eligible person who is entitled to full AHCCCS services.

“Offeror” means an individual or entity that submits a proposal to the Administration in response to an RFP.

“Physician” means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

“Practitioner” means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a registered nurse practitioner certified under A.R.S. Title 32, Chapter 15.

“Prescription” means an order to provide covered services that is signed or transmitted by a provider authorized to prescribe the services.

“Primary care provider” or “PCP” means an individual who meets the requirements of A.R.S. § 36-2901 (14), and who is responsible for the management of a member’s health care.

“Prior authorization” means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness, compliance with this Article and any applicable contract provisions. Prior authorization is not a guarantee of payment.

“Prior period coverage” means the period prior to the member’s enrollment during which a member is eligible for covered services. PPC begins on the first day of the month of application or the first eligible month, which-

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ever is later, and continues until the day the member is enrolled with a contractor.

“Proposal” means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.

“Radiology” means professional and technical services rendered to provide medical imaging, radiation oncology, and radioisotope services.

“Referral” means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

“Rehabilitation services” means physical, occupational, and speech therapies, and items to assist in improving or restoring a person’s functional level.

“Responsible offeror” means an individual or entity that has the capability to perform the requirements of a contract and that ensures good faith performance.

“Responsive offeror” means an individual or entity that submits a proposal that conforms in all material respects to an RFP.

“Review” means a review of all factors affecting a member’s eligibility.

“Review month” means the month in which the individual’s or family’s circumstances and case record are reviewed.

“RFP” means Request for Proposals, including all documents, whether attached or incorporated by reference, that are used by the Administration for soliciting a proposal under 9 A.A.C. 22, Article 6.

“Service location” means a location at which a member obtains a covered service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.

“Service site” means a location designated by a contractor as the location at which a member is to receive covered services.

“S.O.B.R.A.” means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 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).

“Specialist” means a Board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.

“Spouse” means a person who has entered into a contract of marriage recognized as valid by this state.

“SSN” means Social Security number.

“Standard of care” means a medical procedure or process that is accepted as treatment for a specific illness, injury, or medical condition through custom, peer review, or consensus by the professional medical community.

“Subcontract” means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member,

A marketing organization, or

Any other organization or person that agrees to perform any administrative function or service for the contractor specifically related to securing or fulfilling the contractor’s obligation to the Administration under the terms of a contract.

“Taxi” is as defined in A.R.S. § 28-101(53).

#### Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-101 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-101 repealed, former Sections R9-22-102 and R9-22-301 renumbered as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency by adding new paragraphs (24), (46), (84) and (91) and renumbering accordingly effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Amended as an emergency by adding new paragraphs (2) and (15) and renumbering accordingly effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment added paragraphs (2) and (15) and renumbered accordingly effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended paragraphs (10) and (15) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended by deleting paragraphs (39) and (62) and renumbering accordingly effective July 1, 1988 (Supp. 88-3). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted effective December 8, 1997 (Supp. 97-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking

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at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 3830, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 461, effective April 1, 2012 (Supp. 12-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

**R9-22-102. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-102 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1092 (Supp. 82-4). Former Section R9-22-102 renumbered together with former Section R9-22-301 as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). New Section adopted effective December 8, 1997 (Supp. 97-4). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Section repealed by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3).

**R9-22-103. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-104. Reserved****R9-22-105. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final

rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-106. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4).

**R9-22-107. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Section repealed by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

**R9-22-108. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-109. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. effective 4484, effective January 6, 2007 (Supp. 06-4).

**R9-22-110. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

**R9-22-111. Reserved****R9-22-112. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Repealed by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1).

**R9-22-113. Reserved****R9-22-114. Repealed**

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**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4).

**R9-22-115. Repealed****Historical Note**

Final Section adopted at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4).

**R9-22-116. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-117. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

**R9-22-118. Reserved****R9-22-119. Reserved****R9-22-120. Repealed****Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

**ARTICLE 2. SCOPE OF SERVICES****R9-22-201. Scope of Services-related Definitions**

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“Anticipatory guidance” means a person responsible for a child receives information and guidance of what the person should expect of the child’s development and how to help the child stay healthy.

“Behavioral health recipient” means a Title XIX or Title XXI acute care member who is eligible for, and is receiving, behavioral health services through ADHS/DBHS.

“Benefit year” means a one-year time period of October 1st through September 30th.

“Emergency behavioral health condition for a non-FES member” means a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health

and medicine could reasonably expect the absence of immediate medical attention to result in:

Placing the health of the person, including mental health, in serious jeopardy;

Serious impairment to bodily functions;

Serious dysfunction of any bodily organ or part; or

Serious physical harm to another person.

“Emergency behavioral health services for a non-FES member” means those behavioral health services provided for the treatment of an emergency behavioral health condition.

“Emergency medical condition for a non-FES member” means treatment for a medical condition, including labor and delivery, which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

Placing the member’s health in serious jeopardy,

Serious impairment to bodily functions, or

Serious dysfunction of any bodily organ or part.

“Emergency medical services for a non-FES member” means services provided for the treatment of an emergency medical condition.

“Hearing aid” means an instrument or device designed for, or represented by the supplier as aiding or compensating for impaired or defective human hearing, and includes any parts, attachments, or accessories of the instrument or device.

“Home health services” means services and supplies that are provided by a home health agency that coordinates in-home intermittent services for curative, rehabilitative care, including home-health aide services, licensed nurse services, and medical supplies, equipment, and appliances.

“Occupational therapy” means medically prescribed treatment provided by or under the supervision of a licensed occupational therapist, to restore or improve an individual’s ability to perform tasks required for independent functioning.

“Pharmaceutical service” means medically necessary medications that are prescribed by a physician, practitioner, or dentist under R9-22-209.

“Physical therapy” means treatment services to restore or improve muscle tone, joint mobility, or physical function provided by or under the supervision of a registered physical therapist.

“Post-stabilization services” means covered services related to an emergency medical or behavioral health condition provided after the condition is stabilized.

“Primary care provider services” means healthcare services provided by and within the scope of practice, as defined by law, of a licensed physician, certified nurse practitioner, or licensed physician assistant.

“Psychosocial rehabilitation services” means services that provide education, coaching, and training to address or prevent residual functional deficits and may include services that may assist a member to secure and maintain employment. Psychosocial rehabilitation services may include:

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Living skills training,  
Cognitive rehabilitation,  
Health promotion,  
Supported employment, and

Other services that increase social and communication skills to maximize a member's ability to participate in the community and function independently.

"RBHA" or "Regional Behavioral Health Authority" means the same as in A.R.S. § 36-3401.

"Residual functional deficit" means a member's inability to return to a previous level of functioning, usually after experiencing a severe psychotic break or state of decompensation.

"Respiratory therapy" means treatment services to restore, maintain, or improve respiratory functions that are provided by, or under the supervision of, a respiratory therapist licensed according to A.R.S. Title 32, Chapter 35.

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

"Speech therapy" means medically prescribed diagnostic and treatment services provided by or under the supervision of a certified speech therapist.

"Sterilization" means a medically necessary procedure, not for the purpose of family planning, to render an eligible person or member barren in order to:

Prevent the progression of disease, disability, or adverse health conditions; or

Prolong life and promote physical health.

"Substance abuse" means the chronic, habitual, or compulsive use of any chemical matter that, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse for adults who are 21 years of age or older

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-201 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 3217, effective October 1, 2005 (Supp. 05-3). Section repealed; new Section made by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

**R9-22-202. General Requirements**

- A.** For the purposes of this Article, the following definitions apply:
1. "Authorization" means written, verbal, or electronic authorization by:
    - a. The Administration for services rendered to a fee-for-service member, or
    - b. The contractor for services rendered to a prepaid capitated member.
  2. Use of the phrase "attending physician" applies only to the fee-for-service population.
- B.** In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:
1. Only medically necessary, cost effective, and federally-reimbursable and state-reimbursable services are covered services.
  2. Covered services for the federal emergency services program (FESP) are under R9-22-217.
  3. The Administration or a contractor may waive the covered services referral requirements of this Article.
  4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.
  5. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider.
  6. A member may receive physical and behavioral health services as specified in Articles 2 and 12.
  7. The Administration or a contractor shall provide services under the Section 1115 Waiver as defined in A.R.S. § 36-2901.
  8. An AHCCCS registered provider shall provide covered services within the provider's scope of practice.
  9. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
    - a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;
    - b. Services or items furnished gratuitously, and
    - c. Personal care items except as specified under R9-22-212.
  10. Medical or behavioral health services are not covered services if provided to:
    - a. An inmate of a public institution; or
    - b. A person who is in residence at an institution for the treatment of tuberculosis.
- C.** The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained as specified in this Article and Article 7 of this Chapter. The Administration or a contractor shall not provide prior authorization for services unless the provider submits documentation of the medical necessity of the treatment along with the prior authorization request.

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- D.** Services under A.R.S. § 36-2908 provided during the prior period coverage do not require prior authorization.
- E.** Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.
- F.** A service is not a covered service if provided outside the GSA unless one of the following applies:
1. A member is referred by a primary care provider for medical specialty care outside the GSA. If a member is referred outside the GSA to receive an authorized medically necessary service, the contractor shall also provide all other medically necessary covered services for the member;
  2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member's family;
  3. The contractor authorizes placement in a nursing facility located out of the GSA; or
  4. Services are provided during prior period coverage or during the prior quarter coverage.
- G.** If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.
- H.** A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.
- I.** The Administration shall determine the circumstances under which a FFS member may receive services, other than emergency services, from service providers outside the member's county of residence or outside the state. Criteria considered by the Administration in making this determination shall include availability and accessibility of appropriate care and cost effectiveness.
- J.** The restrictions, limitations, and exclusions in this Article do not apply to a contractor electing to provide noncovered services.
1. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.
  2. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.
  3. If a member requests a service that is not covered or is not authorized by a contractor, or the Administration, an AHCCCS-registered service provider may provide the service according to R9-22-702.
- K.** Subject to CMS approval, the restrictions, limitations, and exclusions specified in the following subsections do not apply to American Indians receiving services through IHS or a tribal health program operating under P.L. 93-638 when those services are eligible for 100 percent federal financial participation:
1. R9-22-205(A)(8),
  2. R9-22-206,
  3. R9-22-207,
  4. R9-22-212(C),
  5. R9-22-212(D),
  6. R9-22-212(E)(8),
  7. R9-22-215(C)(5), (C)(6), and
  8. R9-22-215(C)(4).

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-202 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Amended effective July 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 22, 1995 (Supp. 95-3). Amended effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Section repealed effective September 22, 1997 (Supp. 97-3). New Section made by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4). Amended by final rulemaking at 21 A.A.R. 1225, effective July 7, 2015 (Supp. 15-3).

**R9-22-203. Experimental Services**

- A.** Experimental services are not covered. A service is not experimental if:
1. It is generally and widely accepted as a standard of care in the practice of medicine in the United States and is a safe and effective treatment for the condition for which it is intended or used.
  2. The service does not meet the standard in subsection (A)(1), but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of the evidence in peer-reviewed articles in medical journals published in the United States.
  3. The service does not meet the standard in subsection (A)(2) because the condition for which the service is intended or used is rare, but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of opinions from specialists who provide the service or related services.
- B.** The following factors shall be considered when evaluating the weight of peer-reviewed articles or the opinions of specialists:
1. The mortality rate and survival rate of the service as compared to the rates for alternative non-experimental services.
  2. The types, severity, and frequency of complications associated with the services as compared with the complications associated with alternative non-experimental services.
  3. The frequency with which the service has been performed in the past.
  4. Whether there is sufficient historical information regarding the service to provide reliable data regarding risks and benefits.

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5. The reputation and experience of the authors and/or specialists and their record in related areas.
6. The extent to which medical science in the area develops rapidly and the probability that more definite data will be available in the foreseeable future.
7. Whether the peer reviewed article describes a random controlled trial or an anecdotal clinical case study.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-203 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2).

Amended effective April 13, 1990 (Supp. 90-2).

Amended effective September 29, 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). Amended effective December 13, 1993 (Supp. 93-4). Section repealed effective September 22, 1997 (Supp. 97-3). New Section made by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Section amended by final rulemaking at 20 A.A.R. 1956, effective September 6, 2014 (Supp. 14-3).

**R9-22-204. Inpatient General Hospital Services**

- A.** The following limitations apply to inpatient general hospital services that are provided by FFS providers.
1. Providers shall obtain prior authorization from the Administration for the following inpatient hospital services:
    - a. Nonemergency and elective admission, including psychiatric hospitalization;
    - b. Elective surgery; and
    - c. Services or items provided to cosmetically reconstruct or improve personal appearance after an illness or injury.
  2. The Administration or a contractor may deny a claim if a provider fails to obtain prior authorization.
  3. Providers are not required to obtain prior authorization from the Administration for the following inpatient hospital services:
    - a. Voluntary sterilization,
    - b. Dialysis shunt placement,
    - c. Arteriovenous graft placement for dialysis,
    - d. Angioplasties or thrombectomies of dialysis shunts,
    - e. Angioplasties or thrombectomies of arteriovenous graft for dialysis,
    - f. Hospitalization for vaginal delivery that does not exceed 48 hours,
    - g. Hospitalization for cesarean section delivery that does not exceed 96 hours, and
    - h. Other services identified by the Administration through the Provider Participation Agreement.
  4. The Administration may perform concurrent review for hospitalizations of non-FES members to determine whether there is medical necessity for the hospitalization. A provider shall notify the Administration no later than 72 hours after an emergency admission.
- B.** Coverage of in-state and out-of-state inpatient hospital services is limited to 25 days per benefit year for members age 21

and older for claims with discharge dates on or before September 30, 2014. The limit applies for all inpatient hospital services with dates of service during the benefit year regardless of whether the member is enrolled in Fee for Service, is enrolled with one or more contractors, or both, during the benefit year.

1. For purposes of calculating the limit:
  - a. Inpatient days are counted towards the limit if paid by the Administration or a contractor;
  - b. Inpatient days will be counted toward the limit in the order of the adjudication date of a paid claim;
  - c. Paid inpatient days are allocated to the benefit year in which the date of service occurs;
  - d. Each 24 hours of paid observation services is counted as one inpatient day if the patient is not admitted to the same hospital directly following the observation services,
  - e. Observation services, which are directly followed by an inpatient admission to the same hospital are not counted towards the inpatient limit; and
  - f. After 25 days of inpatient hospital services have been paid as provided for in this rule Section:
    - i. Outpatient services that are directly followed by an inpatient admission to the same hospital, including observation services, are not covered.
    - ii. Continuous periods of observation services of less than 24 hours that are not directly followed by an inpatient admission to the same hospital are covered.
    - iii. For continuous periods of observation services of 24 hours or more that are not directly followed by an inpatient admission to the same hospital, 23 hours of observations services are covered.
2. The following inpatient days are not included in the inpatient hospital limitation described in this Section:
  - a. Days reimbursed under specialty contracts between AHCCCS and a transplant facility that are included within the component pricing referred to in the contract;
  - b. Days related to Behavioral Health:
    - i. Inpatient days that qualify for the psychiatric tier under R9-22-712.09 and reimbursed by the Administration or its contractors, or
    - ii. Inpatient days with a primary psychiatric diagnosis code reimbursed by the Administration or its contractors, or
    - iii. Inpatient days paid by the Arizona Department of Health Services Division of Behavioral Health Services or a RBHA or TRBHA.
  - c. Days related to treatment for burns and burn late effects at an American College of Surgeons verified burn center;
  - d. Same Day Admit Discharge services are excluded from the 25 day limit; and
  - e. Subject to approval by CMS, days for which the state claims 100% FFP, such as payments for days provided by IHS or 638 facilities.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-204 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective

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tive December 22, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1745, effective October 1, 2012 (Supp. 12-2). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 1956, effective September 6, 2014 (Supp. 14-3). The incorrect label C was changed to B (Supp. 22-3).

**R9-22-205. Attending Physician, Practitioner, and Primary Care Provider Services**

- A.** A primary care provider, attending physician, or practitioner shall provide primary care provider services within the provider's scope of practice under A.R.S. Title 32. A member may receive primary care provider services in an inpatient or outpatient setting including at a minimum:
1. Periodic health examination and assessment;
  2. Evaluation and diagnostic workup;
  3. Medically necessary treatment;
  4. Prescriptions for medication and medically necessary supplies and equipment;
  5. Referral to a specialist or other health care professional if medically necessary;
  6. Patient education;
  7. Home visits if medically necessary; and
  8. Preventive health services, such as, well visits, immunizations, colonoscopies, mammograms and PAP smears.
- B.** The following limitations and exclusions apply to attending physician and practitioner services and primary care provider services:
1. Specialty care and other services provided to a member upon referral from a primary care provider, or to a member upon referral from the attending physician or practitioner are limited to the service or condition for which the referral is made, or for which authorization is given by the Administration or a contractor.
  2. A member's physical examination is not covered if the sole purpose is to obtain documentation for one or more of the following:
    - a. Qualification for insurance,
    - b. Pre-employment physical evaluation,
    - c. Qualification for sports or physical exercise activities,
    - d. Pilot's examination for the Federal Aviation Administration,
    - e. Disability certification to establish any kind of periodic payments,
    - f. Evaluation to establish third-party liabilities, or
    - g. Physical ability to perform functions that have no relationship to primary objectives of the services listed in subsection (A).
  3. Orthognathic surgery is covered only for a member who is less than 21 years of age;

4. The following services are excluded from AHCCCS coverage:
  - a. Infertility services, reversal of surgically induced infertility (sterilization), and gender reassignment surgeries;
  - b. Pregnancy termination counseling services;
  - c. Pregnancy terminations, unless required by state or federal law.
  - d. Services or items furnished solely for cosmetic purposes; and
  - e. Hysterectomies unless determined medically necessary.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-205 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A), paragraph (15) and added paragraph (20) effective December 22, 1987 (Supp. 87-4). Amended subsection (C)(2) effective May 30, 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 December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

*Editor's Note: The following Section was renumbered and a new Section adopted under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not published as a proposed rule in the Arizona Administrative Register; the rule was not reviewed or approved by the Governor's Regulatory Review Council; and the agency was not required to hold public hearings on the rule. This Section was subsequently amended through the regular rulemaking process.*

**R9-22-206. Organ and Tissue Transplant Services**

- A.** Organ and tissue transplant services are covered for a member if prior authorized and coordinated with the member's contractor, or the Administration. Only the following transplants are covered for individuals 21 years of age or older:
1. Heart, including transplants for the treatment of non-ischemic cardiomyopathy;
  2. Liver, including transplants for patients with hepatitis C;
  3. Kidney (cadaveric and live donor);
  4. Simultaneous Pancreas/Kidney (SPK);
  5. Autologous and Allogeneic related and unrelated Hematopoietic Cell transplants;
  6. Cornea;
  7. Bone;
  8. Lung; and
  9. Pancreas after a kidney transplant (PAK).
- B.** The following transplants are not covered for members 21 years of age or older:

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1. Pancreas only transplants if it is not performed simultaneously with or following a kidney transplant. Partial pancreas transplants and autologous and allogeneic pancreas islet cell transplants are not covered even if performed simultaneously with or following a kidney transplant.
  2. Intestine transplants, and
  3. Any other type of transplant not specifically listed in subsection (A).
- C. When there is a transplant of multiple organs, reimbursement will only be made for those covered.
- D. Organ and tissue transplant services are not covered for non-qualified aliens or noncitizens members of FESP under A.R.S. § 36-2903.03(D).
- C. For the purposes of this subsection, simple restorations means silver amalgam or composite resin fillings, stainless steel crowns or preformed crowns. In addition, dental services for an individual 21 years of age or older include:
1. The elimination of oral infections and the treatment of oral disease, which includes dental cleanings, treatment of periodontal disease, medically necessary extractions and the provision of simple restorations as a medically necessary pre-requisite to covered transplantation; and
  2. Prophylactic extraction of teeth in preparation for covered radiation treatment of cancer of the jaw, neck or head.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-207 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-207 repealed, new Section R9-22-207 adopted effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3).

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-206 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-206 renumbered to R9-22-218, new Section R9-22-206 adopted effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by exempt rulemaking at 16 A.A.R. 1386, effective July 15, 2010 (Supp. 10-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by exempt rulemaking at 17 A.A.R. 1122, April 1, 2011 (Supp. 11-2).

**R9-22-207. Dental Services**

- A. The Administration or a contractor shall cover dental services for a member less than 21 years of age under R9-22-213.
- B. For individuals age 21 years of age or older, the Administration or a contractor shall cover medical and surgical services furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician.
  1. Except as specified in subsection (C), such services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. Covered dental services include examination of the oral cavity, radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate level of anesthesia and the prescription of pain medication and antibiotics.
  2. Such services do not include services that physicians are not generally competent to perform such as dental cleanings, routine dental examinations, dental restorations including crowns and fillings, extractions, pulpotomies, root canals, and the construction or delivery of complete or partial dentures. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.

**R9-22-208. Laboratory, Radiology, and Medical Imaging Services**

Laboratory, radiology, and medical imaging services are covered services if:

1. Prescribed by the member's attending physician, practitioner, primary care provider or a dentist, or prescribed by a physician or practitioner upon referral from the primary care provider or dentist.
2. Provided by licensed health care providers in a:
  - a. Hospital,
  - b. Clinic,
  - c. Physician's office, or
  - d. Other health care facility.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-208 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-208 repealed, new Section R9-22-208 adopted effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended effective December 13, 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. 2325, effective May 9, 2002 (Supp. 02-2).

**R9-22-209. Pharmaceutical Services**

- A. An inpatient or outpatient provider, including a hospital, clinic, other appropriately licensed health care facility, and pharmacy may provide covered pharmaceutical services.
- B. The Administration or a contractor shall require a provider to make pharmaceutical services:
  1. Available during customary business hours, and
  2. Located within reasonable travel distance of a member's residence.
- C. Pharmaceutical services are covered if:

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1. Prescribed for a member by the member's primary care provider, attending physician, practitioner, or dentist;
  2. Prescribed by a specialist upon referral from the primary care provider or attending physician; or
  3. The contractor or its designee authorizes the service.
- D.** The following limitations apply to pharmaceutical services:
1. A medication personally dispensed by a physician, dentist, or a practitioner within the individual's scope of practice is not covered, except in geographically remote areas where there is no participating pharmacy or if accessible pharmacies are closed.
  2. A new prescription or refill in excess of a 30 day supply is not covered unless:
    - a. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed a 90 day supply; or
    - b. The Contractor authorizes the prescription for an extended time period not to exceed a 90-day supply.
  3. An over-the-counter medication, in place of a covered prescription medication, is covered only if the over-the-counter medication is appropriate, equally effective, safe, and less costly than the covered prescription medication.
- E.** A contractor shall monitor and ensure sufficient services to prevent any gap in the pharmaceutical regimen of a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well being.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-209 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective September 24, 1986 (Supp. 86-5). Amended subsections (A) and (C) effective December 22, 1987 (Supp. 87-4). Amended subsection (C)(3), effective May 30, 1989 (Supp. 89-2). Amended under an exemption from 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 December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

**R9-22-210. Emergency Medical Services for Non-FES Members**

- A.** General provisions.
1. Applicability. This Section applies to emergency medical services for non-FES members. Provisions regarding emergency behavioral health services for non-FES members are in R9-22-210.01. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
  2. Definitions.
    - a. For the purposes of this Section, "contractor" has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS or a subcontractor of ADHS/DBHS.
    - b. For the purposes of this Section and R9-22-210.01, "fiscal agent" means a person who bills and accepts payment for a hospital or emergency room provider.
  3. Verification. A provider of emergency medical services shall verify a person's eligibility status with AHCCCS, and if eligible, determine whether the person is enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor.
  4. Prior authorization.
    - a. Emergency medical services. A provider is not required to obtain prior authorization for emergency medical services.
    - b. Non-emergency medical services. If a non-FES member's medical condition does not require emergency medical services, the provider shall obtain prior authorization as required by the terms of the provider agreement under R9-22-714(A) or the provider's subcontract with the contractor, whichever is applicable.
  5. Prohibition against denial of payment. Neither the Administration nor a contractor shall:
    - a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms,
    - b. Deny or limit payment because the provider failed to obtain prior authorization for emergency services,
    - c. Deny or limit payment because the provider does not have a subcontract.
  6. Grounds for denial. The Administration and a contractor may deny payment for emergency medical services for reasons including but not limited to:
    - a. The claim was not a clean claim;
    - b. The claim was not submitted timely; and
    - c. The provider failed to provide timely notification under subsection (B)(4) to the contractor or the Administration, as appropriate, and the contractor does not have actual notice from any other source that the member has presented for services.
- B.** Additional requirements for emergency medical services for non-FES members enrolled with a contractor.
1. Responsible entity. A contractor is responsible for the provision of all emergency medical services to non-FES members enrolled with the contractor.
  2. Prohibition against denial of payment. A contractor shall not limit or deny payment for emergency medical services when an employee of the contractor instructs the member to obtain emergency medical services.
  3. Contractor notification. A contractor shall not deny payment to a hospital, emergency room provider, or fiscal agent for an emergency medical service rendered to a non-FES member based on the failure of the hospital, emergency room provider, or fiscal agent to notify the member's contractor within 10 days from the day that the member presented for the emergency medical service.
  4. Contractor notification. A hospital, emergency room provider, or fiscal agent shall notify the contractor no later than the 11th day after presentation of the non-FES member for emergency inpatient medical services. A contractor may deny payment for a hospital's, emergency room provider's, or fiscal agent's failure to provide timely notice, under this subsection.
- C.** Post-stabilization services for non-FES members enrolled with a contractor.
1. After the emergency medical condition of a member enrolled with a contractor is stabilized, a provider shall

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request prior authorization from the contractor for post-stabilization services.

2. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that have been prior authorized by the contractor.
  3. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor for prior authorization of further post-stabilization services;
  4. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain, improve, or resolve the member's stabilized condition if:
    - a. The contractor does not respond to a request for prior authorization within one hour;
    - b. The contractor authorized to give the prior authorization cannot be contacted; or
    - c. The contractor representative and the treating physician cannot reach an agreement concerning the member's care and the contractor physician is not available for consultation. In this situation, the contractor shall give the treating physician the opportunity to consult with a contractor physician. The treating physician may continue with care of the member until the contractor physician is reached or:
      - i. A contractor physician with privileges at the treating hospital assumes responsibility for the member's care,
      - ii. A contractor physician assumes responsibility for the member's care through transfer,
      - iii. The contractor's representative and the treating physician reach agreement concerning the member's care, or
      - iv. The member is discharged.
  5. Transfer or discharge. The attending physician or practitioner actually treating the member for the emergency medical condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor.
- D. Additional requirements for FFS members.**
1. Responsible entity. The Administration is responsible for the provision of all emergency medical services to non-FES FFS members.
  2. Grounds for denial. The Administration may deny payment for emergency medical services if a provider fails to provide timely notice to the Administration.
  3. Notification. A provider shall notify the Administration no later than 72 hours after a FFS member receiving emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-210 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-210 repealed, new Section R9-22-210 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), para-

graph (1) effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

**R9-22-210.01. Emergency Behavioral Health Services for Non-FES Members****A. General provisions.**

1. Applicability. This Section applies to emergency behavioral health services for non-FES members. Provisions regarding emergency medical services for non-FES members are in R9-22-210. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
2. Definition. For the purposes of this Section, "contractor" has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS, a subcontractor of ADHS/DBHS, or Children's Rehabilitative Services.
3. Responsible entity for inpatient emergency behavioral health services.
  - a. Members enrolled with a contractor. ADHS/DBHS. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services to non-FES members with psychiatric or substance abuse diagnoses who are enrolled with the contractor.
  - b. FFS members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services for non-FES FFS members with psychiatric or substance abuse diagnoses unless services are provided in an IHS or tribally operated 638 facility.
4. Responsible entity for non-inpatient emergency behavioral health services for non-FES members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all non-inpatient emergency behavioral health services for non-FES members.
5. Verification. A provider of emergency behavioral health services shall verify a person's eligibility status with AHCCCS, and if eligible, determine whether the person is a member enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor, and determine whether the member is a behavioral health recipient as defined in R9-22-201.
6. Prior authorization.
  - a. Emergency behavioral health services. A provider is not required to obtain prior authorization for emergency behavioral health services.
  - b. Non-emergency behavioral health services. When a non-FES member's behavioral health condition is determined by the provider not to require emergency behavioral health services, the provider shall follow the prior authorization requirements of a contractor

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and ADHS/DBHS or a subcontractor of ADHS/DBHS.

7. Prohibition against limitation or denial of payment. A contractor, TRBHA, the Administration, ADHS/DBHS, or a subcontractor of ADHS/DBHS shall not limit or deny payment to an emergency behavioral health provider for emergency behavioral health services to a non-FES member for the following reasons:
    - a. On the basis of lists of diagnoses or symptoms;
    - b. Prior authorization was not obtained;
    - c. The provider does not have a contract;
    - d. An employee of the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS instructs the member to obtain emergency behavioral health services; or
    - e. The failure of a hospital, emergency room provider, or fiscal agent to notify the member's contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS within 10 days from the day the member presented for the emergency service.
  8. Grounds for denial. A contractor, the Administration, ADHS/DBHS, or a subcontractor of ADHS/DBHS may deny payment for emergency behavioral health services for reasons including but not limited to the following:
    - a. The claim was not a clean claim;
    - b. The claim was not submitted timely; or
    - c. The provider failed to provide timely notification under subsection (A)(9) to the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS or the Administration.
  9. Notification.
    - a. A hospital, emergency room provider, or fiscal agent shall notify a contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, whichever is appropriate, no later than the 11th day from presentation of the non-FES member for emergency inpatient behavioral health services.
    - b. A hospital, emergency room provider, or fiscal agent shall notify the Administration no later than 72 hours after a FFS member receiving emergency behavioral health services presents to a hospital for inpatient services.
  10. Transfer or discharge. The attending physician or the provider actually treating the non-FES 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 contractor and ADHS/DBHS or a subcontractor of ADHS/DBHS.
- B. Post-stabilization requirements for non-FES members.**
1. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that have been prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS.
  2. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor, ADHS/DBHS, or a subcontractor for prior authorization of further post-stabilization services;
  3. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain, improve, or resolve the member's stabilized condition if:
    - a. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, does not respond to a request for prior authorization within one hour;
    - b. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS authorized to give the prior authorization cannot be contacted; or
    - c. The representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician cannot reach an agreement concerning the member's care and the contractor's, ADHS/DBHS' or the subcontractor's physician, is not available for consultation. The treating physician may continue with care of the member until ADHS/DBHS', the contractor's, or the subcontractor's physician is reached, or:
      - i. A contracted physician with privileges at the treating hospital assumes responsibility for the member's care;
      - ii. ADHS/DBHS', a contractor's, or a subcontractor's physician assumes responsibility for the member's care through transfer;
      - iii. A representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician reach agreement concerning the member's care; or
      - iv. The member is discharged.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

**R9-22-211. Transportation Services**

- A. Emergency ambulance services.**
1. A member shall receive medically necessary emergency transportation in a ground or air ambulance:
    - a. To the nearest appropriate provider or medical facility capable of meeting the member's medical needs, and
    - b. If no other appropriate means of transportation is available.
  2. The Administration or a member's contractor shall reimburse a ground or air ambulance transport that originates in response to a 911 call or other emergency response system:
    - a. If the member's medical condition justifies the medical necessity of the type of ambulance transportation received,
    - b. The transport is to the nearest appropriate provider or medical facility capable of meeting the member's medical needs, and
    - c. No prior authorization is required for reimbursement of these transports.
  3. The member's medical condition at the time of transport determines whether the transport is medically necessary.

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4. A ground or air ambulance provider furnishing transport in response to a 911 call or other emergency response system shall notify the member's contractor within 10 working days from the date of transport. Failure of the provider to provide notification is cause for denial.
  5. Notification to the Administration of emergency transportation provided to a FFS member is not required, but the provider shall submit documentation with the claim that justifies the service.
- B.** The Administration or a contractor covers air ambulance services only if at least one criterion in subsection (B)(1) is met and at least one criterion in subsection (B)(2), or the criterion in subsection (B)(3) is met. The criteria are:
1. The air ambulance transport is initiated at the request of:
    - a. An emergency response unit,
    - b. A law enforcement official,
    - c. A clinic or hospital medical staff member, or
    - d. A physician or practitioner, and
  2. The point of pickup:
    - a. Is inaccessible by ground ambulance, or
    - b. Is a great distance from the nearest hospital or other provider with appropriate facilities to treat the member's condition and ground ambulance service will not suffice, or
  3. The medical condition of the member requires immediate intervention from emergency ambulance personnel or providers with the appropriate facilities to treat the member's condition.
- C.** Coverage of medically necessary nonemergency transportation is limited to the cost of transporting the member to an appropriate provider capable of meeting the member's medical needs.
1. As specified in contract, a contractor shall arrange or provide medically necessary nonemergency transportation services for a member who is unable to arrange transportation to a service site or location.
  2. For a fee-for-service member, the Administration shall authorize medically necessary nonemergency transportation for a member who is unable to arrange transportation to a service site or location.
- D.** For the purposes of this subsection, an individual means a person who is not in the business of providing transportation services such as a family or household member, friend, or neighbor. The Administration or a contractor shall cover expenses for transportation in traveling to and returning from an approved and prior authorized health care service site provided by an individual if:
1. The transportation services are authorized by the Administration or the member's contractor or designee,
  2. The individual is an AHCCCS registered provider, and
  3. No other means of appropriate transportation is available.
- E.** The Administration or a contractor shall cover expenses for meals, lodging, and transportation for a member traveling to and returning from an approved health care service site outside of the member's service area or county of residence.
- F.** The Administration or a contractor shall cover the expense of meals, lodging, and transportation for:
1. A family member accompanying a member if:
    - a. The member is traveling to or returning from an approved health care service site outside of the member's service area or county of residence; and
    - b. The meals, lodging, and transportation services are authorized by the Administration or the member's contractor or designee.
  2. An escort who is not a family member as follows:
    - a. If the member is traveling to or returning from an approved and prior authorized health care service site, including an inpatient facility, outside of the member's service area or county of residence;
    - b. If the escort services are authorized by the Administration or the member's contractor or designee; and
    - c. Wage paid to an escort as reimbursement shall not exceed the federal minimum wage.
- G.** A provider shall obtain prior authorization from the Administration for transportation services provided for a member for the following:
1. Medically necessary nonemergency transportation services not originated through a 911 call or other emergency response system when the distance traveled exceeds 100 miles (whether one way or round trip); and
  2. All meals, lodging, and services of an escort accompanying the member under this Section.
- H.** A charitable organization routinely providing transportation service at no cost to an ambulatory or chairbound person shall not charge or seek reimbursement from the Administration or a contractor for the provision of the service to a member but may enter into a subcontract with a contractor for medically necessary transportation services provided to a member.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-211 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3).

**R9-22-212. Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies**

- A.** Durable medical equipment, orthotic and prosthetic devices, and medical supplies, including incontinence briefs as specified in subsection (E), are covered services to the extent permitted in this Section if provided in compliance with requirements of this Chapter; and
1. Prescribed by the primary care provider, attending physician, or practitioner; or
  2. Prescribed by a specialist upon referral from the primary care provider, attending physician, or practitioner; and
  3. Authorized as required by the Administration, contractor, or contractor's designee.
- B.** Covered medical supplies are consumable items that are designed specifically to meet a medical purpose, are disposable, and are essential for the member's health.
- C.** Covered DME is any item, appliance, or piece of equipment that is not a prosthetic or orthotic; and
1. Is designed for a medical purpose, and is generally not useful to a person in the absence of an illness or injury, and
  2. Can withstand repeated use, and
  3. Is generally reusable by others.
- D.** Prosthetics are devices prescribed by a physician or other licensed practitioner to artificially replace missing, deformed or malfunctioning portion of the body. Only those prosthetics

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that are medically necessary for rehabilitation are covered, except as otherwise provided in R9-22-215.

E. The following limitations on coverage apply:

1. The DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the DME does not exceed the cost of the DME if purchased.
2. Reasonable repair or adjustment of purchased DME is covered if necessary to make the DME serviceable and if the cost of repair or adjustment is less than the cost of renting or purchasing another unit.
3. A change in, or addition to, an original order for DME is covered if approved by the prescriber in subsection (A), or prior authorized by the Administration or contractor, and the change or addition is indicated clearly on the order and initialed by the vendor. No change or addition to the original order for DME may be made after a claim for services is submitted to the member's contractor, or the Administration, without prior written notification of the change or addition to the Administration or the contractor.
4. Reimbursement for rental fees shall terminate:
  - a. No later than the end of the month in which the prescriber in subsection (A) certifies that the member no longer needs the DME;
  - b. If the member is no longer eligible for AHCCCS services; or
  - c. If the member is no longer enrolled with a contractor, with the exception of transitions of care as specified in R9-22-509.
5. Except for incontinence briefs for persons over 3 years old and under 21 years old as provided in subsection (E)(6), personal care items including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition. Personal care items are not covered services if used solely for preventive purposes.
6. Incontinence briefs, including pull-ups are covered to prevent skin breakdown and enable participation in social, community, therapeutic and educational activities under the following circumstances:
  - a. The member is over 3 years old and under 21 years old;
  - b. The member is incontinent due to a documented disability that causes incontinence of bowel or bladder, or both;
  - c. The PCP or attending physician has issued a prescription ordering the incontinence briefs;
  - d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder;
  - e. The member obtains incontinence briefs from providers in the contractor's network;
  - f. Prior authorization has been obtained as required by the Administration, contractor, or contractor's designee. Contractors may require a new prior authorization to be issued no more frequently than every 12 months. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit. Prior authorization will be permitted to ascertain that:

- i. The member is over age 3 and under age 21;
  - ii. The member has a disability that causes incontinence of bladder or bowel, or both;
  - iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by the contractor; and
  - iv. The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.
7. First aid supplies are not covered unless they are provided in accordance with a prescription.
  8. The following services are not covered for individuals 21 years of age or older:
    - a. Hearing aids;
    - b. Prescriptive lenses unless they are the sole visual prosthetic device used by the member after a cataract extraction;
    - c. Bone Anchor Hearing Aid (BAHA);
    - d. Cochlear implant;
    - e. Percussive vest;
    - f. Insulin pump;
    - g. Microprocessor-controlled lower limbs or microprocessor-controlled joints for lower limbs; and
    - h. Orthotics, which are defined as devices that are prescribed by a physician or other licensed practitioner of the healing arts to support a weak or deformed portion of the body.

F. Liability and ownership.

1. Purchased DME that is provided to a member and no longer needed by the member may be disposed of in accordance with each contractor's policy.
2. The Administration shall retain title to purchased DME provided to a member who becomes ineligible or no longer requires use of the DME.
3. If customized DME is purchased by the Administration or contractor for a member, the equipment shall remain with the person during times of transition to a different contractor, or upon loss of eligibility. For purposes of this subsection, customized DME refers to equipment that is altered or built to specifications unique to a member's medical needs and that, most likely, cannot be used or reused to meet the needs of another individual.
4. A member shall return DME obtained fraudulently to the Administration or the contractor.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-212 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-212 repealed, new Section R9-22-212 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (2), and deleted subsection (C) effective October 1, 1986 (Supp. 86-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3272, effective September 11, 2007

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(Supp. 07-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3).

**R9-22-213. Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)**

- A.** The following E.P.S.D.T. services are covered for a member less than 21 years of age:
1. Screening services including:
    - a. Comprehensive health and developmental history;
    - b. Comprehensive unclothed physical examination;
    - c. Appropriate immunizations according to age and health history;
    - d. Laboratory tests; and
    - e. Health education, including anticipatory guidance;
  2. Vision services including:
    - a. Diagnosis and treatment for defects in vision;
    - b. Eye examinations for the provision of prescriptive lenses;
    - c. Prescriptive lenses; and
    - d. Frames.
  3. Hearing services including:
    - a. Diagnosis and treatment for defects in hearing;
    - b. Testing to determine hearing impairment; and
    - c. Hearing aids;
  4. Dental services including:
    - a. Emergency dental services as specified in R9-22-207;
    - b. Preventive services including screening, diagnosis, and treatment of dental disease; and
    - c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
  5. Orthognathic surgery;
  6. Medically necessary, nutritional assessment and nutritional therapy as specified in contract to provide complete daily dietary requirements or supplement a member's daily nutritional and caloric intake;
  7. Behavioral health services under 9 A.A.C. 22, Article 12;
  8. Hospice services do not include home-delivered meals or services provided and covered through Medicare. The following hospice services are covered:
    - 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. Services available to a member receiving hospice care are limited to those allowable under 42 CFR 418.202, October 1, 2006, incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments;
  9. Incontinence briefs as specified under R9-22-212; and
  10. Other necessary health care, diagnostic services, treatment, and measures required by 42 U.S.C. 1396d(r)(5).
- B.** Providers of E.P.S.D.T. services shall meet the following standards:
1. Ensure that services are provided by or under the direction of the member's primary care provider, attending physician, practitioner, or dentist.
  2. Perform tests and examinations under 42 CFR 441 Subpart B, October 1, 2006, which is incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments.
  3. Refer a member as necessary for dental diagnosis and treatment and necessary specialty care.

4. Refer a member as necessary for behavioral health evaluation and treatment services.

**C.** Contractors shall meet other E.P.S.D.T. requirements as specified in contract.

**D.** A primary care provider, attending physician, or practitioner shall refer a member with special health care needs under R9-7-301 to CRS.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-213 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-213 repealed, new Section R9-22-213 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3272, effective September 11, 2007 (Supp. 07-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

**R9-22-214. Repealed**

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-214 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-214 repealed, new Section R9-22-214 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (4) and added subsection (C), paragraph (2) effective October 1, 1986 (Supp. 86-5). Correction to subsection (C), paragraph (2) (Supp. 87-4). Section repealed effective September 22, 1997 (Supp. 97-3).

**R9-22-215. Other Medical Professional Services**

- A.** The following medical professional services are covered services if a member receives these services in an inpatient, outpatient, or office:
1. Dialysis;
  2. The following family planning services if provided to delay or prevent pregnancy:
    - a. Medications,
    - b. Supplies,
    - c. Devices, and
    - d. Surgical procedures;
  3. Family planning services are limited to:
    - a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
    - b. Sterilization; and
    - c. Natural family planning education or referral;
  4. Midwifery services provided by a certified nurse practitioner in midwifery;
  5. Midwifery services for low-risk pregnancies and home deliveries provided by a licensed midwife;
  6. Respiratory therapy;

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7. Ambulatory and outpatient surgery facilities services;
  8. Home health services under A.R.S. § 36-2907(D);
  9. Private or special duty nursing services;
  10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology within limitations in subsection (C);
  11. Total parenteral nutrition services, which are the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract; and
  12. Chemotherapy.
- B.** Prior authorization from the Administration for a member is required for services listed in subsections (A)(3)(b), and (A)(4) through (11); except for:
1. Voluntary sterilization;
  2. Dialysis shunt placement;
  3. Arteriovenous graft placement for dialysis;
  4. Angioplasties or thrombectomies of dialysis shunts;
  5. Angioplasties or thrombectomies of arteriovenous grafts for dialysis;
  6. Eye surgery for the treatment of diabetic retinopathy;
  7. Eye surgery for the treatment of glaucoma;
  8. Eye surgery for the treatment of macular degeneration;
  9. Home health visits following an acute hospitalization (limited up to five visits);
  10. Hysteroscopies (up to two, one before and one after) when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization;
  11. Physical therapy subject to the limitation in subsection (C);
  12. Facility services related to wound debridement,
  13. Apnea management and training for premature babies up to the age of 1; and
  14. Other services identified by the Administration through the Provider Participation Agreement.
- C.** The following are not covered services:
1. Occupational and speech therapies provided on an outpatient basis for a member age 21 or older;
  2. Abortion counseling;
  3. Services or items furnished solely for cosmetic purposes;
  4. Services provided by a podiatrist; or
  5. More than 15 outpatient physical therapy visits per benefit year for persons age 21 years or older for the purpose of restoring a skill or level of function and maintaining that skill or level of function once restored.
  6. More than 15 outpatient physical therapy visits per benefit year for persons age 21 years or older for the purpose of acquiring a new skill or a new level of function and maintaining that skill or level of function once acquired.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-215 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final

rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

**R9-22-216. NF, Alternative HCBS Setting, or HCBS**

- A.** Services provided in a NF, including room and board, an alternative HCBS setting as defined in R9-28-101, or a HCBS as defined in A.R.S. § 36-2939 are covered for a maximum of 90 days per contract year if the member's medical condition would otherwise require hospitalization.
- B.** Except as otherwise provided in 9 A.A.C. 28, the following services are not itemized for separate billing if provided in a NF, alternative HCBS setting, or HCBS:
1. Nursing services, including:
    - a. Administering medication;
    - b. Tube feedings;
    - c. Personal care services, including but not limited to assistance with bathing and grooming;
    - d. Routine testing of vital signs; and
    - e. Maintenance of a catheter;
  2. Basic patient care equipment and sickroom supplies, including:
    - a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over-the-counter remedies;
    - b. Bathing and grooming supplies;
    - c. Identification device;
    - d. Skin lotion;
    - e. Medication cup;
    - f. Alcohol wipes, cotton balls, and cotton rolls;
    - g. Rubber gloves (non-sterile);
    - h. Laxatives;
    - i. Bed and accessories;
    - j. Thermometer;
    - k. Ice bags;
    - l. Rubber sheeting;
    - m. Passive restraints;
    - n. Glycerin swabs;
    - o. Facial tissue;
    - p. Enemas;
    - q. Heating pad; and
    - r. Incontinence briefs.
  3. Dietary services including preparation and administration of special diets, and adaptive tools for eating;
  4. Any service that is included in a NF's room and board charge or a service that is required of the NF to meet a federal or state licensure standard or county certification requirement;
  5. Physician visits made solely for the purpose of meeting state licensure standards or county certification requirements;
  6. Physical therapy prescribed only as a maintenance regimen; and
  7. Assistive devices and non-customized durable medical equipment.
- C.** A provider shall obtain prior authorization from the Administration for a NF admission for a FFS member.

**Historical Note**

Adopted effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Subsection (C) amended to correct a typographical error (Supp. 00-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3272, effective September

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11, 2007 (Supp. 07-3). Amended by final rulemaking at 13 A.A.R. 4122, effective November 6, 2007 (Supp. 07-4).

**R9-22-217. Services Included in the Federal Emergency Services Program**

- A.** Definition. Notwithstanding the definition in R9-22-201, for the purposes of this Section, an emergency medical or behavioral health condition for a FES member means a medical condition or a behavioral health condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
1. Placing the member's health in serious jeopardy,
  2. Serious impairment to bodily functions,
  3. Serious dysfunction of any bodily organ or part, or
  4. Serious physical harm to another person.
- B.** Services. "Emergency services for a FES member" mean those medical or behavioral health services provided for the treatment of an emergency condition. Emergency services include outpatient dialysis services for a FES member with End Stage Renal Disease (ESRD) where a treating physician has certified for the month in which services are received that in the physician's opinion the absence of receiving dialysis at least three times per week would reasonably be expected to result in:
1. Placing the member's health in serious jeopardy, or
  2. Serious impairment of bodily function, or
  3. Serious dysfunction of a bodily organ or part.
- C.** Covered services. Services are considered emergency services if all of the criteria specified in subsection (A) are satisfied at the time the services are rendered. The Administration shall determine whether an emergency condition exists on a case-by-case basis.
- D.** Prior authorization. A provider is not required to obtain prior authorization for emergency services for FES members. Prior authorization for outpatient dialysis services is met when the treating physician has completed and signed a monthly certification as described in subsection (B).
- E.** Services rendered through the Federal Emergency Services Program are subject to all exclusions and limitation on services in this Article including but not limited to the limitations on inpatient hospital services in R9-22-204.

**Historical Note**

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 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. 5701, effective December 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1868, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended

by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

**R9-22-218. Repealed**

**Historical Note**

Section R9-22-218 renumbered from R9-22-206 effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Section repealed effective September 22, 1997 (Supp. 97-3).

**ARTICLE 3. GENERAL ELIGIBILITY REQUIREMENTS**

**R9-22-301. General Eligibility Definitions**

Definitions. In addition to definitions contained in R9-22-101 and A.R.S. § 36-2901, the words and phrases in this Article, Article 14 and Article 15 have the following meanings unless the context explicitly requires another meaning:

"Applicant," notwithstanding R9-22-101, means a person listed on an application for whom AHCCCS coverage is being sought.

"BHS" means the division of Behavioral Health Services within the Arizona Department of Health Services.

"CRS" means the program administered by the Administration or its designee that provides covered medical services and covered support services in accordance with A.R.S. 36-261.

"DCSS" means the Division of Child Support Services, which is the division within the Department that administers the Title IV-D program and includes a contract agent operating a child support enforcement program on behalf of the Department.

"FAA" means the Family Assistance Administration, the administration within the Department's Division of Benefits and Medical Eligibility with responsibility for providing cash and food stamp assistance to a member and for determining eligibility for AHCCCS medical coverage.

"Income" means combined earned and unearned income.

"Medical support" means to provide health care coverage in the form of health insurance or court-ordered payment for medical care.

"Member" means an applicant who has been determined to qualify for AHCCCS coverage by the Administration or its designee.

"Pre-enrollment process" means the process that provides an applicant the opportunity to choose an AHCCCS health plan before the determination of eligibility is completed.

"Resources" means real and personal property, including liquid assets.

"Sponsor" means an individual who signs the USCIS I-864 Affidavit of Support agreeing to support a non-citizen as a condition of the non-citizen's admission for permanent residence in the United States.

"Sponsor deemed income" means the unearned income deemed available to the applicant named on the USCIS I-864 Affidavit of Support.

"SVES" means the State Verification and Exchange System, a system through which the Department exchanges income and benefit information with the Internal Revenue Service, Social

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Security Administration, and State Wage and Unemployment Insurance Benefit data files.

“USCIS” means the United States Citizen and Immigration Services.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-301 renumbered together with former Section R9-22-102 as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). New Section R9-22-301 adopted effective November 20, 1984 (Supp. 84-6).

Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (8), subsection (E), paragraph (3), and subsection (J), paragraph (5) effective October 1, 1986 (Supp. 86-5). Amended subsections (C) and (E) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B) and (C) effective October 1, 1987; amended subsection (D) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section reserved by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4). New Section made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014; the adoption of this Section was slated to be codified in Supp. 14-1 but due to a clerical error, was not published. The new Section was published in Supp. 20-4 and no additional amendments have been made to this Section since January 7, 2014 (Supp. 20-4).

**R9-22-302. AHCCCS Eligibility Application****Application Process**

1. Right to apply. A person may apply for AHCCCS medical coverage by submitting an Administration-approved application to the Administration or its designee, an FAA office, or one of the following outstation locations:
  - a. A BHS site;
  - b. A Federally Qualified Health Center or disproportionate share hospital under 42 U.S.C. 1396r-4; or
  - c. Any other site, including a hospital, approved by the Administration or its designee.
2. Application. To initiate the application process, the Administration or its designee will accept an application from the applicant, an adult who is in the applicant’s household, as defined in 42 CFR 435.603(f), or family, as defined in section 36B(d)(1) of the Internal Revenue Service (IRS) Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant by submitting a written or online application under 42 CFR 435.907.
  - a. A phone or written application must contain at least the following to be submitted to the Administration or its designee:
    - i. Applicant’s legible name,
    - ii. Address or location where the applicant can be reached,
    - iii. Signature of the person submitting the application,
    - iv. Date the application was signed.
    - v. The Administration or its designee shall require that a third party witness the signing and attest

by signing the application if the individual signing the application signs with a mark.

- b. An online application must be completed in full in order to be submitted to the Administration or its designee.
3. Incomplete application. If the application is incomplete, the Administration or its designee shall do at least one of the following:
  - a. Contact an applicant or an applicant’s representative by telephone or electronic medium to obtain the missing information required for an eligibility determination;
  - b. Mail a request for additional information to an applicant or an applicant’s representative, allowing 10 days from the date of the request to provide the required additional information; or
  - c. Meet with the applicant, representative, or household member.
4. Date of application. The date of application is the date application is received by the Administration or its designee either on-line or at a location listed in subsection (1).
5. Complete application form. The Administration or its designee shall consider an application complete when all questions are answered. The same person as listed under subsection (2) is the person that must sign the completed application. The application shall be witnessed and signed by a third party if the individual signing the application signs with a mark.
6. Assistance with application. The Administration or its designee shall allow a person of the applicant’s choice to accompany, assist, and represent the applicant in the application process.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-302 repealed, new Section R9-22-302 adopted effective November 20, 1984 (Supp. 84-6). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section reserved by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4). New Section made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014; the adoption of this Section was slated to be codified in Supp. 14-1 but due to a clerical error, was not published. The new Section was published in Supp. 20-4 and no additional amendments have been made to this Section since January 7, 2014 (Supp. 20-4).

**R9-22-303. Prior Quarter Eligibility**

- A. Subject to CMS approval, prior quarter coverage eligibility shall be limited to applicants who meet the requirements in subsection (B) and who also:
  1. Are eligible during any of the three months prior to application; and
  2. Received one or more covered services described in 9 A.A.C. 22, Article 2 and Article 12, and 9 A.A.C. 28, Article 2 during the month; and
  3. Would have qualified for Medicaid at the time services were received if the person had applied regardless of whether the person is alive when the application is made.

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B. Prior quarter coverage eligibility is limited to applicants who are:

1. Under the age of 19, or
2. Pregnant, or
3. In the 60 day post-partum period beginning with the last day of the pregnancy.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-303 repealed, new Section R9-22-303 adopted effective November 20, 1984 (Supp. 84-6).

Amended effective October 1, 1985 (Supp. 85-5).

Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section made by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 1849, with an immediate effective date of July 1, 2019 (Supp. 19-3).

**R9-22-304. Verification of Eligibility Information**

- A. Except as provided in subsection (E), if information provided by or on behalf of an applicant or member on an application, renewal form or otherwise does not conflict with information obtained by the agency through an electronic data match, the Administration or its designee shall determine or renew eligibility based on such information.
- B. The Administration or its designee shall not require an applicant, member, or representative to provide additional verification unless the verification cannot be obtained electronically or the verification obtained electronically conflicts with information provided by or on behalf of the applicant or member.
- C. If information provided by or on behalf of an applicant or member does conflict with information obtained through an electronic data match, the applicant or member shall provide the Administration or its designee with information or documentation necessary to verify eligibility, including evidence originating from an agency, organization, or an individual with actual knowledge of the information.
- D. Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both meet or both exceed the applicable income limit.
- E. The Administration or its designee shall not accept the applicant's or member's statement by itself as verification of:
  1. SSN;
  2. Qualified alien status, except as described under 42 USC 1320b-7(d)(4)(A); or
  3. Citizenship, except as described under 42 USC 1396a(ee)(1).
- F. The Administration or its designee shall give an applicant or member at least 10 days from the date of a written or electronic request for information to provide required verification. The Administration or its designee may deny the application or discontinue eligibility if an applicant or a member does not provide the required information timely.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-304 repealed, new Section R9-22-304 adopted effective November 20, 1984 (Supp. 84-6).

Amended effective October 1, 1985 (Supp. 85-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-304

made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-305. Eligibility Requirements**

As a condition of eligibility, the Administration or its designee must require applicants, and members to do the following:

1. Take all necessary steps to obtain any annuities, pensions, retirement, disability benefits to which they are entitled, unless they can show good cause for not doing so.
2. Furnish a SSN under 42 CFR 435.910 and 435.920, or in the absence of an SSN, provide proof of a submitted application of SSN. The Administration or its designee will assist in obtaining or verifying the applicant's SSN under 42 CFR 435.910 if an applicant cannot recall the applicant's SSN or has not been issued a SSN. An applicant is not required to furnish an SSN if the applicant is not able to legally obtain a SSN. The Administration or its designee shall determine eligibility notwithstanding the applicant's lack of a SSN, if the applicant is cooperating with the Administration or its designee to obtain a SSN and obtain a SSN prior to the next scheduled review of eligibility.
3. Provide proof of residency of Arizona. An applicant or a member is not eligible unless the applicant or member is a resident of Arizona under 42 CFR 435.403 effective October 1, 2012, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
4. A written declaration, signed under penalty of perjury, must be provided for each person for whom benefits are being sought stating whether the individual is a citizen or national of the United States, and, if that individual is not a citizen or national of the United States, that the individual is a qualified alien. The declaration must be provided by the individual for whom eligibility is being sought or an adult member of the individual's family or household.
5. Each applicant who claims qualified alien status must provide either:
  - a. Alien registration documentation or other proof of immigration registration from the Immigration and Naturalization Service that contains the individual's alien admission number or alien file number (or numbers if the individual has more than one number), or
  - b. Other documents that the Administration or its designee accepts as evidence of immigration status, such as:
    - i. A Form I-94 Departure Record issued by the USCIS,
    - ii. A Foreign Passport,
    - iii. A USCIS Parole Notice,
    - iv. A Victim of Trafficking Certification or Eligibility Letter issued by the US DHHS Office of Refugee Resettlement,
    - v. Other documentation consistent with 42 CFR 435.406 or 435.407.
  - c. Sufficient information for the Administration or its designee to obtain electronic verification of immigration status from the USCIS.
6. If a person for whom eligibility is being sought, states that they are an alien, that person is not required to comply with subsections (4) and (5); however, if they do not

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comply with those sections, and if they meet all other eligibility criteria, benefits will be limited to those necessary to treat an emergency medical condition.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-305 repealed, new Section R9-22-305 adopted effective November 20, 1984 (Supp. 84-6). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-305 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-306. Administration, Administration's designee or Member Responsibilities**

A. The Administration or its designee is responsible for the following:

1. The Administration or its designee shall determine eligibility within 90 days for an applicant applying on the basis of disability and 45 days for all other applicants, unless:
  - a. The agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action, or
  - b. When there is an administrative or other emergency beyond the agency's control.
2. If an applicant dies while an application is pending, the Administration or its designee shall complete an eligibility determination for the deceased applicant.
3. The Administration or its designee shall complete an eligibility determination on an application filed on behalf of a deceased applicant.
4. During the application process the Administration or its designee shall provide information to the applicant or member explaining the requirements to:
  - a. Cooperate with DCSS in establishing paternity and enforcing medical support, except in circumstances when good cause under 42 CFR 433.147 exists for not cooperating;
  - b. Establish good cause for not cooperating with DCSS in establishing paternity and enforcing medical support, when applicable;
  - c. Report a change listed under subsection (B)(3)(c) no later than 10 days from the date the applicant or member knows of the change;
  - d. Send to the Administration or its designee any medical support payments resulting from a court order;
  - e. Cooperate with the Administration or its designee's assignment of rights and securing payments received from any liable party for a member's medical care.
5. Offer to help the applicant or member to complete the application form and to obtain the required verification;
6. Provide the applicant or member with information explaining:
  - a. The eligibility and verification requirements for AHCCCS medical coverage;
  - b. The requirement that the applicant or member obtain and provide a SSN to the Administration or its designee;
  - c. How the Administration or its designee uses the SSN;
7. Explain to the applicant or member the practice of exchange of eligibility and income information through the electronic service established by the Secretary;
8. Explain to the applicant and member the right to appeal an adverse action under R9-22-315;
9. Use any information provided by the member to complete data matches with potentially liable parties;
10. Explain the eligibility review process;
11. Explain the AHCCCS pre-enrollment process;
12. Use the Systematic Alien Verification for Entitlements (SAVE) process to verify qualified alien status;
13. Provide information regarding the penalties for perjury and fraud on the application;
14. Review any verification items provided by the applicant or member and inform the member of any additional verification items and time-frames within which the applicant or member shall provide information to the Administration or its designee;
15. Explain to the applicant or member the applicant's and member's responsibilities under subsection (B);
16. Transfer the applicant's information to other insurance affordability programs as described under 42 CFR 435.1200(e) when the applicant does not qualify for Medicaid;
17. Attain a written record of a collateral contact: such as a verbal statement from a representative of an agency or organization, or an individual with actual knowledge of the information;
18. Complete a review of eligibility:
  - a. Any time there is a change in a member's circumstance that may affect eligibility,
  - b. For a member approved for the MED program under R9-22-1435 through R9-22-1440 before the end of the six-month eligibility period,
  - c. Of each member's continued eligibility for AHCCCS medical coverage once every 12 months;
19. The Administration or its designee shall discontinue eligibility and notify the member of the discontinuance under R9-22-307 if the member:
  - a. Fails to comply with the review of eligibility,
  - b. Fails to comply under 42 CFR 433.148 with the requirements and conditions of eligibility under this Article regarding assignment of rights and cooperation of establishing paternity and obtaining medical support, or
  - c. Does not meet the eligibility requirements; and
20. Redetermine eligibility for a person terminated from the SSI cash program.
  - a. Continuation of AHCCCS medical coverage. The Administration shall continue AHCCCS medical coverage for a person terminated from the SSI cash program until a redetermination of eligibility is completed.
  - b. Coverage group screening. Before terminating a person from the SSI cash program, the Administration shall determine if the person is eligible for coverage as a person described in A.R.S. §§ 36-2901(6)(a)(i) through (vi) or 36-2934.
  - c. Eligibility decision.
    - i. If a person is eligible under this Article or 9 A.A.C. 28, Article 4, the Administration shall send a notice informing the applicant that AHCCCS medical coverage is approved.

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- ii. If a person is ineligible, the Administration shall send a notice to deny AHCCCS medical coverage.
- B. Applicant and Member Responsibilities.**
1. An applicant or a member shall authorize the Administration or its designee to obtain verification for initial eligibility or continuation of eligibility.
  2. As a condition of eligibility, an applicant or a member shall:
    - a. Provide the Administration or its designee with complete and truthful information. The Administration or its designee may deny an application or discontinue eligibility if:
      - i. The applicant or member fails to provide information necessary for initial or continuing eligibility;
      - ii. The applicant or member fails to provide the Administration or its designee with written authorization or electronic authorization to permit the Administration or its designee to obtain necessary initial or continuing eligibility verification;
      - iii. The applicant or member fails to provide verification under R9-22-304 after the Administration or its designee made an effort to obtain the necessary verification but has not obtained the necessary information; or
      - iv. The applicant or member does not assist the Administration or its designee in resolving incomplete, inconsistent, or unclear information that is necessary for initial or continuing eligibility;
    - b. Cooperate with the Division of Child Support Services (DCSS) in establishing paternity and enforcing medical support obligations when requested unless good cause exists for not cooperating under 42 CFR 433.147 as of October 1, 2012, which is incorporated by reference, on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol St., NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments. The Administration or its designee shall not deny AHCCCS eligibility to an applicant who would otherwise be eligible, is a minor child, and whose parent or legal representative does not cooperate with the medical support requirements or first- and third-party liability requirements under Article 10 of this Chapter; and
    - c. Provide the information needed to pursue third party coverage for medical care, such as:
      - i. Name of policyholder,
      - ii. Policyholder's relationship to the applicant or member,
      - iii. Name and address of the insurance company, and
      - iv. Policy number.
  3. A member or an applicant shall:
    - a. Send to the Administration or its designee any medical support payments received while the member is eligible that result from a medical support order;
    - b. Cooperate with the Administration or its designee regarding any issues arising as a result of Eligibility

Quality Control described under A.R.S. § 36-2903.01; and

- c. Inform the Administration or its designee of the following changes within 10 days from the date the applicant or member knows of a change:
  - i. In address;
  - ii. In the household's composition;
  - iii. In income;
  - iv. In resources, when required under the Medical Expense Deduction (MED) program;
  - v. In Arizona state residency;
  - vi. In citizenship or immigrant status;
  - vii. In first- or third-party liability that may contribute to the payment of all or a portion of the person's medical costs;
  - viii. That may affect the member's or applicant's eligibility, including a change in a woman's pregnancy status;
  - ix. Death;
  - x. Change in marital status; or
  - xi. Change in school attendance.

4. As a condition of eligibility, an applicant or a member shall cooperate with the assignment of rights as required by R9-22-311. If the applicant or member receives medical care and services for which a first or third party is or may be liable, the applicant or member shall cooperate with the Administration or its designee in assisting, identifying and providing information to assist the Administration or its designee in pursuing any first or third party who is or may be liable to pay for medical care and services.

5. A pregnant woman under A.R.S. § 36-2901(6)(a)(ii) is not required to provide the Administration or its designee with information regarding paternity or medical support from a father of a child born out of wedlock.

**C. Administration or its designee responsibilities at Eligibility Renewal.**

1. The Administration or its designee shall renew eligibility without requiring information from the individual if able to do so based on reliable information available to the agency, including through an electronic data match. If able to renew eligibility based on such information, the Administration or its designee shall send the member notice of:
  - a. The eligibility determination; and
  - b. The member's requirement to notify the Administration or its designee if any of the information contained in the renewal notice is inaccurate.
2. If unable to renew eligibility, the Administration or its designee shall:
  - a. Send a pre-populated renewal form listing the information needed to renew eligibility,
  - b. Give the member 30 days from the date of the renewal form to submit the signed renewal form and the information needed,
  - c. Send the member notice of the renewal decision under R9-22-312 or R9-22-1413(B) as applicable.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-306 repealed, new Section R9-22-306 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraphs (1) and (6) effective October 1, 1986 (Supp. 86-5). Amended subsection (B),

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paragraph (1) and added a new subsection (N) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6).

Amended subsection (B) effective October 1, 1987; amended subsection (N) effective December 22, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-306 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-307. Approval or Denial of Eligibility**

**A.** Approval. If the applicant meets all the eligibility requirements and conditions of eligibility of this Article, the Administration or its designee shall approve the application and provide the applicant with an approval notice. The approval notice shall contain:

1. The name of each approved applicant,
2. The effective date of eligibility for each approved applicant,
3. The reason and the legal citations if a member is approved for only emergency medical services, and
4. The applicant's right to appeal the decision.

**B.** Denial. If an applicant fails to meet the eligibility requirements or conditions of eligibility of this Article, the Administration or its designee shall deny the application and provide the applicant with a denial notice. The denial notice shall contain:

1. The name of each ineligible applicant,
2. The specific reason why the applicant is ineligible,
3. The income and resource calculations for the applicant compared to the income or resource standards for eligibility when the reason for the denial is due to the applicant's income or resources exceeding the applicable standard,
4. The legal citations supporting the reason for the ineligibility,
5. The location where the applicant can review the legal citations,
6. The date of the application being denied; and
7. The applicant's right to appeal the decision and request a hearing.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsections (A) and (C), added subsection (G) and (H) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-307 repealed, new Section R9-22-307 adopted effective November 20, 1984 (Supp. 84-6).

Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) as an emergency effective December 4, 1985 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 85-6). Permanent amendment to subsection (A) effective February 5, 1986 (Supp. 86-1).

Amended subsections (E) and (F) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Pro-

cedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-307 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-308. Reinstating Eligibility**

The Administration or its designee shall reopen an application or reinstate eligibility of a member when any of the following conditions are met:

1. The denial or discontinuance of eligibility was due to an administrative error,
2. The discontinuance of eligibility was due to noncompliance with a condition of eligibility and the applicant or member complies prior to the effective date of the discontinuance,
3. The member informs the Administration or its designee of a change of circumstances prior to the effective date of the discontinuance, that would allow for continued eligibility, or
4. Following a discontinuance, the member qualifies for continuation of medical coverage pending an appeal.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended by adding subsection (C) effective March 2, 1984 (Supp. 84-2). Former Section R9-22-308 repealed, new Section R9-22-308 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-308 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-309. Confidentiality and Safeguarding of Information**

The Administration or its designee shall maintain the confidentiality of an applicant or member's records and limit the release of safeguarded information under R9-22-512 and 6 A.A.C. 12, Article 1. In the event of a conflict between R9-22-512 and 6 A.A.C. 12, Article 1, R9-22-512 prevails.

**Historical Note**

Adopted effective August 30, 1984 (Supp. 82-4). Amended (D)(1)(d) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-309 repealed, new Section R9-22-309 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5).

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Amended subsection (F) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (A), (B) and (C) effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-309 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-310. Ineligible Person**

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

1. An inmate of a public institution, or
2. Over age 64 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except as allowed in 42 USC 1396d(h) or as allowed under the Administration's Section 1115 waiver.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended (B)(7) and added subsections (C) and (D) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-310 repealed, new Section R9-22-310 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) and deleted subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (7) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-310 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-311. Assignment of Rights Under Operation of Law**

By operation of law and under A.R.S. § 36-2903, a person determined eligible assigns rights to the system medical benefits to which the person is entitled.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-311 repealed, new Section R9-22-311 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-311 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-312. Member Notices**

**A.** Contents of notice. The Administration or its designee shall issue a notice by mail, personal delivery, or electronic means when an action is taken regarding a person's eligibility or premiums. The notice shall contain the following information:

1. The date of the notice issued;
2. A statement of the action being taken;
3. The effective date of the action;
4. The specific reason for the intended action;
5. If eligibility is being discontinued due to income in excess of the income standards, the actual figures used in the eligibility determination and the amount by which the person exceeds income standards;
6. If a premium is imposed or increased, the actual figures used in determining the premium amount;
7. The specific law or regulation that supports the action, or a change in federal or state law that requires an action;
8. An explanation of the member's rights to an appeal and continued benefits.

**B.** Advance notice of changes in eligibility or premiums. "Advance notice" means a notice that is issued to a person at least 10 days before the effective date of the change. Except as specified in subsection (C), advance notice shall be issued whenever the following adverse action is taken:

1. To discontinue or suspend or reduce eligibility or covered services; or
2. To impose a premium or increase a person's premium.

**C.** The Administration or its designee shall issue a Notice of Adverse Action to a member no later than the effective date of action if:

1. The Administration or its designee receives a request to withdraw;
2. A person provides information that requires termination of eligibility or an increase or imposition of the premium and the person signs a clear written statement waiving advance notice;
3. A person cannot be located and mail sent to that person has been returned as undeliverable;
4. A person has been admitted to a public institution where the person is ineligible under R9-22-310;
5. A person has been approved for Medicaid or CHIP in another state; or
6. The Administration or its designee has information that confirms the death of the person.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsections (A) and (B), added subsection (D) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-312 repealed, new Section R9-22-312 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-312 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-313. Withdrawal of Application**

**A.** An applicant may withdraw an application at any time before the Administration or its designee completes an eligibility determination by making an oral or written request for with-

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drawal to the Administration or its designee and stating the reason for withdrawal.

- B.** If an applicant orally requests withdrawal of the application, the Administration or its designee shall document the:
1. Date of the request,
  2. Name of the applicant for whom the withdrawal applies, and
  3. Reason for the withdrawal.
- C.** An applicant may withdraw an application in writing by:
1. Completing an Administration-approved voluntary withdrawal form; or
  2. Submitting a written, signed, and dated request to withdraw the application.
- D.** The effective date of the withdrawal is the date of the application.
- E.** If an applicant requests to withdraw an application, the Administration or its designee shall:
1. Deny the application, and
  2. Notify the applicant of the denial following the notice requirements under R9-22-307.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4).  
Amended effective October 1, 1983 (Supp. 83-5).  
Amended subsections (C) and (D) as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended subsections (D) and (E) as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-313 repealed, new Section R9-22-313 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsections (B), (C), (E) and (G) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B) and (C) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-313 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-314. Withdrawal from AHCCCS Medical Coverage**

- A.** A member may withdraw from AHCCCS medical coverage at any time by giving oral or written notice of withdrawal to the Administration or its designee. The member or the member's legal or authorized representative shall provide the Administration or its designee with:
1. The reason for the withdrawal,
  2. The date the notice is effective, and
  3. The name of the member for whom AHCCCS medical coverage is being withdrawn.

- B.** If a notice of withdrawal does not identify specific members the Administration or its designee shall discontinue eligibility for any members that the person submitting the withdrawal has legal authority to act on behalf of.
- C.** The Administration or its designee shall notify the member of the discontinuance as required by R9-22-312.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4).  
Amended subsection (A) and added subsection (F) as an emergency effective February 28, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1).  
Amended subsection (A) and added subsection (F) as a permanent rule effective May 16, 1983; text of the amended rule identical to the emergency (Supp. 83-3).  
Former Section R9-22-314 repealed, new Section R9-22-314 adopted effective November 20, 1984 (Supp. 84-6).  
Amended effective October 1, 1985 (Supp. 85-5).  
Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-314 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-315. Notice of Adverse Action**

- A.** Adverse actions. An applicant or member may appeal, as described under Chapter 34, by requesting a hearing from the Administration or its designee concerning any of the following adverse actions:
1. Complete or partial denial of eligibility under R9-22-307 and R9-22-313(E);
  2. Suspension, termination, or reduction of AHCCCS medical coverage under R9-22-307, R9-22-312 and R9-22-314;
  3. Delay in the eligibility determination beyond the timeframes under this Article;
  4. The imposition of or increase in a premium or copayment; or
  5. The effective date of eligibility.
- B.** Notice of Adverse Action. The Administration or its designee shall personally deliver or send, by mail, or electronic means a Notice of Adverse Action to the person affected by the action. For the purpose of this Section, the date of the Notice of Adverse Action shall be the date of personal delivery to the applicant or the postmark date, if mailed.
- C.** Automatic change and hearing rights.
1. An applicant or a member is not entitled to a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.
  2. An applicant or a member is entitled to a hearing if a federal or state law requires an automatic change and the applicant or member timely files an appeal that alleges a misapplication of the facts to the law.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-315 repealed, new Section R9-22-315 adopted effective November 20, 1984 (Supp. 84-6). Repealed effective October 1, 1985 (Supp. 85-5). New Section R9-22-315 adopted effective February 5, 1986 (Supp. 86-1). Amended effective February 26, 1988 (Supp. 88-1). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions

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of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-315 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-316. Exemptions from Sponsor Deemed Income**

- A.** An applicant shall provide proof to the Administration or its designee when claiming an exemption from sponsor deemed income.
- B.** The Administration or its designee shall grant an exemption from deeming a sponsor's income for a Lawful Permanent Resident applicant if the applicant:
1. Adjusted immigration status to Lawful Permanent Resident from status as a refugee or asylee;
  2. Is the spouse or dependent child of the sponsor and lives with the sponsor;
  3. Is indigent as specified in subsection (C);
  4. Is a victim of domestic violence or extreme cruelty as specified in subsection (D); or
  5. Has acquired 40 qualified quarters of work credit based on earnings as specified in subsection (E).
- C.** Exemption from sponsor deeming based on indigence.
1. The Administration or its designee shall consider the applicant indigent and grant an exemption from sponsor deemed income for an applicant, for a period of 12 months beginning with the first month of eligibility if all the following are met:
    - a. An applicant is indigent if all of the following are met:
      - i. The applicant does not reside with the applicant's sponsor;
      - ii. The applicant does not receive free room and board; and
      - iii. The applicant's total gross income including monies received from the sponsor and the value of any vendor payments received for food, utilities, or shelter does not exceed 100% of the FPL for the size of the income group.
    2. The Administration or its designee shall send a notice under 8 U.S.C. 1631(e)(2) to the Attorney General's Office when approving an applicant who is exempt from sponsor deemed income due to indigence.
- D.** The Administration or its designee shall grant an exemption from sponsor deemed income for an applicant who is a victim of domestic violence or extreme cruelty under 8 CFR 204.2 for a period of 12 months beginning with the first month of eligibility. The Administration or its designee shall redetermine the exemption status at each renewal.
1. The Administration or its designee considers an applicant to be a victim of domestic violence or extreme cruelty when all of the following are met:
    - a. The applicant is the victim, the parent of a child victim, or the child of a parent victim;
    - b. The perpetrator of the domestic violence or extreme cruelty was the spouse or parent of the victim or other family member related by blood, marriage or adoption to the victim;
    - c. The perpetrator was residing in the same household as the victim when the abuse occurred;
    - d. The abuse occurred in the United States;
    - e. The applicant did not participate in the domestic violence or cruelty; and
  2. The applicant shall provide proof that the applicant or the applicant's child is a victim of domestic violence or extreme cruelty by presenting one of the following:
    - a. USCIS form I-360 Petition for Amerasian, Widow, or Special Immigrant;
    - b. USCIS form I-797 USCIS approval of the I-360 petition;
    - c. Reports or affidavits concerning the domestic violence or cruelty documented by police, judges, or other court officials, medical personnel, school officials, clergy, social workers, counseling or mental health personnel, or other social service agency personnel;
    - d. Legal documentation, such as an order of protection against the perpetrator or an order convicting the perpetrator of committing an act of domestic violence or extreme cruelty that chronicles the existence of domestic violence or extreme cruelty;
    - e. Evidence that indicates that the applicant sought safe haven in a battered women's shelter or similar refuge because of the domestic violence or extreme cruelty against the applicant or the applicant's child; or
    - f. Photographs of the applicant or applicant's child showing visible injury.
- E.** The Administration or its designee shall grant an exemption from sponsor deemed income for an applicant who has reached 40 qualifying quarters of work credit.
1. The Administration or its designee shall not count quarters credited after January 1, 1997 that were earned while the applicant was receiving any federal means-tested benefits.
  2. The Administration or its designee shall not count the 40 qualifying quarters of work credit unless the credited quarters are:
    - a. Quarters that the applicant worked;
    - b. Quarters worked by the applicant's spouse or deceased spouse during their marriage; or
    - c. Quarters worked by the applicant's parents when the applicant was under age 18.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as an emergency effective February 9, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as a permanent rule effective May 16, 1983; text of permanent rule identical to the emergency (Supp. 83-3). Amended effective October 1, 1983 (Supp. 83-5). Correction subsection (A), paragraph (1) amended effective October 1, 1983, (Supp. 83-6). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-316 repealed, new Section R9-22-316 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective October 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective April 13, 1990 (Supp. 90-2). Section

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repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-316 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-317. Sponsor Deemed Income**

- A.** The Administration or its designee shall use income of a USCIS sponsor to determine eligibility for a non-citizen applicant, whether or not the income is available, to the non-citizen applicant unless exempt under R9-22-316.
- B.** Counting the income from a sponsor.
1. This Section applies to non-citizen applicants who:
    - a. Are Lawful Permanent Residents under 8 CFR 101.3;
    - b. Applied for Lawful Permanent Resident Status on or after December 19, 1997;
    - c. Are sponsored by an individual who signed a USCIS I-864 Affidavit of Support; and
    - d. Are eligible for full AHCCCS medical coverage.
  2. Sponsor deemed income shall be considered the income of the non-citizen applicant only.
  3. The Administration or its designee shall not use the provisions of this Section when:
    - a. The applicant becomes a naturalized U.S. citizen;
    - b. The applicant qualifies for an exemption listed in R9-22-316; or
    - c. The sponsor dies.
- C.** Determining income from a sponsor.
1. For an applicant who is exempt from sponsor deeming under R9-22-316, only cash contributions actually received from the sponsor are countable income to the applicant.
  2. For an applicant to whom the sponsor's income is deemed, the Administration or its designee shall exclude any cash contributions received from the sponsor.
- D.** Calculation of income from a sponsor.
1. The Administration or its designee shall include the total gross income of the sponsor and the sponsor's spouse, when living with the sponsor;
  2. The Administration or its designee shall subtract an amount equal to 100% of the FPL for the sponsor's household size from the total gross income under (D)(1); and
  3. The amount calculated under subsection (D)(2) is deemed as income to the applicant for purposes of determining eligibility.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-317 repealed, new Section R9-22-317 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1986 (Supp. 86-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-317 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-318. Repealed****Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90

days (Supp. 84-4). Emergency expired. Former Section R9-22-318 repealed, new Section R9-22-318 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) and added subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective October 1, 1987; amended subsection (A) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective December 13, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-319. Repealed****Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-319 repealed, new Section R9-22-319 adopted effective November 20, 1984 (Supp. 84-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-320. Repealed****Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-320 repealed, new Section R9-22-320 adopted effective November 20, 1984 (Supp. 84-6). Amended effective April 13, 1990 (Supp. 90-2). Repealed effective December 13, 1993 (Supp. 93-4).

**R9-22-321. Repealed****Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-321 repealed, new Section R9-22-321 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (B) through (E) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987 (Supp. 87-4). Amended subsections (B) and (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended December 13, 1993 (Supp. 93-4).

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Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-322. Repealed****Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective May 27, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-3). Former Section R9-22-322 repealed, new Section R9-22-322 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-322 repealed, new Section R9-22-322 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective September 29, 1992 (Supp. 92-3). Amended December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-323. Repealed****Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-323 repealed, new Section R9-22-323 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-323 repealed, new Section R9-22-323 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (B) through (D) effective October 1, 1986 (Supp. 86-5). Amended subsections (A), (B) and (D) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B), (D) and (E) effective October 1, 1987 (Supp. 87-4). Amended subsections (B) and (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-324. Repealed****Historical Note**

Adopted as an emergency effective July 27, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-4). Former Section R9-22-324 adopted as an emergency renumbered as Section R9-22-327. New Section R9-22-324 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-324 repealed, former Section R9-22-323 renumbered as Section R9-22-324 and adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Former Section R9-22-324 repealed, new Section R9-22-324 adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-324

repealed, new Section R9-22-324 adopted effective November 20, 1984 (Supp. 84-6). Change in heading only effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-325. Repealed****Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-325 repealed, new Section R9-22-325 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-326. Repealed****Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-326 repealed, new Section R9-22-326 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Change in heading only effective October 1, 1987 (Supp. 87-4). Amended subsection (A) effective May 30, 1989 (Supp. 89-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-327. Repealed****Historical Note**

Former Section R9-22-324 adopted as an emergency effective July 27, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days renumbered as Section R9-22-327 and adopted as a permanent rule effective October 1, 1983 (Supp. 83-5). Former Section R9-22-327 repealed, new Section R9-22-327 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (A), (D), (E), (G), (H), and (I) effective October 1, 1986 (Supp. 86-5). Amended subsection (D) and added a new subsection (J) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (A) and (E) effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-328. Repealed****Historical Note**

Adopted as an emergency effective October 6, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-5). Emergency Expired. New Section R9-22-328 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5).

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Amended subsections (A) and (E) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (D) effective October 1, 1987 (Supp. 87-4). Amended subsection (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-329. Repealed****Historical Note**

Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. New Section R9-22-329 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-330. Repealed****Historical Note**

Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. New Section R9-22-330 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended subsection (A) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-331. Repealed****Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-332. Repealed****Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-333. Repealed****Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended under an exemption from

the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-334. Repealed****Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-335. Repealed****Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-336. Repealed****Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective September 16, 1987 (Supp. 87-3). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-337. Repealed****Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Correction to subsection (B), paragraph (1) (Supp. 87-3). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-338. Repealed****Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Heading changed effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-339. Repealed****Historical Note**

Adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective October 1, 1987 (Supp. 87-4). Amended effective January 14, 1997 (Supp.

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97-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-340. Reserved****Historical Note**

Adopted effective October 1, 1986 (Supp. 86-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-341. Repealed****Historical Note**

Adopted effective March 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-342. Repealed****Historical Note**

Adopted effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-343. Repealed****Historical Note**

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-344. Repealed****Historical Note**

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**ARTICLE 4. PENALTY FOR OBTAINING ELIGIBILITY BY FRAUD****R9-22-401. Definitions**

Definitions. The following definitions apply specifically to terms used within this Article:

“Amounts incurred by the system” include capitation payments, costs incurred by any contractor in excess of capitation, reinsurance, and other administrative, legal or investigative costs associated with a person who obtained eligibility contrary to A.R.S. §§ 36-2905.04 and/or A.R.S. § 36-2991.

“Application for eligibility” means any request for benefits administered by AHCCCS under the authority of A.R.S. Title 36, Chapter 29, including applications for presumptive eligibility submitted to hospitals as described under Article 16 of this Chapter.

“Penalty” means an amount not to exceed the amounts incurred by the system during any time period that the person would have been ineligible for benefits but for the false or fraudulent information provided on the application for eligibility. A penalty does not include, and does not need to be reduced by, the amount of any overpayments that AHCCCS

may be entitled to recoup from a person who violated A.R.S. § 36-2905.04 and/or A.R.S. § 36-2991.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-401 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 31, 1997 (Supp. 97-1). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

**R9-22-402. Determining the Amount of the Penalty**

- A. AHCCCS shall determine the amount of a penalty according to A.R.S. § 36-2905.04(B) or A.R.S. § 36-2991(B), whichever is applicable, and this Article.
- B. In addition to any penalty imposed pursuant to ARS §§ 36-2905.04 or 36-2991, and this Article, the Administration may also recoup from the person the amounts incurred by the system as a part of the notice and appeal process described in this Article.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-402 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

**R9-22-403. Mitigating and Aggravating Circumstances**

- A. AHCCCS shall consider any of the following to be mitigating circumstances when determining the amount of a penalty for obtaining eligibility by fraud.
  1. Degree of culpability. The degree of culpability of a person is a mitigating circumstance if the person did not intend to provide or cause to be provided false information on the application for eligibility but was negligent as to the truthfulness of the information provided.
  2. Prior Offenses. At the time of the submittal of the application the person:
    - a. Did not have any prior criminal convictions; and
    - b. Had not been held civilly liable for defrauding a public assistance program.
  3. Financial condition. The financial condition of a person who violates A.R.S. §§ 36-2905.04 or 36-2991 is a mitigating circumstance if the imposition of a penalty without reduction will render the person incapable of obtaining necessities of life such as food, clothing, and shelter. AHCCCS may consider the resources available to the person when determining the amount of the penalty.
  4. Other matters as justice may require. AHCCCS shall take into account other circumstances of a mitigating nature, if in the interest of justice; the circumstances require a reduction of the penalty.

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**B.** AHCCCS shall consider any of the following to be aggravating circumstances when determining the amount of a penalty for obtaining eligibility by fraud.

1. Degree of culpability. The degree of culpability of a person who provides or causes to be provided false information on the application for eligibility is an aggravating circumstance if the person knows or had reason to know that the information provided on the application for eligibility was false, or the person failed to correct the false information prior to AHCCCS incurring a financial loss as a result of the application for eligibility.
2. Prior offenses. At any time before the submittal of the application for eligibility, the person was held criminally or civilly liable for committing any fraud, waste, or abuse against any public assistance program.
3. Financial Loss. The person's violation of A.R.S. §§ 36-2905.04 or 36-2991 caused a loss to the system equal to or exceeding \$5,000.00.
4. Other matters as justice may require. AHCCCS shall take into account other circumstances of an aggravating nature, if in the interest of justice; the circumstances require an increase of the penalty.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-403 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended by adding subsection (C) effective October 1, 1987 (Supp. 87-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

**R9-22-404. Notice of Intent**

- A.** If AHCCCS imposes a penalty pursuant to this Article, AHCCCS shall hand deliver or send by certified mail, return receipt requested, or Federal Express to the person, a written Notice of Intent to impose a penalty.
- B.** The Notice of Intent shall include:
  1. The legal and factual basis for AHCCCS' determination that there has been a violation of A.R.S. §§ 36-2905.04 and/or 36-2991;
  2. The penalty;
  3. The amounts incurred by the system as a result of the violation of A.R.S. §§ 36-2905.04 and/or 36-2991, if AHCCCS intends to recoup those amounts through this process; and
  4. The procedure for requesting a State Fair Hearing.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-404 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

**R9-22-405. Failure to Respond to the Notice of Intent**

If a person fails to respond to the Notice of Intent within the time-frame described in A.A.C. § R9-22-406(A), AHCCCS shall uphold the penalty and recoupment amounts described in the Notice of Intent.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-405 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of the amended rule similar to the emergency (Supp. 83-3). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

**R9-22-406. Request for State Fair Hearing**

- A.** To dispute the agency action described in the Notice of Intent, the person shall file a written Request for State Fair Hearing with AHCCCS within sixty (60) days from the date of receipt of the Notice of Intent.
- B.** If AHCCCS receives a timely request for a State Fair Hearing from the person, AHCCCS shall mail a Notice of Hearing pursuant to the Uniform Administrative Hearing Procedures described in A.R.S. Title 41, Chapter 6, Article 10.
- C.** AHCCCS shall accept a written request for withdrawal of a hearing request if the written request for withdrawal is received from the person before AHCCCS mails a Notice of Hearing under the Uniform Administrative Hearing Procedures described in A.R.S. Title 41, Chapter 6, Article 10.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-406 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-406 repealed, new Section R9-22-406 adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as a permanent rule effective May 16, 1983; text of the Section identical to the emergency (Supp. 83-3). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

**R9-22-407. Burden of Proof**

- A.** In any State Fair Hearing conducted under this Article, AHCCCS shall prove a violation of A.R.S. §§ 36-2905.04 and/or 36-2991, and any aggravating circumstances by a preponderance of the evidence.
- B.** AHCCCS does not have to prove any specific intent to defraud.
- C.** A person shall bear the burden of producing and proving by a preponderance of the evidence any affirmative defense or any

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circumstance that would justify reducing the amount of the penalty.

**Historical Note**

New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

**R9-22-408. Rescission of the Notice of Intent**

AHCCCS may rescind the Notice of Intent at any time prior to the State Fair Hearing without prejudice.

**Historical Note**

New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

**ARTICLE 5. GENERAL PROVISIONS AND STANDARDS****R9-22-501. General Provisions and Standards - Related Definitions**

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“Quality management” means a process used by professional health personnel through a formal program involving multiple organizational components and committees to:

- Assess the degree to which services provided conform to desired medical standards and practices; and
- Quality improvement or maintenance of care and services.

“Quality Improvement” means a process designed to achieve, through ongoing measurements and intervention, significant improvement that is sustained over time, in the areas of clinical care and non-clinical care and is expected to have a favorable effect on health outcomes and member satisfaction. Quality Improvement includes focusing organizational efforts on improving performance and utilizing data to develop intervention strategies to improve performance and outcomes.

“Utilization management/review” means a methodology used by professional health personnel to assess the medical indications, appropriateness, and efficiency of care provided. Utilization management applies to a contractor’s process to evaluate and approve or deny the medical necessity, appropriateness, efficacy and efficiency of health care services, procedures, or settings. Utilization review includes processes for prior authorization, concurrent review, retrospective review, and case management.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-501 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-501 repealed, former Section R9-22-502 renumbered and adopted without change as Section R9-22-501 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-501 repealed, former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-502. Pre-existing Conditions**

- A. A contractor shall not impose a pre-existing condition exclusion with respect to covered services.
- B. A contractor or subcontractor shall not adopt or use any procedure to identify a person who has an existing or anticipated medical or psychiatric condition in order to discourage or exclude the person from enrolling in the contractor’s health plan or encourage the person to enroll in another health plan.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-502 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-502 renumbered without change as Section R9-22-501, former Section R9-22-503 renumbered and amended as Section R9-22-502 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-502 repealed, new Section R9-22-502 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4). Amended by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

**R9-22-503. Provider Requirements Regarding Records**

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. A provider shall maintain and upon request, make available to a contractor and to the Administration, financial and medical records relating to payment 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. Providers shall provide one copy of a medical record at no cost if requested by the member.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-503 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-503 renumbered and amended as Section R9-22-502, new Section R9-22-503 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective May 30, 1986 (Supp. 86-3). Amended subsection (D) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (F) and (G) effective December 22, 1987 (Supp. 87-4). Amended subsection (I) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). New Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-504. Marketing; Prohibition Against Inducements; Misrepresentations; Discrimination; Sanctions**

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- A.** A contractor or the contractor's marketing representative shall not offer or give any form of compensation or reward, or engage in any behavior or activity that may be reasonably construed as coercive, to induce or procure AHCCCS enrollment with the contractor. Any marketing solicitation offering a benefit, good, or service in excess of the covered services in Article 2 is deemed an inducement.
- B.** A marketing representative shall not misrepresent itself, the contracting health plan represented, or the AHCCCS program, through false advertising, false statements, or in any other manner to induce a member of another contractor to enroll in the represented health plan. Violations of this subsection include, but are not limited to, false or misleading claims, inferences, or representations such as:
1. A member will lose benefits under the AHCCCS program or lose any other health or welfare benefits to which a member is legally entitled, if the member does not enroll in the represented contracting health plan;
  2. Marketing representatives are employees of the state or representatives of the Administration, a county, or any health plan other than the health plan by which they are employed, or by which they are reimbursed; and
  3. The represented health plan is recommended or endorsed as superior to its competition by any state or county agency, or any organization, unless the organization has certified its endorsement in writing to the health plan and the Administration.
- C.** A marketing representative shall not engage in any marketing or pre-enrollment practice that discriminates against a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.
- D.** The Administration shall hold a contractor responsible for a violation of this Section resulting from the performance of any marketing representative, subcontractor, agent, program, or process under the contractor's employ or direction and shall impose contract sanctions on the contractor as specified in contract.
- E.** A contractor shall produce and distribute informational materials that are approved by the Administration to each enrolled member or designated representative after the contractor receives notification of enrollment from the Administration. The contractor shall ensure that the informational materials include, at a minimum:
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;
  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.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-504 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-504 repealed, former Section R9-22-505 renumbered and adopted without change as Section R9-22-504 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-504 repealed, former Section R9-22-528 renumbered and

amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-505. Standards, Licensure, and Certification for Providers of Hospital and Medical Services**

A provider shall not provide hospital or medical services to a member unless the provider is licensed by the Arizona Department of Health Services and meets the requirements in 42 CFR 441 and 482, as of October 1, 2007, and 42 CFR 456 Subpart C, as of October 1, 2007, 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 as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-505 adopted as an emergency expired, former Section R9-22-506 adopted as an emergency now adopted, amended and renumbered as Section R9-22-505 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-505 renumbered without change as Section R9-22-504, new Section R9-22-505 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-505 renumbered and amended as Section R9-22-509, former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5). Editorial correction, spelling of "paraphernalia" in subsection (A) (Supp. 87-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). New Section made by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-506. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-506 adopted as an emergency adopted, amended and renumbered as Section R9-22-505, former Section R9-22-507 adopted as an emergency now adopted, amended and renumbered as Section R9-22-506 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-506 repealed, new Section R9-22-506 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-506 repealed, new Section R9-22-506 adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (D) effective December 22, 1987 (Supp. 87-4). Repealed effective April 13, 1990 (Supp. 90-2). New Section adopted effective December 13, 1993 (Supp. 93-4). Repealed effective December 8, 1997 (Supp. 97-4).

**R9-22-507. Repealed**

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**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-507 adopted as an emergency adopted, amended and renumbered as Section R9-22-506, former Section R9-22-508 adopted as an emergency now adopted, amended and renumbered as Section R9-22-507 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-507 repealed, new Section R9-22-507 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-508. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-508 adopted as an emergency adopted, amended and renumbered as Section R9-22-507, former Section R9-22-509 adopted as an emergency now adopted, amended and renumbered as Section R9-22-508 as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-509. Transition and Coordination of Member Care**

- A. A contractor shall assist in the transition of members to and from other AHCCCS contractors.
1. Both the receiving and relinquishing contractor shall:
    - a. Coordinate with the other contractor to facilitate and schedule appointments for medically necessary services for the transitioned member within the Administration's timelines specified in the contract. If requested by the Administration, a contractor shall submit the policies and procedures regarding transition of members to the Administration for review and approval;
    - b. Assist in the referral of transitioned members to other community health agencies or county medical assistance programs for medically necessary services not covered by the Administration, as appropriate; and
    - c. Develop policies and procedures to be followed when transitioning members who have significant medical conditions; are receiving ongoing services; or have, at the time of the transition, received prior authorization or approval for undelivered, specific services.
  2. The relinquishing contractor shall notify the receiving contractor of relevant information about the member's medical condition and current treatment regimens within the timelines defined in contract;
  3. The relinquishing contractor shall forward medical records and other relevant materials to the receiving contractor. The relinquishing contractor shall bear the cost of reproducing and forwarding medical records and other relevant materials;
  4. Within the timelines specified in contract, the receiving contractor shall ensure that the member selects or is assigned to a primary care provider, and provide the member with:
    - a. Information regarding the contractor's providers,

- b. Emergency numbers, and
- c. Instructions about how to obtain services.

- B. A contractor shall not use a county or noncontracting provider health resource alternative to diminish the contractor's contractual responsibility or accountability for providing the full scope of covered services. The Administration may impose sanctions as described in contract if a contractor makes referrals to other agencies or programs to reduce expenses incurred by the contractor on behalf of its members.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-509 adopted as an emergency adopted, amended and renumbered as Section R9-22-508, former Section R9-22-510 adopted as an emergency now adopted and renumbered as Section R9-22-509 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-509 repealed, former Section R9-22-505 renumbered and amended as Section R9-22-509 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-510. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-510 adopted as an emergency adopted and renumbered as Section R9-22-509, former Section R9-22-511 adopted as an emergency now adopted, amended and renumbered as Section R9-22-510 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-510 repealed, new Section R9-22-510 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-511. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-511 adopted as an emergency adopted, amended and renumbered as Section R9-22-510, former Section R9-22-512 adopted as an emergency now adopted, amended and renumbered as Section R9-22-511 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-511 repealed, new Section R9-22-511 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-512. Release of Safeguarded Information**

- A. The Administration, contractors, providers, and noncontracting providers shall limit the release of safeguarded information to persons or agencies for the following purposes in accordance with 45 CFR 160 and 45 CFR 164, October 1, 2004, and 42 CFR 431.300 through 431.307, October 1, 2004, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N.

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Capitol St., N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments:

1. Official purposes directly related to the administration of the AHCCCS program including:
    - a. Establishing eligibility and post-eligibility treatment of income, as applicable;
    - b. Determining the amount of medical assistance;
    - c. Providing services for members;
    - d. Performing evaluations and analysis of AHCCCS operations;
    - e. Filing liens on property as applicable;
    - f. Filing claims on estates, as applicable; and
    - g. Filing, negotiating, and settling medical liens and claims.
  2. Law enforcement. The Administration may release safeguarded information without the applicant's or member's written or verbal consent, for the purpose of conducting or assisting an investigation, prosecution, or criminal or civil proceeding related to the administration of the AHCCCS program.
  3. The Administration may release safeguarded member information to a review committee in accordance with the provisions of A.R.S. § 36-2917, without the consent of the applicant or member.
- B.** Except as provided in subsection (A), the Administration, contractors, providers, and noncontracting providers shall disclose safeguarded information only to:
1. An applicant;
  2. A member;
  3. An unemancipated minor, with written permission of a parent, custodial relative, or designated representative, if:
    - a. An Administration employee, authorized representative, or responsible caseworker is present during the examination of the safeguarded information; or
    - b. After written notification to the provider, and at a reasonable time and place.
  4. Persons authorized by the applicant or member; or
  5. A court order or subpoena compliant with 45 CFR 164.512(e), 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.** The Administration, contractors, providers, and noncontracting providers shall safeguard identifiable information, protected health information as specified in 45 CFR 160, and information obtained in the course of application for or redetermination of eligibility concerning an applicant or member, that includes, but is not limited to the following:
1. Name and address;
  2. Social Security number;
  3. Social and economic conditions or circumstances;
  4. Agency evaluation of personal information;
  5. Medical data and information concerning medical services received, including diagnosis and history of disease or disability;
  6. State Data Exchange (SDX) tapes, and other types of information received from outside sources for the purpose of verifying income eligibility and amount of medical assistance payments; and
  7. Any information received in connection with the identification of legally liable third-party resources.
- D.** The restriction upon disclosure of information in this Section does not apply to:

1. De-identified information as described by 45 CFR 164.514, October 1, 2004, incorporated by reference in subsection (A); or
  2. A disclosure, in response to a request for information, that complies with 45 CFR 160 and 45 CFR 164, October 1, 2004, and 42 CFR 431.300 through 431.307, October 1, 2004, incorporated by reference in subsection (A).
- E.** A provider shall furnish records requested by the Administration or a contractor to the Administration or the contractor at no charge.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-512 adopted as an emergency adopted and renumbered as Section R9-22-511, former Section R9-22-513 adopted as an emergency now adopted and renumbered as Section R9-22-512 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-512 repealed, new Section R9-22-512 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-513. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-513 adopted as an emergency adopted and renumbered as Section R9-22-512, former Section R9-22-514 adopted as an emergency now adopted, amended and renumbered as Section R9-22-513 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-513 repealed, former Section R9-22-526 renumbered and amended as Section R9-22-513 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-514. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-514 adopted as an emergency adopted, amended and renumbered as Section R9-22-513, former Section R9-22-515 adopted as an emergency now adopted, amended and renumbered as Section R9-22-514 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-514 repealed, former Section R9-22-517 renumbered and amended as Section R9-22-514 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-515. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-515 adopted as an emergency

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adopted, amended and renumbered as Section R9-22-514, former Section R9-22-517 adopted as an emergency now adopted, amended and renumbered as Section R9-22-515 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-515 repealed, former Section R9-22-522 renumbered and amended as Section R9-22-515 effective October 1, 1985 (Supp. 85-5). Repealed effective December 8, 1997 (Supp. 97-4).

**R9-22-516. Renumbered****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-516 adopted as an emergency expired, former Section R9-22-518 adopted as an emergency now adopted, amended and renumbered as Section R9-22-516 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-516 renumbered as Section R9-22-513 effective October 1, 1985 (Supp. 85-5).

**R9-22-517. Renumbered****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-517 adopted as an emergency adopted, amended and renumbered as Section R9-22-515, former Section R9-22-519 adopted as an emergency now adopted and renumbered and amended as Section R9-22-517 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-517 renumbered and amended as Section R9-22-514 effective October 1, 1985 (Supp. 85-5).

**R9-22-518. Information to Enrolled Members**

- A. Each contractor shall produce and distribute printed informational materials to each member or family unit no later than 10 days of receipt of notification of enrollment from the Administration. The contractor shall ensure that the informational materials meet the requirements specified in the contractor's current contract.
- B. A contractor shall provide a member with the name, address, and telephone number of the member's primary care provider no later than 10 days from the date of enrollment. The contractor shall include information on how the member may change primary care providers.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-518 adopted as an emergency adopted, amended and renumbered as Section R9-22-516, former Section R9-22-520 adopted as an emergency now adopted, amended and renumbered as Section R9-22-518 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-518 repealed, new Section R9-22-518 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-519. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-519 adopted as an emergency adopted, amended and renumbered as Section R9-22-517, former Section R9-22-521 adopted as an emergency now adopted, amended and renumbered as Section R9-22-519 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-519 repealed, new Section R9-22-519 adopted effective October 1, 1985 (Supp. 85-5). Repealed effective December 8, 1997 (Supp. 97-4).

**R9-22-520. Expired****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-520 adopted as an emergency adopted, amended and renumbered as Section R9-22-518, former Section R9-22-522 adopted as an emergency now adopted, amended and renumbered as Section R9-22-520 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-520 repealed, new Section R9-22-520 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). 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).

**R9-22-521. Program Compliance Audits**

- A. The Administration shall conduct an onsite program compliance audit of a contractor at least once every three years during the term of the Administration's contract with the contractor. The Administration may conduct, without prior notice, inspections of contractor facilities or perform other elements of a program compliance audit.
- B. An audit team may perform any or all of the following procedures:
  1. Conduct private interviews and group conferences with members, physicians, other health professionals, and members of the contractor's administrative staff including, but not limited to, the contractor's principal management persons;
  2. Examine records, books, reports, and papers of the contractor and any management company, and all providers or subcontractors providing health care and other services. The examination may include, but need not be limited to: minutes of medical staff meetings, peer review and quality of care review records, duty rosters of medical personnel, appointment records, written procedures for the internal operation of the health plan, contracts and correspondence with members and with providers of health care services and other services to the plan, and additional documentation deemed necessary by the Administration to review the quality of medical care.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-521 adopted as an emergency adopted, amended and renumbered as Section R9-22-519, former Section R9-22-523 adopted as an emergency now adopted, amended and renumbered as Section R9-22-521 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-521 repealed, new Section R9-22-521 adopted effective October 1, 1985 (Supp. 85-5).

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Amended effective December 8, 1997 (Supp. 97-4).  
Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

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

**R9-22-522. Quality Management/Utilization Management (QM/UM) Requirements**

- A.** A contractor shall comply with Quality Management/Utilization Management (QM/UM) requirements specified in this Section and in contract. The contractor shall ensure compliance with QM/UM requirements that are accomplished through delegation or subcontract with another party.
- B.** In addition to any requirements specified in contract, a contractor shall:
1. Submit to the Administration a written QM/UM plan that includes a description of the systems, methodologies, protocols, and procedures to be used in:
    - a. Monitoring and evaluating the types of services provided,
    - b. Identifying the numbers and costs of services provided,
    - c. Assessing and improving the quality and appropriateness of care and services,
    - d. Evaluating the outcome of care provided to members, and
    - e. Determining the actions necessary to improve service delivery;
  2. Submit the QM/UM plan to the Administration on an annual basis within timelines specified in contract. If the QM/UM plan is changed during the year, the contractor shall submit the revised plan to the Administration before implementation;
  3. Receive approval from the Administration before implementing the initial or revised QM/UM plan;
  4. Ensure that a QM/UM committee operates under the control of the contractor's medical director and includes representation from medical and executive management personnel. The committee shall:
    - a. Oversee the development, revision, and implementation of the QM/UM plan; and
    - b. Ensure that there are qualified QM/UM personnel and sufficient resources to implement the contractor's QM/UM activities; and
  5. Ensure that the QM/UM activities include at least:
    - a. Prior authorization for non-emergency or scheduled hospital admissions;
    - b. Concurrent review of inpatient hospitalization;
    - c. Retrospective review of hospital claims;
    - d. Program and provider audits designed to detect over- or under-utilization, service delivery effectiveness, and outcome;
    - e. Medical records audits;
    - f. Surveys to determine satisfaction of members;

- g. Assessment of the adequacy and qualifications of the contractor's provider network;
- h. Review and analysis of QM/UM data;
- i. Measurement of performance using objective quality indicators;
- j. Ensuring individual and systemic quality of care;
- k. Integrating quality throughout the organization;
- l. Process improvement;
- m. Credentialing a provider network;
- n. Resolving quality of care grievances; and
- o. Quality improvement activities focused on improving the quality of care and the efficient, cost-effective delivery and utilization of services.

- C.** A member's primary care provider shall maintain medical records that:
1. Conform to professional medical standards and practices for documentation of medical diagnostic and treatment data;
  2. Facilitate follow-up treatment; and
  3. Permit professional medical review and medical audit processes.
- D.** Within 30 days following termination of the contract between a subcontractor and a contractor, the subcontractor or the subcontractor's designee shall forward to the primary care provider medical records or copies of medical records of all members assigned to the subcontractor or for whom the subcontractor has provided services.
- E.** The Administration shall monitor each contractor and the contractor's providers to ensure compliance with Administration QM/UM requirements and adherence to the contractor's QM/UM plan.
1. A contractor and the contractor's providers shall cooperate with the Administration in the performance of the Administration's QM/UM monitoring activities; and
  2. A contractor and the contractor's providers shall develop and implement mechanisms for correcting deficiencies identified through the Administration's QM/UM monitoring.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-522 adopted as an emergency adopted, amended and renumbered as Section R9-22-520, former Section R9-22-524 adopted as an emergency now adopted and renumbered as Section R9-22-522 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-522 renumbered and amended as Section R9-22-515, new Section R9-22-522 adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-523. Expired**

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-523 adopted as an emergency adopted, amended and renumbered as Section R9-22-521,

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former Section R9-22-525 adopted as an emergency now adopted, amended and renumbered as Section R9-22-523 as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). 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).

**R9-22-524. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-524 adopted as an emergency adopted and renumbered as Section R9-22-522, former Section R9-22-526 adopted as an emergency now adopted, amended and renumbered as Section R9-22-524 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-524 repealed, new Section R9-22-524 adopted effective October 1, 1985 (Supp. 85-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-525. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-525 adopted as an emergency adopted, amended and renumbered as Section R9-22-523, former Section R9-22-527 adopted as an emergency now adopted, amended and renumbered as Section R9-22-525 as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1985 (Supp. 85-5).

**R9-22-526. Renumbered****Historical Note**

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of the permanent rule identical to the emergency (Supp. 83-3). Former Section R9-22-526 repealed, new Section R9-22-526 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-1).

**R9-22-527. Renumbered****Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5).

**R9-22-528. Renumbered****Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-528 renumbered and amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5).

**R9-22-529. Renumbered****Historical Note**

Adopted as Section R9-22-529 effective October 1, 1985, then renumbered as Section R9-22-1002 effective October 1, 1985 (Supp. 85-5).

**ARTICLE 6. RFP AND CONTRACT PROCESS****R9-22-601. General Provisions**

- A.** The Director has full operational authority to adopt rules for the RFP process and the award of contracts under A.R.S. § 36-2906.
- B.** This Article applies to the award of contracts under A.R.S. §§ 36-2904 and 36-2906 to provide services under A.R.S. § 36-2907 and the expenditure of public monies by the Administration pertaining to covered services when the procurement so states. The Administration shall establish conflict-of-interest safeguards for officers and employees of this state with responsibilities relating to contracts that comply with 42 U.S.C. 1396u-2(d)(3).
- C.** The Administration is exempt from the procurement code under A.R.S. § 41-2501.
- D.** The Administration and contractors shall retain all contract records for five years under A.R.S. § 36-2903 and dispose of the records under A.R.S. § 41-2550.
- E.** The following terms are defined as related to this Article: "Procurement file" means the official records file of the Director whether located in the Office of the Director or at the public procurement unit. The procurement file shall include in electronic or paper form a list of notified vendors, final solicitation, solicitation amendments, bids/offers, final proposal revisions, clarifications, and final evaluation report.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-601 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

**R9-22-602. RFP**

- A.** RFP content. The Administration shall include the following items in any RFP under this Article:
  1. Instructions and information to an offeror concerning the proposal submission including:
    - a. The deadline for submitting a proposal,
    - b. The address of the office at which a proposal is to be received,
    - c. The period during which the RFP remains open, and
    - d. Any special instructions and information;
  2. The scope of covered services under Article 2 of this Chapter and A.R.S. §§ 36-2906 and 36-2907, covered populations, geographic coverage, service and performance requirements, and a delivery or performance schedule;
  3. The contract terms and conditions, including bonding or other security requirements, if applicable;
  4. The factors used to evaluate a proposal;
  5. The location and method of obtaining documents that are incorporated by reference in the RFP;
  6. A requirement that the offeror acknowledge receipt of all RFP amendments issued by the Administration;
  7. The type of contract to be used and a copy of a proposed contract form or provisions;

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8. The length of the contract service;
  9. A requirement for cost or pricing data;
  10. The minimum RFP requirements; and
  11. A provision requiring an offeror to certify that a submitted proposal does not involve collusion or other anti-competitive practices.
- B. Proposal process.**
1. After the deadline for submitting proposals, the Administration may open a proposal publicly and announce and record the name of the offeror. The Administration shall keep all other information contained in a proposal confidential. The Administration shall open a proposal for public inspection after contract award unless the Administration determines that disclosure is not in the best interest of the state.
  2. The Administration shall evaluate a proposal based on the GSA and the evaluation factors listed in the RFP.
  3. The Administration may initiate discussions with a responsive and responsible offeror to clarify and assure full understanding of an offeror's proposal. The Administration shall provide an offeror fair treatment with respect to discussion and revision of a proposal. The Administration shall not disclose information derived from a proposal submitted by a competing offeror.
  4. The Administration shall allow for the adjustment of covered services by expansion, deletion, segregation, or combination in order to secure the most financially advantageous proposals for the state.
  5. The Administration may conduct an investigation of a person or organization who has ownership or management interests in corporate offerors or affiliated corporate organizations of an offeror.
  6. The Administration may issue a written request for best and final offers. The Administration shall state in the request the date, time, and place for the submission of best and final offers.
  7. The Administration shall not request best and final offers more than once unless the Administration determines that it is advantageous to the state to request additional best and final offers. The Administration shall state in the written request for best and final offers that if the offeror does not submit a notice of withdrawal or a best and final offer, the Administration shall take the most recent offer as the offeror's best and final offer.
- C. Proposal rejection.**
1. The Administration may reject an offeror's proposal if the offeror fails to supply the information requested by the Administration.
  2. The offeror shall not disclose information pertaining to its proposal to any other offeror prior to contract award. The offeror may disclose proposal information to a person other than another offeror if the recipient agrees to keep the information confidential until contract award. Disclosure in violation of this subsection may be grounds for rejecting a proposal.
  3. The Administration shall provide written notification to an offeror whose proposal is rejected. The rejection notice shall be part of the contract file and a public record.
  4. If the Administration determines that it is in the best interest of the state, the Administration may reject any and all proposals, in whole or in part, under the RFP. The reasons for rejection shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if a proposal is rejected in whole or in part.
- D. Proposal cancellation.** If the Administration determines that it is in the best interest of the state, the Administration may cancel a RFP. The reasons for cancellation shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if a RFP is cancelled.
- Historical Note**
- Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-602 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).
- R9-22-603. Contract Award**
- The Administration shall award a contract to the responsible and responsive offeror whose proposal is determined most advantageous to the state under A.R.S. § 36-2906. If the Administration determines that multiple contracts are in the best interest of the state, the Administration may award multiple contracts. The contract file shall contain the basis on which the award is made.
- Historical Note**
- Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-603 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).
- R9-22-604. Contract or Proposal Protests; Appeals**
- A.** Disputes related to contract performance. This Section does not apply to a dispute related to contract performance. A contract performance dispute is governed by 9 A.A.C. 34.
- B.** Resolution of a proposal protest. The procurement officer issuing a RFP shall have the authority to resolve proposal protests. An appeal from the decision of the procurement officer shall be made to the Director.
- C. Filing of a protest.**
1. A person may file a protest with the procurement officer regarding:
    - a. A RFP issued by the Administration,
    - b. A proposed award, or
    - c. An award of a contract.
  2. A protester shall submit a written protest and include the following information:
    - a. The name, address, and telephone number of the protester;
    - b. The signature of the protester or protester's representative;
    - c. Identification of a RFP or contract number;

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- d. A detailed statement of the legal and factual grounds of the protest including copies of any relevant documents; and
- e. The relief requested.
- D. Time for filing a protest.**
1. A protester filing a protest alleging improprieties in an RFP or an amendment to an RFP shall file the protest at least 14 days before the due date of receipt of proposals.
  2. Any protest alleging improprieties in an amendment issued 14 or fewer days before the due date of the proposal shall be filed before the due date for receipt of proposals.
  3. In cases other than those covered in subsections (D)(1) and (2), a protester shall file a protest no later than 10 days after the procurement officer makes the procurement file available for public inspection.
- E. Stay of procurement during the protest.** If a protester files a protest before the contract award, the procurement officer may issue a written stay of the contract award. In considering whether to issue a written stay of contract, the procurement officer shall consider but is not limited to considering whether:
1. A reasonable probability exists that the protest will be sustained, and
  2. The stay of the contract award is in the best interest of the state.
- F. Stay of contract award during an appeal to the Director.** The Director shall automatically continue the stay of a contract award if:
1. An appeal is filed before a contract award, and
  2. The procurement officer issues a stay of the contract award under subsection (E), unless
  3. The Director issues a written determination that the contract award is necessary to protect the best interest of the state.
- G. Decision by the procurement officer.**
1. The procurement officer shall issue a written decision no later than 14 days after a protest has been filed. The decision shall contain an explanation of the basis of the decision.
  2. The procurement officer shall furnish a copy of the decision to the protester by:
    - a. Certified mail, return receipt requested; or
    - b. Any other method that provides evidence of receipt.
  3. The Administration may extend, for good cause, the time-limit for decisions in subsection (G)(1) for a time not to exceed 30 days. The procurement officer shall notify the protester in writing that the time for the issuance of a decision has been extended and the date by which a decision shall be issued.
  4. If the procurement officer fails to issue a decision within the time-limits in subsection (G)(1) or (G)(3), the protester may proceed as if the procurement officer issued an adverse decision.
- H. Remedies.**
1. If the procurement officer sustains the protest in whole or in part and determines that the RFP, proposed contract award, or contract award does not comply with applicable statutes and rules, the procurement officer shall order an appropriate remedy.
  2. In determining an appropriate remedy, the procurement officer shall consider all the circumstances of the procurement or proposed procurement, including:
    - a. Seriousness of the procurement deficiency,
    - b. Degree of prejudice to other interested parties or to the integrity of the RFP process,
    - c. Good faith of the parties,
    - d. Extent of performance,
    - e. Costs to the state, and
    - f. Urgency of the procurement.
    - g. Best interest of the state.
3. An appropriate remedy may include one or more of the following:
- a. Terminating the contract;
  - b. Reissuing the RFP;
  - c. Issuing a new RFP;
  - d. Awarding a contract consistent with statutes, rules, and the terms of the RFP; or
  - e. Any relief determined necessary to ensure compliance with applicable statutes and rules.
- I. Appeals to the Director.**
1. A person may file an appeal of a procurement officer's decision with both the Director and the procurement officer no later than five days from the date the decision is received. The date the decision is received shall be determined under subsection (G)(2).
  2. The appeal shall contain:
    - a. The information required in subsection (C)(2),
    - b. A copy of the procurement officer's decision,
    - c. The alleged factual or legal error in the decision of the procurement officer on which the appeal to the Director is based, and
    - d. A request for hearing unless the person requests that the Director's decision be based solely upon the procurement file.
- J. Dismissal.** The Director shall not schedule a hearing and shall dismiss an appeal with a written determination if:
1. The appeal does not state a basis for protest,
  2. The appeal is untimely under subsection (I)(1), or
  3. The appeal is moot.
- K. Hearing.** Hearings under this Section shall be conducted using the Arizona Administrative Procedure Act under A.R.S. Title 41, Ch. 6.

**Historical Note**

Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

**R9-22-605. Waiver of Contractor's Subcontract with Hospitals**

If a contractor is unable to obtain a subcontract with a hospital as contractually required, the contractor may request in writing a waiver from the Administration as allowed by A.R.S. § 36-2906. The contractor shall state in the request the reasons a waiver is believed to be necessary and all efforts the contractor has made to secure a subcontract.

**Historical Note**

Adopted effective January 31, 1986 (Supp. 86-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemak-

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ing at 18 A.A.R. 2340, effective November 11, 2012  
(Supp. 12-3).

**R9-22-606. Contract Compliance Sanction**

- A. The Director may impose sanctions upon a contractor for violation of any provision of this Chapter or of a contract. Sanctions include but are not limited to:
1. Suspension of any or all further member enrollment, by choice and/or assignment for a period of time.
  2. Imposition of a monetary sanction.
- B. The Director shall consider the nature, severity, and length of the violation when determining a sanction.
- C. The Director shall provide a contractor with written notice specifying grounds and terms for the sanction.
- D. Nothing contained in this Section shall be construed to prevent the Administration from imposing sanctions as provided in contract under A.R.S. § 36-2903.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

**ARTICLE 7. STANDARDS FOR PAYMENTS****R9-22-701. Standards for Payments Related Definitions**

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Article have the following meanings unless the context explicitly requires another meaning:

“Accommodation” means room and board services provided to a patient during an inpatient hospital stay and includes all staffing, supplies, and equipment. The accommodation is semi-private except when the member must be isolated for medical reasons. Types of accommodation include hospital routine medical/surgical units, intensive care units, and any other specialty care unit in which room and board are provided.

“Aggregate” means the combined amount of hospital payments for covered services provided within and outside the GSA.

“AHCCCS inpatient hospital day or days of care” means each day of an inpatient stay for a member beginning with the day of admission and including the day of death, if applicable, but excluding the day of discharge, provided that all eligibility, medical necessity, and medical review requirements are met.

“Ancillary service” means all hospital services for patient care other than room and board and nursing services, including but not limited to, laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, and occupational).

“APC” means the Ambulatory Payment Classification system under 42 CFR 419.31 used by Medicare for grouping clinically and resource-similar procedures and services.

“Billed charges” means charges for services provided to a member that a hospital includes on a claim consistent with the rates and charges filed by the hospital with Arizona Department of Health Services (ADHS).

“Business agent” means a company such as a billing service or accounting firm that renders billing statements and receives payment in the name of a provider.

“Capital costs” means costs as reported by the hospital to CMS as required by 42 CFR 413.20.

“Copayment” means a monetary amount, specified by the Director, that a member pays directly to a contractor or provider at the time covered services are rendered.

“Cost-to-charge ratio” (CCR) means a hospital’s costs for providing covered services divided by the hospital’s charges for the same services. The CCR is the percentage derived from the cost and charge data for each revenue code provided to AHC-CCS by each hospital.

“Covered charges” means billed charges that represent medically necessary, reasonable, and customary items of expense for covered services that meet medical review criteria of AHC-CCS or a contractor.

“CHC” means a Community Health Center, which includes both Federally Qualified Health Centers and Rural Health Clinics.

“CPT” means Current Procedural Terminology, published, and updated by the American Medical Association. CPT is a nationally-accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians that provide a uniform language to accurately designate medical, surgical, and diagnostic services.

“Critical Access Hospital” is a hospital certified by Medicare under 42 CFR 485 Subpart F and 42 CFR 440.170(g).

“Direct graduate medical education costs” or “direct program costs” means the costs that are incurred for the education activities of an approved graduate medical education program that are the proximate result of training medical residents in the hospital, including resident salaries and fringe benefits, the portion of teaching physician salaries and fringe benefits that are related to the time spent in teaching and supervision of residents, and other related GME overhead costs.

“DRI inflation factor” means Global Insights Prospective Hospital Market Basket.

“Eligibility posting” means the date a member’s eligibility information is entered into the AHCCCS Pre-paid Medical Management Information System (PMMIS).

“Encounter” means a record of a medically-related service rendered by an AHCCCS-registered provider to a member enrolled with a contractor on the date of service.

“Existing outpatient service” means a service provided by a hospital before the hospital files an increase in its charge master as defined in R9-22-712(G), regardless of whether the service was explicitly described in the hospital charge master before filing the increase or how the service was described in the charge master before filing the increase.

“Expansion funds” means funds appropriated to support GME program expansions as described under A.R.S. § 36-2903.01(G)(9)(b) and (c)(i).

“Factor” means a person or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the organization for an added fee or a deduction of a portion of the accounts receivable. Factor does not include a business agent.

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“Fiscal intermediary” means an organization authorized by CMS to make determinations and payments for Part A and Part B provider services for a given region.

“Freestanding Children’s Hospital” means a separately standing hospital with at least 120 pediatric beds that is dedicated to providing the majority of the hospital’s services to children.

“GME program approved by the Administration” or “approved GME program” means a graduate medical education program that has been approved by a national organization as described in 42 CFR 415.152.

“Graduate medical education (GME) program” means an approved residency or fellowship program that prepares a physician for independent practice of medicine by providing didactic and clinical education in a medical environment to a medical student who has completed a recognized undergraduate medical education program.

“HCAC” means a health care acquired condition described under 42 CFR 447.26 but does not include Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

“HCPCS” means the Health Care Procedure Coding System, published, and updated by Center for Medicare and Medicaid Services (CMS). HCPCS is a listing of codes and descriptive terminology used for reporting the provision of physician services, other health care services, and substances, equipment, supplies, or other items used in health care services.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as specified under 45 CFR 162, that establishes standards and requirements for the electronic transmission of certain health information by defining code sets used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

“ICU” means the intensive care unit of a hospital.

“Indirect program costs” means the marginal increase in operating costs that a provider experiences as a result of having an approved graduate medical education program and that is not accounted for by the direct program costs.

“Intern and Resident Information System” means a software program used by teaching providers and the provider community for collecting and reporting information on resident training in hospital and non-hospital settings.

“Medical education costs” means direct costs for intern and resident salaries, fringe benefits, program costs, nursing school education, and paramedical education, as described in the Medicare Provider Reimbursement Manual.

“Medical review” means a clinical evaluation of documentation conducted by AHCCCS or a contractor for purposes of prior authorization, concurrent review, post-payment review, or determining medical necessity. The criteria for medical review are established by AHCCCS or a contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

“Medicare Urban or Rural Cost-to-Charge Ratio (CCR)” means statewide average capital cost-to-charge ratio published annually by CMS added to the urban or rural statewide average operating cost-to-charge ratio published annually by CMS.

“National Standard code sets” means codes that are accepted nationally in accordance with federal requirements under 45 CFR 160 and 45 CFR 164.

“New hospital” means a hospital for which Medicare Cost Report claim and encounter data are not available for the fiscal year used for initial rate setting or rebasing.

“NICU” means the neonatal intensive care unit of a hospital that is classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.

“Non-IHS Acute Hospital” means a hospital that is not run by Indian Health Services, is not a free-standing psychiatric hospital, such as an IMD, and is paid under ADHS rates.

“Observation day” means a physician-ordered evaluation period of less than 24 hours to determine whether a person needs treatment or needs to be admitted as an inpatient. Each observation day consists of a period of 24 hours or less.

“Operating costs” means AHCCCS-allowable accommodation costs and ancillary department hospital costs excluding capital and medical education costs.

“OPPC” means an Other Provider Preventable Condition that is: (1) a wrong surgical or other invasive procedure performed on a patient, (2) a surgical or other invasive procedure performed on the wrong body part, or (3) a surgical or other invasive procedure performed on the wrong patient.

“Organized health care delivery system” means a public or private organization that delivers health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization.

“Outlier” means a hospital claim or encounter in which the operating costs per day for an AHCCCS inpatient hospital stay meet the criteria described under this Article and A.R.S. § 36-2903.01(G).

“Outpatient hospital service” means a service provided in an outpatient hospital setting that does not result in an admission.

“Ownership change” means a change in a hospital’s owner, lessor, or operator under 42 CFR 489.18(a).

“Participating institution” means an institution at which portions of a graduate medical education program are regularly conducted and to which residents rotate for an educational experience for at least one month.

“Peer group” means hospitals that share a common, stable, and independently definable characteristic or feature that significantly influences the cost of providing hospital services, including specialty hospitals that limit the provision of services to specific patient populations, such as rehabilitative patients or children.

“PPC” means prior period coverage. PPC is the period of time, prior to the member’s enrollment, during which a member is eligible for covered services. The time-frame is the first day of the month of application or the first eligible month, whichever is later, until the day a member is enrolled with a contractor.

“PPS bed” means Medicare-approved Prospective Payment beds for inpatient services as reported in the Medicare cost reports for the most recent fiscal year for which the Administration has a complete set of Medicare cost reports for every rural hospital as determined as of the first of February of each year.

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“Primary care GME program” means a graduate medical education program that prepares a physician for the practice of internal medicine, family medicine, pediatrics, obstetrics, geriatrics, or psychiatry.

“Procedure code” means the numeric or alphanumeric code listed in the CPT or HCPCS manual by which a procedure or service is identified.

“Prospective rates” means inpatient or outpatient hospital rates set by AHCCCS in advance of a payment period and representing full payment for covered services excluding any quick-pay discounts, slow-pay penalties, and first-and third-party payments regardless of billed charges or individual hospital costs.

“Public hospital” means a hospital that is owned and operated by county, state, or hospital health care district.

“Qualifying health information exchange organization” means a non-profit health information organization as defined in A.R.S. § 36-3801 that provides the statewide exchange of patient health information among disparate health care organizations and providers not owned, operated, or controlled by the health information exchange. A qualifying health information exchange organization must include representation by the administration on its board of directors, and have a significant number of health care participants, including hospitals, laboratories, payers, community physicians and Federally Qualified Health Centers.

“Rebase” means the process by which the most currently available and complete Medicare Cost Report data for a year and AHCCCS claim and encounter data for the same year are collected and analyzed to reset the Inpatient Hospital Tiered per diem rates, or the Outpatient Hospital Capped Fee-For-Service Schedule.

“Reinsurance” means a risk-sharing program provided by AHCCCS to contractors for the reimbursement of specified contract service costs incurred by a member beyond a certain monetary threshold.

“Remittance advice” means an electronic or paper document submitted to an AHCCCS-registered provider by AHCCCS to explain the disposition of a claim.

“Resident” means a physician engaged in postdoctoral training in an accredited graduate medical education program, including an intern and a physician who has completed the requirements for the physician’s eligibility for board certification.

“Revenue code” means a numeric code, that identifies a specific accommodation, ancillary service, or billing calculation, as defined by the National Uniform Billing committee for UB04 forms.

“Sub-acute services” means inpatient care for a patient with an acute illness, injury, or exacerbation of a disease process when the patient does not require acute inpatient hospitalization. Sub-acute care is rendered immediately after, or instead of, acute inpatient hospitalization.

“Specialty facility” means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.

“Sponsoring institution” means the institution or entity that is recognized by the GME accrediting organization and designated as having ultimate responsibility for the assurance of

academic quality and compliance with the terms of accreditation.

“Tier” means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure, or revenue codes, peer group, NICU classification level, or any combination of these items.

“Tiered per diem” means an AHCCCS capped fee schedule in which payment is made on a per-day basis depending upon the tier (or tiers) into which an AHCCCS inpatient hospital day of care is assigned.

“Trip” means a one-way transport each time a taxi is called. If the taxi waits for the member, then the transport continues to be part of the one-way trip. If the taxi leaves and is called to pick up the member, that is considered a new one-way trip.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-701 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-701 repealed, new Section R9-22-701 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Section repealed; new Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 2188, effective June 6, 2006 (Supp. 06-2). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 1782, effective June 30, 2007 (Supp. 07-2). Amended by exempt rulemaking at 13 A.A.R. 3190, effective October 1, 2007 (Supp. 07-3). Amended by exempt rulemaking at 13 A.A.R. 4032, effective November 1, 2007 (Supp. 07-4). Amended by final rulemaking at 20 A.A.R. 1956, effective September 6, 2014; amended by exempt rulemaking at 20 A.A.R. 2755, effective January 1, 2015 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 28 A.A.R. 837 (April 29, 2022), with an immediate effective date of April 5, 2022 (Supp. 22-2).

- R9-22-701.01. Reserved**
- R9-22-701.02. Reserved**
- R9-22-701.03. Reserved**
- R9-22-701.04. Reserved**
- R9-22-701.05. Reserved**
- R9-22-701.06. Reserved**
- R9-22-701.07. Reserved**
- R9-22-701.08. Reserved**
- R9-22-701.09. Reserved**
- R9-22-701.10 Scope of the Administration’s and Contractor’s Liability**

The Administration shall bear no liability for providing covered services for any member beyond the date of termination of the member’s eligibility or during the member’s enrollment with a con-

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tractor. A contractor has no financial responsibility for services provided to a member beyond the last date of enrollment except as provided in Articles 2 and 5 of this Chapter and as specified in contract.

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

**R9-22-702. Charges to Members**

- A. For purposes of this subsection, the term "member" includes the member's financially responsible representative as described under A.R.S. § 36-2903.01.
- B. Registered providers must accept payment from the Administration or a contractor as payment in full.
- C. Except as provided in subsection (D) a registered provider shall not request or collect payment from, refer to a collection agency, or report to a credit reporting agency an eligible person or a person claiming to be an eligible person.
- D. An AHCCCS registered provider may charge, submit a claim to, or demand or collect payment from a member:
  1. To collect the copayment described in R9-22-711;
  2. To recover from a member that portion of a payment made by a third party to the member for an AHCCCS covered service if the member has not transferred the payment to the Administration or the contractor as required by the statutory assignment of rights to AHCCCS;
  3. To obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused payment to the provider to be reduced or denied;
  4. For a service that is excluded by statute or rule, or provided in an amount that exceeds a limitation in statute or rule, if the member signs a document in advance of receiving the service stating that the member understands the service is excluded or is subject to a limit and that the member will be financially responsible for payment for the excluded service or for the services in excess of the limit;
  5. When the contractor or the Administration has denied authorization for a service if the member signs a document in advance of receiving the service stating that the member understands that authorization has been denied and that the member will be financially responsible for payment for the service;
  6. For services requested for a member enrolled with a contractor, and rendered by a noncontracting provider under circumstances where the member's contractor is not responsible for payment of "out of network" services under R9-22-705(A), if the member signs a document in advance of receiving the service stating that the member understands the provider is out of network, that the member's contractor is not responsible for payment, and that the member will be financially responsible for payment for the excluded service;
  7. For services rendered to a person eligible for the FESP if the provider submits a claim to the Administration in the reasonable belief that the service is for treatment of an emergency medical condition and the Administration denies the claim because the service does not meet the criteria of R9-22-217; or

8. If the provider has received verification from the Administration that the person was not an eligible person on the date of service.

- E. The signature requirement of subsections (D)(4), (D)(5), and (D)(6) do not apply if:
  1. The member is unable or incompetent to sign such a document, or
  2. When services are rendered for the purpose of treating an emergency medical condition as defined in R9-22-217 and a delay in providing treatment to obtain a signature would have a significant adverse affect on the member's health.
- F. Except as provided for in this Section, registered providers shall not bill a member when the provider could have received reimbursement from the Administration or a contractor but for the provider's failure to file a claim in accordance with the requirements of AHCCCS statutes, rules, the provider agreement, or contract, such as, but not limited to, requirements to request and obtain prior authorization, timely filing, and clean claim requirements.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-702 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text identical to the emergency (Supp. 83-3). Former Section R9-22-702 repealed, new Section R9-22-702 adopted effective October 1, 1983 (Supp. 83-5). Amended by adding subsection (B) effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 3217, effective October 1, 2005 (Supp. 05-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3).

**R9-22-703. Payments by the Administration**

- A. General requirements. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of October 1, 2012, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
- B. Timely submission of claims.
  1. Under A.R.S. § 36-2904, the Administration shall deem a paper claim to be submitted on the date that it is received by the Administration. An electronic claim is deemed received by the Administration when the claim enters the information processing system designated by the Administration for electronic claims in a form that is capable of being processed by the designated information processing system. The Administration shall do one or more of the following for each claim it receives:

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- a. Place a date stamp on the face of the claim,
  - b. Assign a system-generated claim reference number, or
  - c. Assign a system-generated date-specific number.
2. Unless a shorter time period is specified in contract, the Administration shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
    - a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
    - b. Six months from the date of eligibility posting.
  3. Unless a shorter time period is specified in contract, the Administration shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
    - a. Twelve months from the date of service or for an inpatient hospital claim, 12 months from the date of discharge; or
    - b. Twelve months from the date of eligibility posting.
  4. Unless a shorter time period is specified in contract, the Administration shall not pay a claim submitted by an HIS or tribal facility for a covered service unless the claim is initially submitted within 12 months from the date of service, date of discharge, or eligibility posting, whichever is later.
- C. Claims processing.**
1. The Administration shall notify the AHCCCS-registered provider with a remittance advice when a claim is processed for payment.
  2. The Administration shall reimburse a hospital for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and in the manner and at the rate described in A.R.S. § 36-2903.01:
    - a. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
    - b. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
    - c. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a fee of one percent per month for each month or portion of a month following the 60th day of receipt of the bill until date of payment.
  3. A claim is paid on the date indicated on the disbursement check.
  4. A claim is denied as of the date of the remittance advice.
  5. The Administration shall process a hospital claim under this Article.
- D. Prior authorization.**
1. An AHCCCS-registered provider shall:
    - a. Obtain prior authorization from the Administration for non-emergency hospital admissions, covered services as specified in Articles 2 and 12 of this Chapter, and for administrative days as described in R9-22-712.75,
    - b. Notify the Administration of hospital admissions under Article 2 of this Chapter, and
    - c. Make records available for review by the Administration upon request.
  2. The Administration may deny a claim if the provider fails to comply with subsection (D)(1).
  3. If the Administration issues prior authorization for an inpatient hospital admission, a specific service, or level of care but subsequent medical review indicates that the admission, the service, or level of care was not medically appropriate, the Administration shall adjust the claim payment.
- E. Review of claims and coverage for hospital supplies.**
1. The Administration may conduct prepayment and post-payment review of any claims, including but not limited to hospital claims.
  2. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
    - a. Patient care kit,
    - b. Toothbrush,
    - c. Toothpaste,
    - d. Petroleum jelly,
    - e. Deodorant,
    - f. Septi soap,
    - g. Razor or disposable razor,
    - h. Shaving cream,
    - i. Slippers,
    - j. Mouthwash,
    - k. Shampoo,
    - l. Powder,
    - m. Lotion,
    - n. Comb, and
    - o. Patient gown.
  3. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
    - a. Arm board,
    - b. Diaper,
    - c. Underpad,
    - d. Special mattress and special bed,
    - e. Gloves,
    - f. Wrist restraint,
    - g. Limb holder,
    - h. Disposable item used instead of a durable item,
    - i. Universal precaution,
    - j. Stat charge, and
    - k. Portable charge.
  4. The Administration shall determine in a hospital claims review whether services rendered were:
    - a. Covered services as defined in Article 2;
    - b. Medically necessary;
    - c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
    - d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2903.01.
  5. If the Administration adjudicates a claim, a person may file a claim dispute challenging the adjudication under 9 A.A.C. 34.
- F. Overpayment for AHCCCS services.**
1. An AHCCCS-registered provider shall notify the Administration when the provider discovers the Administration made an overpayment.
  2. The Administration shall recoup an overpayment from a future claim cycle if an AHCCCS-registered provider fails to return the overpaid amount to the Administration.
  3. The Administration shall document any recoupment of an overpayment on a remittance advice.

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4. An AHCCCS-registered provider may file a claim dispute under 9 A.A.C. 34 if the AHCCCS-registered provider disagrees with a recoupment action.
- G.** For services subject to limitations or exclusions such as the number of hours, days, or visits covered as described in Article 2 of this Chapter, once the limit is reached the Administration will not reimburse the services.
- H.** Prior quarter reimbursement. A provider shall:
1. Bill the Administration for services provided during a prior quarter eligibility period upon verification of eligibility or upon notification from a member of AHCCCS eligibility.
  2. Reimburse a member when payment has been received from the Administration for covered services during a prior quarter eligibility period. All funds paid by the member shall be reimbursed.
  3. Accept payment received by the Administration as payment in full.
- I.** Payment for in-state inpatient hospital services for claims with discharge dates on or before September 30, 2014. The Administration shall reimburse an in-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article.
- J.** Payment for out-of-state inpatient hospital services for claims with discharge dates on or before September 30, 2014. The Administration shall reimburse an out-of-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, for covered inpatient services by multiplying covered charges by the most recent statewide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b).
- K.** Payment for inpatient hospital services for claims with discharge dates on and after October 1, 2014 regardless of admission date. The Administration shall reimburse an in-state or out-of-state provider of inpatient hospital services rendered with a discharge date on or after October 1, 2014, the DRG rate established by the Administration.
- L.** The Administration may enter into contracts for the provisions of transplant services.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R-22-703 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-703 repealed, new Section R9-22-703 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (1) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective September 16, 1987 (Supp. 87-3). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective

October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 19 A.A.R. 3309, November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 27 A.A.R. 237, effective April 4, 2021 (Supp. 21-1).

**R9-22-704. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-704 adopted as an emergency now adopted and amended as a permanent rule effective August 30 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended subsection A., Paragraph 2. effective October 1, 1985 (Supp. 85-5). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

**R9-22-705. Payments by Contractors**

- A.** General requirements. A contractor shall contract with providers to provide covered services to members enrolled with the contractor. The contractor is responsible for reimbursing providers and coordinating care for services provided to a member. Except as provided in subsection (A)(2), a contractor is not required to reimburse a noncontracting provider for services rendered to a member enrolled with the contractor.
1. Providers. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of March 6, 1992, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
  2. A contractor shall reimburse a noncontracting provider for services rendered to a member enrolled with the contractor as specified in this Article if:
    - a. The contractor referred the member to the provider or authorized the provider to render the services and the claim is otherwise payable under this Chapter, or
    - b. The service is emergent under Article 2 of this Chapter.
- B.** Timely submission of claims.
1. Under A.R.S. § 36-2904, a contractor shall deem a paper or electronic claim as submitted on the date that the claim is received by the contractor. The contractor shall do one or more of the following for each claim the contractor receives:
    - a. Place a date stamp on the face of the claim,
    - b. Assign a system-generated claim reference number, or
    - c. Assign a system-generated date-specific number.
  2. Unless a shorter time period is specified in subcontract, a contractor shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
    - a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
    - b. Six months from the date of eligibility posting.

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3. Unless a shorter time period is specified in subcontract, a contractor shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
  - a. Twelve months from the date of service or for an inpatient hospital claim, 12 months from the date of discharge; or
  - b. Twelve months from the date of eligibility posting.
- C. Date of claim.
  1. A contractor's date of receipt of an inpatient or an outpatient hospital claim is the date the claim is received by the contractor as indicated by the date stamp on the claim, the system-generated claim reference number, or the system-generated date-specific number assigned by the contractor.
  2. A hospital claim is considered paid on the date indicated on the disbursement check.
  3. A denied hospital claim is considered adjudicated on the date of the claim's denial.
  4. For a claim that is pending for additional supporting documentation specified in A.R.S. § 36-2903.01 or 36-2904, the contractor shall assign a new date of receipt upon receipt of the additional documentation.
  5. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. § 36-2903.01 or 36-2904, the contractor shall not assign a new date of receipt.
  6. A contractor and a hospital may, through a contract approved as specified in R9-22-715, adopt a method for identifying, tracking, and adjudicating a claim that is different from the method described in this subsection.
- D. Payment for in-state inpatient hospital services for claims with discharge dates on or before September 30, 2014. A contractor shall reimburse an in-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, at either a rate specified by subcontract or, in absence of the subcontract, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715. This subsection does not apply to an urban contractor as specified in R9-22-718 and A.R.S. § 36-2905.01.
- E. Payment for Inpatient out-of-state hospital payments for claims with discharge dates on or before September 30, 2014. In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent statewide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b).
- F. Payment for inpatient hospital services for claims with discharge dates on and after October 1, 2014 regardless of admission date. Subject to R9-22-718 and A.R.S. § 36-2905.01 regarding urban hospitals, a contractor shall reimburse an in-state or out-of-state provider of inpatient hospital services, at either a rate specified by subcontract or, in absence of a subcontract, the DRG rate established by the Administration and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
- G. Payment for in-state outpatient hospital services.
 

A contractor shall reimburse an in-state provider of outpatient hospital services rendered on or after July 1, 2005, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10, A.R.S. § 36-2903.01 and other Sections of this Article. The terms of the subcontract are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
- H. Outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the contractor shall pay the claim by multiplying the covered charges for the outpatient services by the statewide outpatient cost-to-charge ratio.
- I. Payment for observation days. A contractor shall reimburse a provider and a noncontracting provider for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, as prescribed under R9-22-712, R9-22-712.10, and R9-22-712.45.
- J. Review of claims and coverage for hospital supplies.
  1. A contractor may conduct a review of any claims submitted and recoup any payments made in error.
  2. A hospital shall obtain prior authorization from the appropriate contractor for nonemergency admissions. When issuing prior authorization, a contractor shall consider the medical necessity of the service, and the availability and cost effectiveness of an alternative treatment. Failure to obtain prior authorization when required is cause for nonpayment or denial of a claim. A contractor shall not require prior authorization for medically necessary services provided during any prior period for which the contractor is responsible. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of the subcontract regarding utilization control activities. A hospital shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and shall make the hospital's medical records pertaining to a member enrolled with a contractor available for review.
  3. Regardless of prior authorization or concurrent review activities, a contractor may make prepayment or post-payment review of all claims, including but not limited to a hospital claim. A contractor may recoup an erroneously paid claim. If prior authorization was given for an inpatient hospital admission, a specific service, or level of care but subsequent medical review indicates that the admission, the service, or level of care was not medically appropriate, the contractor shall adjust the claim payment.
  4. A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures if the subcontract meets the requirements of R9-22-715.
  5. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
    - a. Patient care kit,
    - b. Toothbrush,
    - c. Toothpaste,
    - d. Petroleum jelly,
    - e. Deodorant,
    - f. Septi soap,
    - g. Razor,
    - h. Shaving cream,
    - i. Slippers,
    - j. Mouthwash,
    - k. Disposable razor,
    - l. Shampoo,

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- m. Powder,
- n. Lotion,
- o. Comb, and
- p. Patient gown.
- 6. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
  - a. Arm board,
  - b. Diaper,
  - c. Underpad,
  - d. Special mattress and special bed,
  - e. Gloves,
  - f. Wrist restraint,
  - g. Limb holder,
  - h. Disposable item used instead of a durable item,
  - i. Universal precaution,
  - j. Stat charge, and
  - k. Portable charge.
- 7. The contractor shall determine in a hospital claims review whether services rendered were:
  - a. Covered services as defined in R9-22-201;
  - b. Medically necessary;
  - c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
  - d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2904.
- 8. If a contractor adjudicates a claim or recoups payment for a claim, a person may file a claim dispute challenging the adjudication or recoupment as described under 9 A.A.C. 34.
- K.** Non-hospital claims. A contractor shall pay claims for non-hospital services in accordance with contract, or in the absence of a contract, at a rate not less than the Administration's capped fee-for-service schedule or at a lower rate if negotiated between the two parties.
- L.** Payments to hospitals. A contractor shall pay for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and as described in A.R.S. § 36-2904:
  - 1. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
  - 2. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
  - 3. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a 1 percent penalty of the rate for each month or portion of the month following the 60th day of receipt of the bill until date of payment.
- M.** Interest payment. In addition to the requirements in subsection (L), a contractor shall pay interest for late claims as defined by contract.
- N.** For services subject to limitations or exclusions such as the number of hours, days, or visits covered as described in Article 2 of this Chapter, once the limit is reached the Administration will not reimburse the services.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-705 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-

1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of the amended rule identical to emergency (Supp. 83-3). Former Section R9-22-705 repealed, new Section R9-22-705 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment adopted effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (C) effective October 1, 1987; amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended subsections (A) and (C) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-706. Repealed**

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-706 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-706 repealed, new Section R9-22-706 adopted effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Amended as an emergency effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment adopted effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsections (A), (D), (E), (F), and (G) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (F) effective December 22, 1987 (Supp. 87-4). Amended subsections (A) and (F) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 10 A.A.R. 4656, effective January 1, 2005 (Supp. 04-4).

**R9-22-707. Repealed**

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**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-707 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Repealed as a permanent action effective May 16, 1983 (Supp. 83-3). New Section R9-22-707 adopted effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Former Section R9-22-707 repealed, new Section R9-22-707 adopted effective October 1, 1985 (Supp. 85-5). Former Section R9-22-707 repealed, new Section R9-22-707 adopted effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

**R9-22-708. Payments for Services Provided to Eligible American Indians**

- A. For purposes of this Article "IHS enrolled" or "enrolled with IHS" means an American Indian who has elected to receive covered services through IHS instead of a contractor.
- B. For an American Indian who is enrolled with IHS, AHCCCS shall pay IHS the most recent all-inclusive inpatient, outpatient or ambulatory surgery rates published by Health and Human Services (HHS) in the *Federal Register*, or a separately contracted rate with IHS, for AHCCCS-covered services provided in an IHS facility. AHCCCS shall reimburse providers for the Medicare coinsurance and deductible amounts required to be paid by the Administration or contractor in A.A.C. Chapter 29, Article 3 of this Title.
- C. When IHS refers an American Indian enrolled with IHS to a provider other than an IHS or tribal facility, the provider to whom the referral is made shall obtain prior authorization from AHCCCS for services as required under Articles 2, 7 or 12 of this Chapter.
- D. For an American Indian enrolled with a contractor, AHCCCS shall pay the contractor a monthly capitation payment.
- E. Once an American Indian enrolls with a contractor, AHCCCS shall not reimburse any provider other than IHS or a Tribal facility.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-708 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-708 repealed, new Section R9-22-708 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-708 renumbered and amended as Section R9-22-709, new Section R9-22-708 adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended by final rulemaking at 10 A.A.R. 4656, effective January 1, 2005 (Supp. 04-4). Amended by final

rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-709. Contractor's Liability to Hospitals for the Provision of Emergency and Post-stabilization Care**

A contractor is liable for emergency hospitalization and post-stabilization care as described in R9-22-210 and R9-22-210.01.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-709 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-709 repealed, new Section R9-22-709 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-709 renumbered and amended as Section R9-22-713, former Section R9-22-708 renumbered and amended as Section R9-22-709 effective October 1, 1985 (Supp. 85-5). 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. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 13 A.A.R. 856, effective May 5, 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 this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.*

**R9-22-710. Payments for Non-hospital Services**

- A. Capped fee-for-service. The Administration shall provide notice of changes in methods and standards for setting payment rates for services in accordance with 42 CFR 447.205, December 19, 1983, incorporated by reference and on file with the Administration and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
  1. Non-contracted services. In the absence of a contract that specifies otherwise, a contractor shall reimburse a provider or noncontracting provider for non-hospital services according to the Administration's capped-fee-for-service schedule.
  2. Procedure codes. The Administration shall maintain a current copy of the National Standard Code Sets mandated under 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004), incorporated by reference and on file with the Administration and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
    - a. A person shall submit an electronic claim consistent with 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004).
    - b. A person shall submit a paper claim using the National Standard Code Sets as described under 45

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CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004).

- c. The Administration may deny a claim for failure to comply with subsection (A) (2) (a) or (b).
3. Fee schedule. The Administration shall pay providers, including noncontracting providers, at the lesser of billed charges or the capped fee-for-service rates specified in subsections (A)(3)(a) through (A)(3)(d) unless a different fee is specified in a contract between the Administration and the provider, or is otherwise required by law.
  - a. Physician services. Fee schedules for payment for physician services are on file at the central office of the Administration for reference use during customary business hours.
  - b. Dental services. Fee schedules for payment for dental services are on file at the central office of the Administration for reference use during customary business hours.
  - c. Transportation services. Fee schedules for payment for transportation services are on file at the central office of the Administration for reference use during customary business hours. For dates of service beginning:
    - i. October 1, 2012 through September 30, 2013, the Administration and its contractors shall reimburse ambulance services at 68.59 percent of the ADHS rates that are in effect as of August 2, 2012.
    - ii. October 1, 2013 through September 30, 2014, the Administration and its contractors shall reimburse ambulance services at 68.59 percent of the ADHS rates that are in effect as of August 2, 2013.
    - iii. October 1, 2014 through September 30, 2015, the Administration and its contractors shall reimburse ambulance services at 74.74 percent of the ADHS rates that are in effect as of August 2, 2014.
  - d. Medical supplies and durable medical equipment (DME). Fee schedules for payment for medical supplies and DME are on file at the central office of the Administration for reference use during customary business hours. The Administration shall reimburse a provider once for purchase of DME during any two-year period, unless the Administration determines that DME replacement within that period is medically necessary for the member. Unless prior authorized by the Administration, no more than one repair and adjustment of DME shall be reimbursed during any two-year period.
- B. Pharmacy services. The Administration shall not reimburse pharmacy services unless the services are provided by a pharmacy having a subcontract with a Pharmacy Benefit Manager (PBM) contracted with AHCCCS. Except as specified in subsection (C), the Administration shall reimburse pharmacy services according to the terms of the contract.
- C. FQHC Pharmacy reimbursement.
  1. For purposes of this Section the following terms are defined:
    - a. "340B Drug Pricing Program" means the discount drug purchasing program described in 42 U.S.C 256b.
    - b. "340B Ceiling Price" means the maximum price that drug manufacturers can charge covered entities participating in the 340B Drug Pricing Program as reported by the drug manufacturer to HRSA.
    - c. "340B entity" means a covered entity, eligible to participate in the 340B Drug Pricing Program, as defined by the Health Resources and Human Services Administration.
    - d. "Actual Acquisition Cost (AAC)" means the purchase price of a drug paid by a pharmacy net of discounts, rebates, chargebacks and other adjustments to the price of the drug. The AAC excludes dispensing fees.
    - e. "Contracted Pharmacy" means an arrangement through which a 340B entity may contract with an outside pharmacy to provide comprehensive pharmacy services utilizing medications subject to 340B pricing.
    - f. "Dispensing Fee" means the amount paid for the professional services provided by the pharmacist for dispensing a prescription. The Dispensing Fee does not include any payment for the drugs being dispensed.
    - g. "Federally Qualified Health Center" means a public or private non-profit health care organization that has been identified by HRSA and certified by CMS as meeting the criteria under sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act and receives funds under section 330 of the Public Health Service Act.
    - h. "Federally Qualified Health Center Look-Alike" means a public or private non-profit health care organization that has been identified by HRSA and certified by CMS as meeting the definition of "health center" under section 330 of the Public Health Service Act, but does not receive grant funding under section 330.
    - i. "FQHC or FQHC Look-Alike pharmacy" means a pharmacy that dispenses drugs to FQHC or FQHC-LA patients and that is owned and/or operated by an FQHC/FQHC-LA or by an entity that reports the costs of an FQHC/FQHC-LA on its Medicare Cost Report, whether or not collocated with an FQHC or an FQHC Look-Alike.
  2. Effective the later of February 1, 2012, or CMS approval of a State Plan Amendment, an FQHC or FQHC Look-Alike shall:
    - a. Notify the AHCCCS provider registration unit of its status as a 340B covered entity no later than:
      - i. 30 days after the effective date of this Section;
      - ii. 30 days after registration with the Health Resources and Services Administration (HRSA) for participation in the 340B program, or
      - iii. The time of application to become an AHCCCS provider.
    - b. Provide the 340B pricing file to the AHCCCS Administration upon request. The 340B pricing file shall be provided in the file format as defined by AHCCCS.
    - c. Identify 340B drug claims submitted to the AHCCCS FFS PBM or the Managed Care Contractors' PBMs for reimbursement. The 340B drug claim identification and claims processing for a drug claim submission shall be consistent with claim instructions.

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tions issued and required by AHCCCS to identify such claims.

3. The FQHC and the FQHC Look-Alike pharmacies shall submit claims for AHCCCS members for drugs that are identified in the 340B pricing file, whether or not purchased under the 340B pricing file, with the lesser of:
  - a. The actual acquisition cost, or
  - b. The 340B ceiling price.
4. The AHCCCS Fee-for-Service and Managed Care Contractors' PBMs shall reimburse claims for drugs which are identified in the 340B pricing file dispensed by FQHC and FQHC Look -Alike pharmacies, whether or not purchased under the 340B pricing file, at the amount submitted under subsection (C)(3) plus a dispensing fee listed in the AHCCCS Capped Fee-For-Service Schedule unless a contract between the 340B entity and a Managed Care Contractor's PBM specifies a different dispensing fee.
5. Contracted pharmacies shall not submit claims for drugs dispensed under an agreement with the 340B entity as part of the 340B drug pricing program, and the AHCCCS Administration and Managed Care Contractors shall not reimburse such claims.
6. The AHCCCS Administration and Managed Care Contractors shall reimburse contracted pharmacies for drugs not dispensed under an agreement with the 340B entity as part of the 340B program at the price and dispensing fee set forth in the contract between the contracted pharmacy and the AHCCCS or its Managed Care Contractors' PBMs. Neither the Administration nor its Managed Care Contractors will reimburse a contracted pharmacy that does not have a contract with the Administration or MCO's PBM.
7. The AHCCCS Administration and its Managed Care Contractors shall reimburse FQHC and FQHC Look-Alike pharmacies for drugs that are not eligible under the 340B Drug Pricing Program at the price and dispensing fee set forth in their contract with the AHCCCS or its Managed Care Contractors' PBMs.
8. AHCCCS may periodically conduct audits to ensure compliance with this Section.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-710 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of amended rule identical to emergency (Supp. 83-3). Former Section R9-22-710 repealed, new Section R9-22-710 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985. The capped fee-for-service schedules, deleted from Section R9-22-710, are now on file at the central office of the Administration (Supp. 85-5). Amended subsections (B) through (D) effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective July 1, 1988 (Supp. 88-3). Amended subsection (B) effective April 27, 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 December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 11 A.A.R. 3830, effective

November 12, 2005 (Supp. 05-3). Amended by exempt rulemaking at 18 A.A.R. 212, effective February 1, 2012 (Supp. 12-1). Amended by exempt rulemaking at 18 A.A.R. 1971, effective August 1, 2012 (Supp. 12-3).

Amended by exempt rulemaking at 18 A.A.R. 2630, effective October 1, 2012 (Supp. 12-4). Amended by final rulemaking at 19 A.A.R. 1681, effective August 9, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3525, effective October 18, 2013 (Supp. 13-4)

**R9-22-711. Copayments**

- A. For purposes of this Article:
  1. A copayment is a monetary amount that a member pays directly to a provider at the time a covered service is rendered.
  2. An eligible individual is assigned to a hierarchy established in subsections (B) through (E), for the purposes of establishing a copayment amount.
  3. No refunds shall be made for a retroactive period if there is a change in an individual's status that alters the amount of a copayment.
- B. The following services are exempt from AHCCCS copayments for all members:
  1. Family planning services and supplies,
  2. Services related to a pregnancy or any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for a pregnant woman,
  3. Emergency services as described in 42 CFR 447.56(2)(i),
  4. All services paid on a fee-for-service basis,
  5. Preventive services, such as well visits, immunizations, pap smears, colonoscopies, and mammograms,
  6. Provider preventable services.
- C. The following individuals are exempt from AHCCCS copayments:
  1. An individual under age 19, including individuals eligible for the KidsCare Program in A.R.S. § 36-2982;
  2. An individual determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services;
  3. An individual eligible for the Arizona Long-Term Care Program in A.R.S. § 36-2931;
  4. An individual eligible for QMB under Chapter 29;
  5. An individual eligible for the Children's Rehabilitative Services program under A.R.S. § 36-2906(E);
  6. An individual receiving nursing facility or HCBS services under R9-22-216;
  7. An individual receiving hospice care as defined in 42 U.S.C. 1396d(o);
  8. An American Indian individual enrolled in a health plan and has received services through an IHS facility, tribal 638 facility or urban Indian health program;
  9. An individual eligible in the Breast and Cervical Cancer program as described under Article 20;
  10. An individual who is pregnant and through the postpartum period following the pregnancy;
  11. An individual with respect to whom child welfare services are made available under Part B of Title IV of the Social Security Act on the basis of being a child in foster care, without regard to age;
  12. An individual with respect to whom adoption or foster care assistance is made available under Part E of Title IV of the Social Security Act, without regard to age; and
  13. An adult eligible under R9-22-1427(E), with income at or below 106% of the FPL.
- D. Non-mandatory copayments. Unless otherwise listed in subsection (B) or (C), individuals under subsections (D)(1)

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through (6) are subject to the copayments listed in this subsection. A provider shall not deny a service when a member states to the provider an inability to pay a copayment.

1. A caretaker relative eligible under R9-22-1427(A);
2. An individual eligible for Young Adult Transitional Insurance (YATI) in A.R.S. § 36-2901(6)(a)(iii);
3. An individual eligible for State Adoption Assistance in R9-22-1433;
4. An individual eligible for Supplemental Security Income (SSI);
5. An individual eligible for SSI Medical Assistance Only (SSI/MAO) in Article 15; and
6. An individual eligible for the Freedom to Work program in A.R.S. § 36-2901(6)(g).
7. Copayment amount per service:
  - a. \$2.30 per prescription drug.
  - b. \$3.40 per outpatient visit, excluding an emergency room visit, if any of the services rendered during the visit are coded as evaluation and management services or non-emergent surgical procedures according to the National Standard Code Sets. An outpatient visit includes any setting where these services are performed such as a physician's office, an Ambulatory Surgical Center (ASC), or a clinic.
  - c. \$2.30 per visit, if a copayment is not being imposed under subsection (D)(7)(b) and any of the services rendered during the visit are coded as physical, occupational or speech therapy services according to the National Standard Code Sets.

**E. Mandatory copayments.**

1. Copayments for individuals eligible for Transitional Medical Assistance (TMA) under R9-22-1427(B)(1)(c)(i). Unless otherwise listed in subsection (C), an individual is required to pay the following copayments for prescription drugs and outpatient services unless the service is provided during an emergency room visit or the service is otherwise exempt under subsection (B). An outpatient visit includes any setting where these outpatient services are performed such as, an outpatient hospital, a physician's provider's office, HCBS setting, an Ambulatory Surgical Center (ASC), or a clinic:
  - a. \$2.30 per prescription drug.
  - b. \$4.00 per outpatient visit, if any of the services rendered during the visit are coded as evaluation and management services according to the National Standard Code Sets.
  - c. If a copayment is not being imposed under subsection (E)(1)(b), \$3.00 per visit if any of the services rendered during the visit are coded as physical, occupational or speech therapy services according to the National Standard Code Sets.
  - d. If a copayment is not being imposed under subsection (E)(1)(b) or (c), \$3.00 per visit, if any of the services rendered during the visit are coded as non-emergent surgical procedures according to the National Standard Code Sets.
2. Copayments for persons eligible under R9-22-1427(E) with income above 106% of the FPL and for persons eligible under A.R.S. §§ 36-2907.10 and 36-2907.11. Subject to CMS approval, unless otherwise listed in subsection (C), these individuals are required to pay the following copayments for prescription drugs and outpatient services unless the service is provided during an emergency room visit or the service is otherwise exempt

under subsection (B). An outpatient visit includes any setting where these outpatient services are performed such as, an outpatient hospital, a physician's provider's office, HCBS setting, an Ambulatory Surgical Center (ASC), or a clinic:

- a. \$4.00 per prescription drug.
  - b. \$5.00 per outpatient visit when the AHCCCS fee schedule for the visit code is a rate from \$50 to less than \$100, if any of the services rendered during the visit are coded as evaluation and management services according to the National Standard Code Sets.
  - c. \$10.00 per outpatient visit when the AHCCCS fee schedule for the visit code is a rate of \$100 or greater, if any of the services rendered during the visit are coded as evaluation and management services according to the National Standard Code Sets.
  - d. If a copayment is not being imposed under subsection (E)(2)(b) or (E)(2)(c), for services coded as physical, occupational or speech therapy services according to the National Standard Code Sets.
    - i. \$2.00 if the rate on the fee schedule is \$20 to \$39.99,
    - ii. \$4.00 if the rate on the fee schedule is \$40 to \$49.99, or
    - iii. \$5.00 if the rate on the fee schedule is \$50 and above per visit.
  - e. If a copayment is not being imposed under subsection (E)(2)(b) – (E)(2)(d), for services coded as non-emergent surgical procedures according to the National Standard Code Sets,
    - i. \$30.00 if the rate on the fee schedule is \$300 to \$499.99, or
    - ii. \$50.00 if the rate on the fee schedule is \$500 and above per visit.
  - f. Unless the individual is otherwise exempt in subsection (C) or the service is exempted under subsection (B) the individual is required to pay \$2.00 per trip for non-emergency transportation in an urban area.
  - g. Unless the individual is otherwise exempt in subsection (C) or the service is exempted under subsection (B) the individual is required to pay \$8.00 for non-emergency use of the emergency room.
  - h. Unless the individual is otherwise exempt in subsection (C) or the service is exempted under subsection (B) the individual is required to pay \$75 for an Inpatient stay.
3. The provider may deny a service if the member does not pay the copayment required by subsection (E), however, a provider may choose to reduce or waive copayments under this subsection on a case-by-case basis.

- F. A provider is responsible for collecting any copayment imposed under this Section.
- G. The total aggregate amount of copayments under subsections (D) or (E) may not exceed 5% of the family's income as applied on a quarterly basis. The member may establish that the aggregate limit has been met on a quarterly basis by providing the Administration with records of copayments incurred during the quarter. In addition, the Administration shall also use claims and encounters information available to the Administration to establish when a member's copayment obligation has reached 5% of the family's income.
- H. Reduction in payments to providers. The Administration and its contractors shall reduce the payment it makes to any pro-

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vider by the amount of a member's copayment obligation under subsection (E), regardless of whether the provider successfully collects the copayments described in this Section.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Sections R9-22-711 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-711 repealed, new Section R9-22-711 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4).

Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by exempt rulemaking at 9 A.A.R. 4557, effective October 1, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 2194, effective May 3, 2004 (Supp. 04-2). Amended by exempt rulemaking at 10 A.A.R. 4266, effective October 1, 2004 (Supp. 04-3). Amended by final rulemaking at 16 A.A.R. 1449, effective October 1, 2010 (Supp. 10-3). Section amended by exempt rulemaking at 18 A.A.R. 461, effective April 1, 2012 (Supp. 12-1). Section amended by final rulemaking at 19 A.A.R. 2954, effective November 11, 2013 (Supp. 13-3). Amended by exempt rulemaking at 20 A.A.R. 128, effective December 30, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 2755, effective January 1, 2015 (Supp. 14-3).

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

**R9-22-712. Reimbursement: General**

- A.** Inpatient and outpatient discounts and penalties. If a claim is pending for additional documentation required under A.R.S. § 36-2903.01(G)(4), the period during which the claim is pending is not used in the calculation of the quick-pay discounts and slow-pay penalties under A.R.S. § 36-2903.01(G)(5).
- B.** Inpatient and outpatient in-state or out-of-state hospital payments.
1. Payment for inpatient out-of-state hospital services for claims with discharge dates on or before September 30, 2014. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent statewide urban cost-to-charge ratio as determined in R9-22-712.01(6)(d).
  2. Payment for inpatient in-state hospital services for claims with discharge dates on or before September 30, 2014. AHCCCS shall reimburse an in-state provider of inpatient hospital services rendered with a discharge date on

3. Payment for inpatient in-state or out-of-state hospital services for claims with discharge dates on and after October 1, 2014 regardless of admission date. Subject to R9-22-718 and A.R.S. § 36-2905.01 regarding urban hospitals, a contractor shall reimburse an in-state or out-of-state provider of inpatient hospital services, at either a rate specified by subcontract or, in the absence of a subcontract, the DRG rate established by the Administration and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
  4. Outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse an out-of-state hospital for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the Administration shall pay the claim by multiplying the covered charges for the outpatient services by the statewide outpatient cost-to-charge ratio.
  5. Outpatient in-state hospital payments. A contractor shall reimburse an in-state provider of outpatient hospital services rendered on or after July 1, 2005, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10, A.R.S. § 36-2903.01 and other Sections of this Article. The terms of the subcontract are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
- C.** Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall allow the Administration access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or the Administration's designated representative in performance of the Administration's utilization control activities. The Administration shall deny a claim for failure to cooperate.
- D.** Prior authorization. The Administration or contractor may deny a claim if a provider fails to obtain prior authorization as required under R9-22-210.
- E.** Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers, to prepayment medical review or post-payment review, or both. The Administration shall conduct post-payment reviews consistent with A.R.S. § 36-2903.01 and may recoup erroneously paid claims.
- F.** Claim receipt.
1. The Administration's date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the system-generated claim reference number or system-generated date-specific number.
  2. Hospital claims are considered paid on the date indicated on disbursement checks.
  3. A denied claim is considered adjudicated on the date the claim is denied.
  4. Claims that are denied and are resubmitted are assigned new receipt dates.
  5. For a claim that is pending for additional supporting documentation specified in A.R.S. § 36-2903.01 or 36-2904, the Administration shall assign a new date of receipt upon receipt of the additional documentation.

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6. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. § 36-2903.01 or 36-2904, the Administration shall not assign a new date of receipt.
- G.** Outpatient hospital reimbursement. The Administration shall pay for covered outpatient hospital services provided to eligible persons with dates of service from March 1, 1993 through June 30, 2005, at the AHCCCS outpatient hospital cost-to-charge ratio, multiplied by the amount of the covered charges.
1. Computation of outpatient hospital reimbursement. The Administration shall compute the cost-to-charge ratio on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient operating and capital costs are included in the computation but outpatient medical education costs that are included in the inpatient medical education component are excluded. To calculate the outpatient hospital cost-to-charge ratio annually for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in R9-22-712.01. The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:
    - a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters for outpatient hospital services by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital by taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.
    - b. Cost-to-charge limit. To comply with 42 CFR 447.325, the Administration may limit cost-to-charge ratios to 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are non-covered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.
  2. New hospitals. The Administration shall reimburse new hospitals at the weighted statewide average outpatient hospital cost-to-charge ratio multiplied by covered charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for a new hospital until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing.
  3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in a specialty facility.
  4. Reimbursement requirements. To receive payment from the Administration, a hospital shall submit claims that are legible, accurate, error free, and have a covered charge greater than zero. The Administration shall not reimburse hospitals for emergency room treatment, observation hours or days, or other outpatient hospital services performed on an outpatient basis, if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation area, or other outpatient department. Services provided in the emergency room, observation area, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment.
  5. Rebasing. The Administration shall rebase the outpatient hospital cost-to-charge ratios at least every four years but no more than once a year using updated Medicare Cost Reports and claim and encounter data.
  6. If a hospital files an increase in its charge master for an existing outpatient service provided on or after July 1, 2004, and on or before June 30, 2005, which represents an aggregate increase in charges of more than 4.7%, the Administration shall adjust the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (5) by applying the following formula:  

$$CCR * [1.047 / (1 + \% \text{ increase})]$$
 Where "CCR" means the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (5) and "% increase" means the aggregate percentage increase in charges for outpatient services shown on the hospital charge master.  
 "Charge master" means the schedule of rates and charges as described under A.R.S. § 36-436 and the rules that relate to those rates and charges that are filed with the Director of the Arizona Department of Health Services.

**Historical Note**

Adopted as an emergency effective February 23, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to emergency (Supp. 83-3). Former Section R9-22-712 repealed, new Section R9-22-712 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-712 renumbered and amended as Section R9-22-1001 effective October 1, 1985 (Supp. 85-5). New Section R9-22-712 adopted under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective January 14, 1997 (Supp. 97-1). Amended by exempt rulemaking at 10 A.A.R. 3831, effective August 25, 2004 (Supp. 04-3). Amended by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 11 A.A.R. 3231, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by exempt rulemaking at 17 A.A.R. 1337, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.01. Inpatient Hospital Reimbursement for**

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**claims with admission dates and discharge dates from October 1, 1998 through September 30, 2014**

Inpatient hospital reimbursement. The Administration shall pay for covered inpatient acute care hospital services provided to eligible persons for claims with admission dates and discharge dates from October 1, 1998 through September 30, 2014, on a prospective reimbursement basis. The prospective rates represent payment in full, excluding quick-pay discounts, slow-pay penalties, and third-party payments for both accommodation and ancillary department services. The rates include reimbursement for operating and capital costs. The Administration shall make reimbursement for direct graduate medical education as described in A.R.S. § 36-2903.01. For payment purposes, the Administration shall classify each AHCCCS inpatient hospital day of care into one of several tiers appropriate to the services rendered. The rate for a tier is referred to as the tiered per diem rate of reimbursement. The number of tiers is seven and the maximum number of tiers payable per continuous stay is two. Payment of outlier claims, transplant claims, or payment to out-of-state hospitals, freestanding psychiatric hospitals, and other specialty facilities may differ from the inpatient hospital tiered per diem rates of reimbursement described in this Section.

1. Tier rate data. The Administration shall base tiered per diem rates effective on and after October 1, 1998 on Medicare Cost Reports for Arizona hospitals for the fiscal year ending in 1996 and a database consisting of inpatient hospital claims and encounters for dates of service matching each hospital's 1996 fiscal year end.
  - a. Medicare Cost Report data. Because Medicare Cost Report years are not standard among hospitals and were not audited at the time of the rate calculation, the Administration shall inflate all the costs to a common point in time as described in subsection (2) for each component of the tiered per diem rates. The Administration shall not make any changes to the tiered per diem rates if the Medicare Cost Report data are subsequently updated or adjusted. If a single Medicare Cost Report is filed for more than one hospital, the Administration shall allocate the costs to each of the respective hospitals. A hospital shall submit information to assist the Administration in this allocation.
  - b. Claim and encounter data. For the database, the Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were accepted and processed by the Administration at the time the database was developed for rates effective on and after October 1, 1998. The Administration shall subject the claim and encounter data to a series of data quality, reasonableness, and integrity edits and shall exclude from the database or adjust claims and encounters that fail these edits. The Administration shall also exclude from the database the following claims and encounters:
    - i. Those missing information necessary for the rate calculation,
    - ii. Medicare crossovers,
    - iii. Those submitted by freestanding psychiatric hospitals, and
    - iv. Those for transplant services or any other hospital service that the Administration would pay on a basis other than the tiered per diem rate.
2. Tier rate components. The Administration shall establish inpatient hospital prospective tiered per diem rates based on the sum of the operating and capital components. The

rate for the operating component is a statewide rate for each tier except for the NICU and Routine tiers, which are based on peer groups. The rate for the capital component is a blend of statewide and hospital-specific values, as described in A.R.S. § 36-2903.01. The Administration shall use the following methodologies to establish the rates for each of these components.

- a. Operating component. Using the Medicare Cost Reports and the claim and encounter database, the Administration shall compute the rate for the operating component as follows:
  - i. Data preparation. The Administration shall identify and group into department categories, the Medicare Cost Report data that provide ancillary department cost-to-charge ratios and accommodation costs per day. To comply with 42 CFR 447.271, the Administration shall limit cost-to-charge ratios to 1.00 for each ancillary department.
  - ii. Operating cost calculation. To calculate the rate for the operating component, the Administration shall derive the operating costs from claims and encounters by combining the Medicare Cost Report data and the claim and encounter database for all hospitals. In performing this calculation, the Administration shall match the revenue codes on the claims and encounters to the departments in which the line items on the Medicare Cost Reports are grouped. The ancillary department cost-to-charge ratios for a particular hospital are multiplied by the covered ancillary department charges on each of the hospital's claims and encounters. The AHCCCS inpatient days of care on the particular hospital's claims and encounters are multiplied by the corresponding accommodation costs per day from the hospital's Medicare Cost Report. The ancillary cost-to-charge ratios and accommodation costs per day do not include medical education and capital costs. The Administration shall inflate the resulting operating costs for the claims and encounters of each hospital to a common point in time, December 31, 1996, using the DRI inflation factor and shall reduce the operating costs for the hospital by an audit adjustment factor based on available national data and Arizona historical experience in adjustments to Medicare reimbursable costs. The Administration shall further inflate operating costs to the midpoint of the rate year (March 31, 1999).
  - iii. Operating cost tier assignment. After calculating the operating costs, the Administration shall assign the claims and encounters used in the calculation to tiers based on diagnosis, procedure, or revenue codes, or NICU classification level, or a combination of these. For the NICU tier, the Administration shall further assign claims and encounters to NICU Level II or NICU Level III peer groups, based on the hospital's certification by the Arizona Perinatal Trust. For the Routine tier, the Administration shall further assign claims and encounters to the general acute care hospital or rehabilitation

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- hospital peer groups, based on state licensure by the Department of Health Services. For claims and encounters assigned to more than one tier, the Administration shall allocate ancillary department costs to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (6).
- iv. Operating rate calculation. The Administration shall set the rate for the operating component for each tier by dividing total statewide or peer group hospital costs identified in this subsection within the tier by the total number of AHCCCS inpatient hospital days of care reflected in the claim and encounter database for that tier.
  - b. Capital component. For rates effective October 1, 1999 the capital component is calculated as described in A.R.S. § 36-2903.01.
  - c. Statewide inpatient hospital cost-to-charge ratio. For dates of service prior to October 1, 2007, the statewide inpatient hospital cost-to-charge ratio is used for payment of outliers, as described in subsections (4), (5), and (6), and out-of-state hospitals, as described in R9-22-712(B). The Administration shall calculate the AHCCCS statewide inpatient hospital cost-to-charge ratio by using the Medicare Cost Report data and claim and encounter database described in subsection (1) and used to determine the tiered per diem rates. For each hospital, the covered inpatient days of care on the claims and encounters are multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. Similarly, the covered ancillary department charges on the claims and encounters are multiplied by the ancillary department cost-to-charge ratios. The accommodation costs per day and the ancillary department cost-to-charge ratios for each hospital are determined in the same way described in subsection (2)(a) but include costs for operating and capital. The Administration shall then calculate the statewide inpatient hospital cost-to-charge ratio by summing the covered accommodation costs and ancillary department costs from the claims and encounters for all hospitals and dividing by the sum of the total covered charges for these services for all hospitals.
  - d. Unassigned tiered per diem rates. If a hospital has an insufficient number of claims to set a tiered per diem rate, the Administration shall pay that hospital the statewide average rate for that tier.
3. Tier assignment. The Administration shall assign AHCCCS inpatient hospital days of care to tiers based on information submitted on the inpatient hospital claim or encounter including diagnosis, procedure, or revenue codes, peer group, NICU classification level, or a combination of these.
    - a. Tier hierarchy. In assigning claims for AHCCCS inpatient hospital days of care to a tier, the Administration shall follow the Hierarchy for Tier Assignment through September 30, 2014 in R9-22-712.09. The Administration shall not pay a claim for inpatient hospital services unless the claim meets medical review criteria and the definition of a clean claim. The Administration shall not pay for a hospital stay on the basis of more than two tiers, regardless of the number of interim claims that are submitted by the hospital.
    - b. Tier exclusions. The Administration shall not assign to a tier or pay AHCCCS inpatient hospital days of care that do not occur during a period when the person is eligible. Except in the case of death, the Administration shall pay claims in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, including same day transfers, as an outpatient hospital claim. The Administration shall pay same day admit and discharge claims that qualify for either the maternity or nursery tiers based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.
    - c. Seven tiers. The seven tiers are:
      - i. Maternity. The Administration shall identify the Maternity Tier by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the Administration shall pay the AHCCCS inpatient hospital days of care on the claim at the maternity tiered per diem rate.
      - ii. NICU. The Administration shall identify the NICU Tier by a revenue code. A hospital does not qualify for the NICU tiered per diem rate unless the hospital is classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the NICU tier and have a NICU revenue code at the NICU tiered per diem rate. The Administration shall pay any remaining AHCCCS inpatient hospital day on the claim that does not meet NICU Level II or NICU Level III medical review criteria at the nursery tiered per diem rate.
      - iii. ICU. The Administration shall identify the ICU Tier by a revenue code. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that meets the medical review criteria for the ICU tier and has an ICU revenue code at the ICU tiered per diem rate. The Administration may classify any AHCCCS inpatient hospital days on the claim without an ICU revenue code, as surgery, psychiatric, or routine tiers.
      - iv. Surgery. The Administration shall identify the Surgery Tier by a revenue code and a valid surgical procedure code that is not on the AHCCCS excluded surgical procedure list. The excluded surgical procedure list identifies minor procedures such as sutures that do not require the same hospital resources as other procedures. The Administration shall only split a surgery tier with an ICU tier. AHCCCS shall pay at the surgery tier rate only when the surgery occurs on a date during which the member is eligible.
      - v. Psychiatric. The Administration shall identify the Psychiatric Tier by either a psychiatric rev-

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- enue code and a psychiatric diagnosis or any routine revenue code if all diagnosis codes on the claim are psychiatric. The Administration shall not split a claim with AHCCCS inpatient hospital days of care in the psychiatric tier with any tier other than the ICU tier.
- vi. Nursery. The Administration shall identify the Nursery Tier by a revenue code. The Administration shall not split a claim with AHCCCS inpatient hospital days of care in the nursery tier with any tier other than the NICU tier.
  - vii. Routine. The Administration shall identify the Routine Tier by revenue codes. The routine tier includes AHCCCS inpatient hospital days of care that are not classified in another tier or paid under any other provision of this Section. The Administration shall not split the routine tier with any tier other than the ICU tier.
4. Annual update. The Administration shall annually update the inpatient hospital tiered per diem rates through September 30, 2011.
  5. New hospitals. For rates effective on and after October 1, 1998, the Administration shall pay new hospitals the statewide average rate for each tier, as appropriate. The Administration shall update new hospital tiered per diem rates through September 30, 2011.
  6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers under this Section by multiplying the covered charges on a claim by the Medicare Urban or Rural Cost-to-Charge Ratio. The Urban cost-to-charge ratio will be used for hospitals located in a county of 500,000 residents or more. The Rural cost-to-charge ratio will be used for hospitals located in a county of fewer than 500,000 residents.
    - a. Outlier criteria. For rates effective on and after October 1, 1998, the Administration set the statewide outlier cost threshold for each tier at the greater of three standard deviations from the statewide mean operating cost per day within the tier, or two standard deviations from the statewide mean operating cost per day across all the tiers. If the covered costs per day on a claim exceed the urban or rural cost threshold for a tier, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the applicable Medicare Urban or Rural CCR. The resulting amount will be the outlier payment. If there are two tiers on a claim, the Administration shall determine whether the claim is an outlier by using a weighted threshold for the two tiers. The weighted threshold is calculated by multiplying each tier rate by the number of AHCCCS inpatient hospital days of care for that tier and dividing the product by the total tier days for that hospital. Routine maternity stays shall be excluded from outlier reimbursement. A routine maternity is any one-day stay with a delivery of one or two babies. A routine maternity stay will be paid at tier.
    - b. Update. The CCR is updated annually by the Administration for dates of service beginning October 1, using the most current Medicare cost-to-charge ratios published or placed on display by CMS by August 31 of that year. The Administration shall update the outlier cost thresholds for each hospital through September 30, 2011 as described under A.R.S. § 36-2903.01. For inpatient hospital admissions with begin dates of service on and after October 1, 2011, AHCCCS will increase the outlier cost thresholds by 5% of the thresholds that were effective on September 30, 2011.
  - c. Medicare Cost-to-Charge Ratio Phase-In. AHCCCS shall phase in the use of the Medicare Urban or Rural Cost-to-Charge Ratios for outlier determination, calculation and payment. The three-year phase-in does not apply to out-of-state or new hospitals.
    - i. Medicare Cost-to-Charge Ratio Phase-In outlier determination and threshold calculation. For outlier claims with dates of service on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust each hospital specific inpatient cost-to-charge ratio in effect on September 30, 2007 by subtracting one-third of the difference between the hospital specific inpatient cost-to-charge ratio and the effective Medicare Urban or Rural Cost-to-Charge Ratio. For outlier claims with dates of service on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust each hospital specific inpatient cost-to-charge ratio in effect on September 30, 2007 by subtracting two-thirds of the difference between the hospital specific inpatient cost-to-charge ratio and the effective Medicare Urban or Rural Cost-to-Charge Ratio. The adjusted hospital specific inpatient cost-to-charge ratios shall be used for all calculations using the Medicare Urban or Rural Cost-to-Charge Ratios, including outlier determination, and threshold calculation.
    - ii. Medicare Cost-to-Charge Ratio Phase-In calculation for payment. For payment of outlier claims with dates of service on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust the statewide inpatient hospital cost-to-charge ratio in effect on September 30, 2007 by subtracting one-third of the difference between the statewide inpatient hospital cost-to-charge ratio and the effective Medicare urban or rural cost-to-charge ratio. For payment of outlier claims with dates of service on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust the statewide inpatient hospital cost-to-charge ratio in effect on September 30, 2007 by subtracting two-thirds of the difference between the statewide inpatient hospital cost-to-charge ratio and the effective Medicare urban or rural cost-to-charge ratio.
    - iii. Medicare Cost-to-Charge Ratio for outlier determination, threshold calculation, and payment. For outlier claims with dates of service on or after October 1, 2009, the full Medicare Urban or Rural Cost-to-Charge Ratios shall be utilized for all outlier calculations.
  - d. Cost-to-Charge Ratio used for qualification and payment of outlier claims.
    - i. For qualification and payment of outlier claims with begin dates of service on or after April 1, 2011 through September 30, 2011, the CCR

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- will be equal to 95% of the ratios in effect on October 1, 2010.
- ii. For qualification and payment of outlier claims with begin dates of service on or after October 1, 2011, the CCR will be equal to 90.25% of the most recent published Urban or Rural Medicare CCR as described in subsection (6)(b).
  - iii. For qualification and payment of outlier claims with begin dates of service on or after October 1, 2011 through September 30, 2012, AHCCCS will reduce the cost-to-charge ratio determined under subsection (6)(d)(ii) for a hospital that filed a charge master with ADHS on or after April 1, 2011 by an additional percentage equal to the total percent increase reported on the charge master.
  - iv. Subject to approval by CMS, for qualification and payment of outlier claims with begin dates of service on or after October 1, 2012, AHCCCS will reduce the cost-to-charge ratio determined under subsection (6)(d)(ii) for a hospital that filed a charge master with ADHS on or after June 1, 2012 by an additional percentage equal to the total percent increase reported on the charge master.
7. Transplants. The Administration shall reimburse hospitals for an AHCCCS inpatient stay in which a covered transplant as described in R9-22-206 is performed through the terms of the relevant contract. If the Administration and a hospital that performs transplant surgery on an eligible person do not have a contract for the transplant surgery, the Administration shall not reimburse the hospital more than what would have been paid to the contracted hospital for that same surgery.
  8. Ownership change. The Administration shall not change any of the components of a hospital's tiered per diem rates upon an ownership change.
  9. Psychiatric hospitals. The Administration shall pay free-standing psychiatric hospitals an all-inclusive per diem rate based on the contracted rates used by the Department of Health Services.
  10. Specialty facilities. The Administration may negotiate, at any time, reimbursement rates for inpatient specialty facilities or inpatient hospital services not otherwise addressed in this Section as provided by A.R.S. § 36-2903.01. For purposes of this subsection, "specialty facility" means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.
  11. Outliers for new hospitals. Outliers for new hospitals will be calculated using the Medicare Urban or Rural Cost-to-Charge Ratio times covered charges. If the resulting cost is equal to or above the cost threshold, the claim will be paid at the Medicare Urban or Rural Cost-to-Charge ratio.
  12. Reductions to tiered per diem payment for inpatient hospital services. Inpatient hospital admissions with begin dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the tiered per diem rates in effect on September 30, 2011.
- ing at 17 A.A.R. 1337, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.02. Reserved**

**R9-22-712.03. Reserved**

**R9-22-712.04. Reserved**

**R9-22-712.05. Graduate Medical Education Fund Allocation**

**A.** Graduate medical education (GME) reimbursement as of September 30, 1997. Subject to legislative appropriation, the Administration shall make a distribution based on direct graduate medical education costs as described in A.R.S. § 36-2903.01(G)(9)(a).

**B.** Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for the expansions of GME programs approved by the Administration to hospitals for direct program costs eligible for funding under A.R.S. § 36-2903.01(G)(9)(b). A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (B)(3).

1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (B) if all of the following apply:

- a. It is a hospital in Arizona that is the sponsoring institution of, or a participating institution in, one or more of the GME programs in Arizona;
- b. It incurs direct costs for the training of residents in the GME programs, which costs are or will be reported on the hospital's Medicare Cost Report;
- c. It is not administered by or does not receive its primary funding from an agency of the federal government.

2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (B)(4) the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (B)(1)(c):

- a. Filled resident positions in approved programs established as of October 1, 1999 at hospitals that receive funding as described in A.R.S. § 36-2903.01(G)(9)(a) that are additional to the number of resident positions that were filled as of October 1, 1999; and
- b. All filled resident positions in approved programs other than GME programs described in A.R.S. § 36-2903.01(G)(9)(a) that were established before July 1, 2006.

3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (B) shall provide the applicable information listed in this subsection to the Administration:

- a. A GME program shall provide all of the following:
  - i. The program name and number assigned by the accrediting organization;
  - ii. The original date of accreditation;

#### Historical Note

New Section made by final rulemaking at 11 A.A.R. 3231, effective October 1, 2005 (Supp. 05-3). Amended by exempt rulemaking at 13 A.A.R. 3190, effective October 1, 2007 (Supp. 07-3). Amended by exempt rulemak-

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- iii. The names of the sponsoring institution and all participating institutions current as of the date of reporting;
- iv. The number of approved resident positions and the number of filled resident positions current as of the date of reporting;
- v. For programs established as of October 1, 1999, the number of resident positions that were filled as of October 1, 1999, if the program has not already provided this information to the Administration;
- b. A hospital seeking a distribution under subsection (B) shall provide all of the following that apply:
  - i. If the hospital uses the Intern and Resident Information System (IRIS) for tracking and reporting its resident activity to the fiscal intermediary, copies of the IRIS master and assignment files for the hospital's two most recently completed Medicare cost reporting years as filed with the fiscal intermediary;
  - ii. If the hospital does not use the IRIS or has less than two cost reporting years available in the form of the IRIS master and assignment files, the information normally contained in the IRIS master and assignment files in an alternative format for the hospital's two most recently completed Medicare cost reporting years;
  - iii. At the request of the Administration, a copy of the hospital's Medicare Cost Report or any part of the report for the most recently completed cost reporting year.
- 4. Allocation of expansion funds. Annually the Administration shall allocate available funds to each approved GME program in the following manner:
  - a. Information provided by hospitals under subsection (B)(3)(b) shall be used to determine the program in which each eligible resident is enrolled and the number of days that each eligible resident worked in any area of the hospital complex or in a non-hospital setting under agreement with the reporting hospital during the period of assignment to that hospital. For this purpose, the Administration shall use data relating to the most recent 12-month period that is common to all information provided under subsections (B)(3)(b)(i) and (ii).
  - b. The number of eligible residents allocated to each participating institution within each approved GME program shall be determined as follows:
    - i. Total the number of days determined for each participating institution under subsection (B)(4)(a) and divide each total by 365.
    - ii. Proportionally adjust the result of subsection (B)(4)(b)(i) for each participating institution within each program according to the number of residents determined to be eligible under subsection (B)(2).
  - c. The number of allocated eligible residents determined under subsection (B)(4)(b)(ii) shall be adjusted for Arizona Medicaid utilization using the most recent Medicare Cost Report information on file with the Administration as of the date of reporting under subsection (B)(3) and the Administration's inpatient hospital claims and encounter data for the time period corresponding to the Medicare Cost Report information for each hospital. The Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were adjudicated by the Administration as of the date of reporting under subsection (B)(3). The Medicaid-adjusted eligible residents shall be determined as follows:
    - i. For each hospital, the total AHCCCS inpatient hospital days of care shall be divided by the total Medicare Cost Report inpatient hospital days, multiplied by 100 and rounded up to the nearest multiple of 5 percent.
    - ii. The number of allocated eligible residents determined for each participating hospital under subsection (B)(4)(b)(ii) shall be multiplied by the percentage derived under subsection (B)(4)(c)(i) for that hospital. The number of allocated eligible residents determined under subsection (B)(4)(b)(ii) for a participating institution that is not a hospital and not a health care facility made ineligible under subsection (B)(1)(c) shall be multiplied by the percentage derived under subsection (B)(4)(c)(i) for the program's sponsoring institution or, if the sponsoring institution is not a hospital, the sponsoring institution's affiliated hospital. The number of allocated eligible residents determined under subsection (B)(4)(b)(ii) for a participating institution that is made ineligible under subsection (B)(1)(c) shall be multiplied by zero percent.
  - d. The total allocation for each approved program shall be determined by multiplying the Medicaid-adjusted eligible residents determined under subsection (B)(4)(c)(ii) by the per-resident conversion factor determined below and totaling the resulting dollar amounts for all participating institutions in the program. The per-resident conversion factor shall be determined as follows:
    - i. Calculate the total direct GME costs from the most recent Medicare Cost Reports on file with the Administration for all hospitals that have reported such costs.
    - ii. Calculate the total allocated residents determined under subsection (B)(4)(b)(i) for those hospitals described under subsection (B)(4)(d)(i).
    - iii. Divide the total GME costs calculated under subsection (B)(4)(d)(i) by the total allocated residents calculated under subsection (B)(4)(d)(ii).
- 5. Distribution of expansion funds. On an annual basis subject to available funds, the Administration shall distribute the allocated amounts determined under subsection (B)(4) in the following manner:
  - a. The allocated amounts shall be distributed in the following order of priority:
    - i. To eligible hospitals that do not receive funding in accordance with A.R.S. § 36-2903.01(G)(9)(a) for the direct costs of programs established before July 1, 2006;
    - ii. To eligible hospitals that receive funding in accordance with A.R.S. § 36-2903.01(G)(9)(a) for the direct costs of programs established before July 1, 2006;

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- b. The allocated amounts shall be distributed to the eligible hospitals in each approved program in proportion to the number of Medicaid-adjusted eligible residents allocated to each hospital within that program under subsection (B)(4)(c)(ii).
- c. If funds are insufficient to cover all distributions within any priority group described under subsection (B)(5)(a), the Administration shall adjust the distributions proportionally within that priority group.
- C. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for the expansions of GME programs approved by the Administration to hospitals for direct program costs eligible for funding under A.R.S. § 36-2903.01(G)(9)(c)(i). A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (C)(3).
1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (C) if it meets all the conditions of subsections (B)(1)(a) through (c).
  2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (C)(4), the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (B)(1)(c):
    - a. All filled resident positions in approved programs established on or after July 1, 2006; and
    - b. For approved programs established on or after July 1, 2006 that have been established for less than one year as of the date of reporting under subsection (C)(3) and have not yet filled their first-year resident positions, all prospective residents reasonably expected by the program to be enrolled as a result of the most recently completed annual resident match.
  3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (C) shall provide to the Administration:
    - a. A GME program shall provide all of the following:
      - i. The requirements of subsections (B)(3)(a)(i) through (iv);
      - ii. The academic year rotation schedule on file with the program current as of the date of reporting; and
      - iii. For programs described under subsection (C)(2)(b), the number of residents expected to be enrolled as a result of the most recently completed annual resident match.
    - b. A hospital seeking a distribution under subsection (C) shall provide the requirements of subsection (B)(3)(b).
  4. Allocation of expansion funds. Annually the Administration shall allocate available funds to approved GME programs in the following manner:
    - a. Information provided by hospitals in accordance with subsection (B)(3)(b) shall be used to determine the program in which each eligible resident is enrolled and the number of days that each eligible resident worked in any area of the hospital complex or in a non-hospital setting under agreement with the reporting hospital during the period of assignment to that hospital. For this purpose, the Administration shall use data relating to the most recent 12-month period that is common to all information provided in accordance with subsections (B)(3)(b)(i) and (ii).
- b. For approved programs whose resident activity is not represented in the information provided in accordance with subsection (B)(3)(b), information provided by GME programs under subsection (C)(3)(a) shall be used to determine the number of days that each eligible resident is expected to work at each participating institution.
- c. The number of eligible residents allocated to each participating institution for each approved GME program shall be determined by totaling the number of days determined under subsections (C)(4)(a) and (b) and dividing the totals by 365.
- d. The number of allocated residents determined under subsection (C)(4)(c) shall be adjusted for Arizona Medicaid utilization in accordance with subsection (B)(4)(c).
- e. The total allocation for each approved program shall be determined in accordance with subsection (B)(4)(d).
5. Distribution of expansion funds. On an annual basis subject to available funds, the Administration shall distribute the allocated amounts determined under subsection (C)(4) to the eligible hospitals in each approved program in proportion to the number of Medicaid-adjusted eligible residents allocated to each within that program under subsection (C)(4)(d).
- D. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for GME programs approved by the Administration to hospitals for indirect program costs eligible for funding under A.R.S. § 36-2903.01(G)(9)(c)(ii). A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (D)(3).
1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (D) if all of the following apply:
    - a. It is a hospital in Arizona that is the sponsoring institution of, or a participating institution in, one or more of the GME programs in Arizona or is the base hospital for one or more of the GME programs in Arizona whose sponsoring institutions are not hospitals;
    - b. It incurs indirect program costs for the training of residents in the GME programs, which are or will be calculated on the hospital's Medicare Cost Report or are reimbursable under the Children's Hospitals Graduate Medical Education Payment Program administered by HRSA;
    - c. It is not administered by or does not receive its primary funding from an agency of the federal government.
  2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (D)(4) the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (D)(1)(c):

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- a. Any filled resident position in an approved program that includes a rotation of at least one month per year in a county other than Maricopa or Pima whose population was less than 500,000 persons at the time the residency rotation was added to the academic year rotation schedule;
  - b. For approved programs that have been established for less than one year as of the date of reporting under subsection (D)(3) and have not yet filled their first-year resident positions, all prospective residents reasonably expected by the program to be enrolled as a result of the most recently completed annual resident match who will perform rotations of at least one month per year in a county other than Maricopa or Pima whose population was less than 500,000 persons at the time the residency rotation was added to the academic year rotation schedule.
3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (D) shall provide to the Administration:
    - a. A GME program shall provide all of the following:
      - i. The requirements of subsections (B)(3)(a)(i) through (iv);
      - ii. The academic year rotation schedule on file with the program current as of the date of reporting;
      - iii. For programs described under subsection (D)(2)(c), the number of residents expected to be enrolled as a result of the most recently completed annual resident match.
    - b. A hospital seeking a distribution under subsection (D) shall provide the requirements of subsection (B)(3)(b)(iii).
  4. Allocation of funds for indirect program costs. Annually the Administration shall allocate available funds to approved GME programs in the following manner:
    - a. Using the information provided by programs under subsection (D)(3), the Administration shall determine for each program the number of residents in the program who are eligible under subsection (D)(2) and the number of months per year that each eligible resident will perform rotations in counties described by subsection (D)(2), multiply the number of eligible residents by the number of months and multiply the result by the per resident per month conversion factor determined under subsection (D)(4)(b).
    - b. Using the most recent Medicare Cost Reports on file with the Administration for all hospitals that have calculated a Medicare indirect medical education payment, the Administration shall determine a per resident per month conversion factor as follows:
      - i. Calculate each hospital's Medicare share by dividing the Medicare inpatient discharges on the Medicare Cost Report by the total inpatient hospital discharges on the Medicare Cost Report.
      - ii. Calculate the ratio of residents to beds by dividing the total allocated residents described in subsection (B)(4)(d)(ii) by the number of bed days available from the Medicare Cost Report and dividing the result by the number of days in the cost reporting period.
      - iii. Calculate the indirect medical education adjustment factor by adding 1 to the value calculated in (D)(4)(b)(ii), multiplying the result by the exponential value 0.405, subtracting 1 from the result, and multiplying that result by 1.35.
      - iv. Calculate each hospital's total indirect medical education cost by adding the DRG amounts other than outlier payments from the Medicare cost report and the managed care simulated payments from the Medicare Cost Report, multiplying the total by the indirect medical education adjustment factor determined in (D)(4)(b)(iii) and dividing the result by the Medicare share determined in (D)(4)(b)(i).
      - v. Calculate each hospital's Medicaid indirect medical education cost by multiplying the amount determined in (D)(4)(b)(iv) by the value determined in subsection (B)(4)(c)(i).
      - vi. Total the amounts determined in (D)(4)(b)(v) for all hospitals, divide the result by the total allocated residents described in subsection (B)(4)(d)(ii) for all hospitals, and divide that result by 12.
  5. Distribution of funds for indirect program costs. On an annual basis subject to available funds, the Administration shall distribute to each eligible hospital the amount calculated for the hospital at subsection (D)(4)(a).
- E. Reallocation of funds. If funds appropriated for subsection (B) are not allocated by the Administration and funds appropriated for subsections (C) and (D) are insufficient to cover all distributions under subsections (C)(5) and (D)(5), the funds not allocated under subsection (B) shall be allocated under subsections (C) and (D) to the extent of the calculated distributions. If funds are insufficient to cover all distributions under subsections (C)(5) and (D)(5), the Administration shall adjust the distributions proportionally. If funds appropriated for subsections (C) and (D) are not allocated by the Administration and funds appropriated for subsection (B) are insufficient to cover all distributions under subsection (B)(5), the funds not allocated under subsections (C) and (D) shall be allocated under subsection (B) to the extent of the calculated distributions.
  - F. The Administration may enter into intergovernmental agreements with local, county, and tribal governments wherein local, county and tribal governments may transfer funds or certify public expenditures to the Administration. Such funds or certification, subject to approval by CMS, will be used to qualify for additional federal funds. Those funds will be used for the purposes of reimbursing hospitals that are eligible under subsection (D)(1) and specified by the local, county, or tribal government for indirect program costs other than those reimbursed under subsection (D). The Administration shall allocate available funds in accordance with subsection (D) except that reimbursement with such funds is not limited to resident positions or rotations in counties with populations of less than 500,000 persons. On an annual basis subject to available funds, the Administration shall distribute to each eligible hospital the greatest among the following amounts, less any amounts distributed under subsection (D)(5):
    1. The amount that results from multiplying the total number of eligible residents allocated to the hospital under subsection (B)(4)(d)(ii) by 12 by the per resident per month conversion factor determined under subsection (D)(4)(b);

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2. The amount calculated for the hospital at subsection (D)(4)(b)(v);
3. The median of all amounts calculated at subsection (D)(4)(b)(v) if the hospital does not have an indirect medical education payment calculated on the Medicare Cost Report because it is a new training hospital; or
4. If the hospital does not have an indirect medical education payment calculated on the Medicare Cost Report because it is a children's hospital, the median Medicaid indirect medical education payment costs shall be calculated as follows:
  - a. For each hospital with indirect medical education costs on the Medicare Cost Report, determine a per resident total indirect medical education cost by dividing the total indirect medical education costs determined under subsection (D)(4)(b) by the number of filled resident positions under subsection (B)(2).
  - b. Determine the median per resident amount under subsection (F)(4)(a).
  - c. For each hospital without an indirect medical education component on the Medicare cost report, multiply the median per resident amount under subsection (F)(4)(b) by the number of filled resident positions under subsection (B)(2) for that hospital and by the Medicaid utilization percent for that hospital determined in subsection (B)(4)(c)(i).
- c. It is not administered by or does not receive its primary funding from an agency of the federal government;
- d. It has established a new GME program or expanded the number of residents or fellows in an existing GME program on or after July 1, 2020.
3. Eligible positions. For purposes of determining distributions under this Section the following resident and fellowship positions qualify to the extent that the training takes place in Arizona at an eligible health care facility:
  - a. Filled resident or fellow positions in approved programs which began on or after July 1, 2020;
  - b. Eligible positions do not include residents or fellows that receive payments for services under the Access to Professional Services Initiative (APSI) program established in the Contractors' prepaid capitation contracts with the Administration.
4. Annual Reporting
  - a. By December 15 of each year, a GME program shall provide all of the following information for GME programs and positions which are expected to be eligible for funding under this Section as of the upcoming academic year (i.e., July 1 to June 30 of each year):
    - i. The program name and number assigned by the accrediting organization if available;
    - ii. The original date of accreditation if available;
    - iii. The names of the sponsoring institution and all participating institutions expected as of the date of reporting;
    - iv. The number of anticipated resident and fellowship positions eligible for funding as of the upcoming academic year;
    - v. The number of months or partial months during the upcoming academic year that each resident or fellow is expected to work in each hospital or in a non-hospital setting under agreement between the non-hospital setting and the reporting hospital;
    - vi. The academic year of anticipated resident and fellowship positions;
    - vii. The length of the program; and
    - viii. The names and other information requested by AHCCCS to ensure the total GME distributions for each eligible position are not greater than the costs for each eligible position in the Intern and Resident Information System (IRIS) file.
  - b. By December 15 of each year, a GME program located in a county with a population of less than 500,000 persons shall provide the estimated one-time and ongoing costs for each program which it expects to be eligible for funding.
  - c. By September 1 of each year, a GME program shall provide the actual name of residents and fellows hired in the current academic year and other information requested by AHCCCS to ensure that total GME distributions for the eligible position are not greater than the costs for each eligible position in the IRIS file.

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 1782, effective June 30, 2007 (Supp. 07-2). Amended by exempt rulemaking at 13 A.A.R. 4032, effective November 1, 2007 (Supp. 07-4). Amended by final rulemaking at 21 A.A.R. 3469, effective January 30, 2016 (Supp. 15-4). Amended by final rulemaking at 24 A.A.R. 185, effective January 9, 2018 (Supp. 18-1). Amended by final rulemaking at 24 A.A.R. 3321, effective January 5, 2019 (Supp. 18-4).

**R9-22-712.06. Supplemental Graduate Medical Education Fund Allocation**

- A. Gradual Medical Education (GME) reimbursement as of July 1, 2020.
  1. In addition to distributions according to Section R9-22-712.05, and subject to the availability of funds and approval by CMS, the Administration shall annually distribute monies appropriated for the GME programs approved by the Administration to hospitals for direct and indirect costs for graduate medical education programs which were established or expanded on or after July 1, 2020. The Administration shall estimate the distributions using information possessed by the Administration as of December 15 of each calendar year. The actual distributions will be made using information possessed by the Administration as of September first of the year in which the new residency or fellowship begins.
  2. Eligible Hospitals. A hospital is eligible for distributions under this Section if all of the following apply:
    - a. It is a hospital in Arizona that is the sponsoring institution of, or a participating institution in, one or more of the GME programs in Arizona;
    - b. It incurs direct costs for the training of residents in the GME programs, which costs are or will be reported on the hospital's Medicare Cost Report;

- B. Preliminary allocation of funds for urban hospitals. Annually by January 15, the Administration shall estimate the annual GME distributions under this Section using the funds appropriated for hospitals in counties with a populations of 500,000 persons or more based on the number of new residents and fel-

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lows in graduate medical education programs in the following manner:

1. Each eligible resident and fellow is placed into tiers with the following priority:
    - a. Returning residents and fellows. A returning resident or fellow is a resident or fellow whose position received funding under this Section for the previous academic year and who is continuing in the same GME program.
    - b. Residents and fellows that are not a returning resident or fellow but are in a GME program for Family Medicine, Internal Medicine, General Pediatrics, Obstetrics and Gynecology, Psychiatry including Subspecialties, General Surgery, and any other program determined as high needs by the AHCCCS Administration.
    - c. Residents or fellows that are not returning residents or fellows and are not described in subsection (1)(b) but are in a GME program that received funding under this Section in a prior year.
    - d. All other residents and fellows.
  2. Residents and fellows in each tier are further divided into four sub-tiers with the following priority based on the location of the sponsoring or participating hospital:
    - a. Hospitals in a county designated by the Health Resource and Services Administration of the U.S. Department of Health & Human Services as a health professional shortage area (HPSA) with a greater than 85 percent primary care shortage.
    - b. Hospitals in a county designated as a HPSA with a greater than 50 percent to 85 percent primary care shortage.
    - c. Hospitals in a county designated as a HPSA with a 25-50 percent primary care shortage.
    - d. Hospitals in a county designated as a HPSA with a less than 25 percent primary care shortage.
  3. The amount of the distribution for each GME program for direct costs is calculated as the product of:
    - a. The number of eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospitals;
    - b. The Arizona Medicaid utilization as determined by R9-22-712.05(B)(4)(c)(i) in the previous calendar year; and,
    - c. The average direct cost per resident determined under R9-22-712.05(B)(4)(d) in the previous calendar year.
  4. If monies are still remaining after direct funding has been allocated, indirect funding shall be allocated based on the priority of each tier and sub-tier. The amount of the distribution for each GME program for indirect costs is calculated as the product of:
    - a. The number of allocated eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospital;
    - b. The indirect cost per resident per month calculated in R9-22-712.05(D)(4)(b)(vi) in the previous calendar year; and
    - c. Twelve months.
  - d. Funds shall be allocated based on the priority of each tier and sub-tier. Distributions for eligible positions in a tier or sub-tier with a lower priority will not receive a distribution until distributions are allocated for the costs of all positions in a higher tier or sub-tier. If funding is insufficient to fully fund a tier or sub-tier, the remainder of funds will be prorated for eligible positions in that tier or sub-tier.
  5. Payments are made to participating hospitals based on the FTEs who worked at their hospitals per year.
- C. Preliminary allocation of funds for rural hospitals. Annually by January 15, the Administration shall estimate the annual GME distributions under this Section using the funds appropriated for rural hospitals based on the number of eligible resident and fellow positions in graduate medical education programs located in a county with a population of less than 500,000 persons in the following manner:
1. Each resident and fellow will then be placed into a tier with the following priority:
    - a. Returning residents and fellows. A returning resident or fellow is a resident or fellow whose position received funding under this Section for the previous academic year and who is continuing in the same GME program.
    - b. Residents and fellows that are not a returning resident or fellow but are in a GME program for Family Medicine, Internal Medicine, General Pediatrics, Obstetrics and Gynecology, Psychiatry including Subspecialties, General Surgery, and any other program determined as high needs by the AHCCCS Administration.
    - c. Residents or fellows that are not returning residents or fellows and are not described in subsection (1)(b) but are in a GME program that received funding under this Section in a prior year.
    - d. All other residents and fellows.
  2. Residents and fellows in each tier are further divided into four sub-tiers with the following priority based on the location of the sponsoring or participating hospital:
    - a. Hospitals in a county designated by the Health Resource and Services Administration of the U.S. Department of Health & Human Services as a HPSA with a greater than 85 percent primary care shortage.
    - b. Hospitals in a county designated as a HPSA with a greater than 50 percent to 85 percent primary care shortage.
    - c. Hospitals in a county designated as a HPSA with a 25-50 percent primary care shortage.
    - d. Hospitals in a county designated as a HPSA with a less than 25 percent primary care shortage.
  3. Funds shall first be allocated for direct and indirect costs based in order of priority of each tier. If not enough funding is available to fully fund a tier or sub-tier, the remainder of funds will be prorated in a tier or sub-tier.
  4. The amount of the distribution for each GME program for direct costs is calculated as the product of:
    - a. The number of eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospitals;
    - b. The Arizona Medicaid utilization determined under R9-22-712.05(B)(4)(c)(i); and,
    - c. The actual direct cost per resident per year.

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5. The amount of the distribution for each GME program for indirect costs is calculated as the product of:
  - a. The number of allocated eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospital;
  - b. The indirect cost per resident per month calculated in R9-22-712.05(D)(4)(b)(vi) in the previous calendar year; and
  - c. Twelve months.
6. Payments are made to participating hospitals based on the FTEs who worked at their hospitals per year.
- D. Final allocation of funds. Annually no sooner than September 1 following the start of the academic year, the Administration will recalculate the allocation for urban and rural hospitals using the same methodology used to estimate distributions, but using the actual residents and fellows as reported in R9-22-712.06(B)(3)(c).
- F. Exclusions. To ensure that residents and fellows are not double counted residents/fellows which receive funding through R9-22-712.06 shall not receive funding through R9-22-712.05.
  - a. Has 100 or fewer PPS beds, not including beds reported as sub provider beds on the hospital's Medicare Cost Report, and is located in a county with a population of less than 500,000 persons, or
  - b. Is designated as a critical access hospital for the majority of the previous state fiscal year.

**Historical Note**

New Section made by final rulemaking at 27 A.A.R. 2496 (October 29, 2021), with an immediate effective date of October 6, 2021 (Supp. 21-4).

**R9-22-712.07. Rural Hospital Inpatient Fund Allocation**

- A. For purposes of this Section, the following words and phrases have the following meanings unless the context specifically requires another meaning:
  1. "Calculated inpatient costs" means the sum of inpatient covered charges multiplied by the Milliman study's implied cost-to-charge ratio of .8959.
  2. "Claims paid amount" means the sum of all claims paid by the Administration and contractors, as reported by the contractor to the Administration, to a rural hospital for covered inpatient services rendered for dates of service during the previous state fiscal year.
  3. "Fund" means any state funds appropriated by the Legislature for the purposes set forth in A.R.S. § 36-2905.02 and any federal funds that are available for matching the state funds.
  4. "Inpatient covered charges" means the sum of all covered charges billed by a hospital to the Administration or contractors, as reported by the contractors to the Administration, for inpatient services rendered during the previous state fiscal year.
  5. "Milliman study" means the report issued by Milliman USA on March 11, 2004, to the Arizona Hospital and Healthcare Association that updated a portion of a cost study entitled "Evaluation of the AHCCCS Inpatient Hospital Reimbursement System" prepared by Milliman USA for AHCCCS on November 15, 2002. A copy of each report is on file with the Administration.
  6. "Rural hospital" means a health care institution that is licensed as an acute care hospital by the Arizona Department of Health Services for the previous state fiscal year and is not an IHS hospital or a tribally owned or operated facility and:
    - a. Each February, the Administration shall allocate the Fund to the following three pools for the fiscal year:
      1. Rural hospitals with 25 or fewer PPS beds not including sub provider beds and all Critical Access Hospitals, regardless of the number of beds in the Critical Access Hospital;
      2. Rural hospitals other than Critical Access Hospitals with 26 to 75 PPS beds not including sub provider beds; and
      3. Rural hospitals other than Critical Access Hospitals with 76 to 100 PPS beds not including sub provider beds.
    - C. The Administration shall allocate the Fund to each pool according to the ratio of claims paid amount for all hospitals assigned to the pool to total claims paid amount for all rural hospitals.
    - D. The Administration shall determine each hospital's claims paid amount and allocate the funds in each pool to each hospital in the pool based on the ratio of each hospital's claims paid amount to the sum of the claims paid amount for all hospitals assigned to the pool.
    - E. The Administration shall not make a Fund payment to a hospital that will result in the hospital's claims paid amount plus that hospital's Fund payment being greater than that hospital's calculated inpatient costs.
      1. If a hospital's claims paid amount plus the hospital's Fund payment would be greater than the hospital's calculated inpatient costs, the Administration shall make a Fund payment to the hospital equal to the difference between the hospital's calculated inpatient costs and the hospital's claims paid amount.
      2. The Administration shall reallocate any portion of a hospital's Fund allocation that is not paid to the hospital due to the reason in subsection (E)(1) to the other eligible hospitals in the pool based upon the ratio of the claims paid amount for each hospital remaining in the pool to the sum of the claims paid amount for each hospital remaining in the pool.
    - F. If funds remain in a pool after allocations to each hospital in the pool under subsections (D) and (E), the Administration shall reallocate the remaining funds to the other pools based upon the ratio of each pool's original allocation of the Fund as determined under subsection (C) to the sum of the remaining pools' original Fund allocations under subsection (C). The Administration shall allocate remaining funds to the hospitals in the remaining pools under subsection (D) and (E). See Exhibit 1 for an example.
    - G. Subject to CMS approval of the method and distribution of the Fund, the administration or its contractors will distribute the Fund as a lump sum allocation to the rural hospitals in either one or two installments by the end of each state fiscal year.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2188, effective June 6, 2006 (Supp. 06-2). Amended by final rulemaking at 22 A.A.R. 3476, effective January 30, 2016 (Supp. 15-4).

**Exhibit 1. Pool Example**

Pool A receives \$2,000,000. Pool B receives \$7,000,000. Pool C receives \$3,000,000.

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If all of the funds in Pool B are paid to eligible hospitals and there is \$1,000,000 remaining, the remaining funds would be allocated to Pool A and Pool C based on the ratio of each pool's original allocation (original allocations of \$2,000,000 and \$3,000,000) to the total of their original allocation ( $\$2,000,000 + \$3,000,000 = \$5,000,000$ ).

Pool A would receive 2/5 of the remaining funds (\$400,000) and Pool C would receive 3/5 of the remaining funds (\$600,000).

**Historical Note**

Exhibit 1 made by final rulemaking at 12 A.A.R. 2188, effective June 6, 2006 (Supp. 06-2).

**R9-22-712.08. Federally Qualified Health Center and Rural Health Clinic Graduate Medical Education Program**

- A.** Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for primary care GME programs approved by the Administration to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) for direct and indirect program costs eligible for funding under A.R.S. § 36-2907.06(I).
1. A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (D).
  2. For purposes of this subsection, the term "FQHC" includes Federally Qualified Health Center Look-Alikes.
- B.** Eligible health care facilities. A health care facility is eligible for a distribution under subsection (G) if all of the following apply:
1. It is an FQHC or RHC in Arizona that is the sponsoring institution of, or a full member of a consortium that is the sponsoring institution of, or a participating institution in, one or more approved primary care GME programs in Arizona;
  2. It incurs direct or indirect costs for the training of residents in Arizona in approved primary care GME programs;
  3. The GME program is not eligible for funding under R9-22-712.05; and
  4. The GME program is not fully funded by the federal government.
- C.** Eligible residents and resident positions. For purposes of determining program allocation amounts under subsections (E) and (F) the following residents and resident positions are eligible for consideration, to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (B):
1. All filled resident positions in approved primary care GME programs; or
  2. For approved primary care GME programs established for less than one year as of the date of annual reporting under subsection (D) and that have not yet filled their first-year resident positions, all prospective residents reasonably expected by the program to be enrolled as a result of the most recently completed annual resident match.
- D.** Annual reporting. By April 1st of each year, an FQHC or RHC seeking a distribution under this subsection shall:
1. Provide to the Administration the following information about each approved primary care GME program:
    - a. The program name and number assigned by the accrediting organization;
    - b. The original date of accreditation of the program;
    - c. The names of the sponsoring institution and all participating institutions current as of the date of reporting;
  - d. The number of approved resident positions and the number of filled resident positions current as of the date of reporting;
  - e. The academic year rotation schedule on file with the program current as of the date of reporting; and
  - f. For programs described under subsection (C)(2), the number of residents expected to be enrolled as a result of the most recently completed annual resident match.
2. Provide to the Administration the most recent Medicare Cost Report for the FQHC or RHC seeking the distribution, and
  3. For an FQHC or RHC that is a full member of a consortium that is the sponsoring institution of an approved primary care GME program, provide to the Administration a signed letter attesting to the responsibility of the full member FQHC or RHC for direct or indirect costs of training residents in the program.
- E.** Allocation of funds for direct graduate medical education costs. Annually the Administration shall allocate available funds for direct graduate medical education costs to each eligible FQHC or RHC in the following manner:
1. A Medicaid utilization percent for each FQHC or RHC seeking a distribution shall be calculated using the Medicare Cost Report submitted under subsection (D)(2), dividing the Title XIX visit count by the whole number of visits reported and rounding the result up to the nearest multiple of 5 percent.
  2. A total number of residents eligible for funding in each program shall be calculated using the information submitted under subsection (D)(1), dividing the number of resident rotations in the year that take place in Arizona and not at a health care facility made ineligible under subsection (B) by the total number of resident rotations in the program for that year, multiplying the result by the total number of filled resident positions in the program and rounding to two digits after the decimal.
  3. The allocation for direct graduate medical education costs for each eligible FQHC or RHC shall be calculated by multiplying the number of residents determined under subsection (E)(2) by the statewide average per-resident amount determined under this subsection and multiplying the result by the Medicaid utilization percent calculated for the FQHC or RHC under subsection (E)(1). The statewide average per-resident amount for the academic year ending June 30, 2022 is \$170,090. Annually thereafter, a statewide average per-resident amount shall be calculated by applying the Federally Qualified Health Center PPS Market Basket Update less Productivity Adjustment published by CMS for the calendar year in which the GME academic year begins.
- F.** Allocation of funds for indirect program costs. Annually the Administration shall allocate available funds for indirect program costs to each eligible FQHC or RHC in the following manner:
1. By multiplying the number of residents determined under subsection (E)(2) by the statewide average per-resident

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amount determined under this subsection and multiplying the result by the Medicaid utilization percent calculated for the FQHC or RHC under subsection (E)(1). The statewide average per-resident amount for the academic year ending June 30, 2022 is \$167,330;

2. Annually thereafter, a statewide average per-resident amount shall be calculated by applying the Federally Qualified Health Center PPS Market Basket Update less Productivity Adjustment published by CMS for the calendar year in which the GME academic year begins.

G. Distribution of funds. On an annual basis subject to available funds, the Administration shall distribute to each eligible FQHC and RHC the sum of all amounts calculated for the FQHC or RHC under subsections (E)(3) and (F).

H. The Administration may enter into intergovernmental agreements with local, county, and tribal governments and any university under the jurisdiction of the Arizona Board of Regents wherein such entities may transfer funds or certify public expenditures to the Administration. Such funds or certification, subject to approval by CMS, will contribute to the state funding to qualify for federal matching funds. Those funds will be used for the purposes of reimbursing FQHCs and RHCs that are eligible under this rule and designated by the local, county, or tribal governments for receipt of the contributed funds. The Administration shall allocate available funds in accordance with subsections (E) and (F).

**Historical Note**

New Section made by final rulemaking at 28 A.A.R. 837 (April 29, 2022), with an immediate effective date of April 5, 2022 (Supp. 22-2).

**R9-22-712.09. Hierarchy for Tier Assignment through September 30, 2014**

TIER	IDENTIFICATION CRITERIA	ALLOWED SPLITS
MATERNITY	A primary diagnosis defined as maternity 640.xx - 643.xx, 644.2x - 676.xx, v22.xx - v24.xx or v27.xx.	None
NICU	Revenue Code of 174 and the provider has a Level II or Level III NICU.	Nursery
ICU	Revenue Codes of 200-204, 207-212, or 219.	Surgery Psychiatric Routine
SURGERY	Surgery is identified by a revenue code of 36x. To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list.	ICU
PSYCHIATRIC	Psychiatric Revenue Codes of 114, 124, 134, 144, or 154 AND primary Psychiatric Diagnosis = 290.xx - 316.xx. If a routine revenue code is present and all diagnoses codes on the claim are equal to 290.xx - 316.xx, classify as a psychiatric claim.	ICU
NURSERY	Revenue Code of 17x, not equal to 174.	NICU
ROUTINE	Revenue Codes of 100 - 101, 110-113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16x, 206, 213, or 214.	ICU

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 3231, effective October 1, 2005 (Supp. 05-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.10. Outpatient Hospital Reimbursement: General**

- A. Effective rule. The outpatient hospital reimbursement rules apply to dates of service beginning July 1, 2005, subject to Laws 2004, Ch. 279, § 19.
- B. Basis For Payment. Except as provided under R9-22-712.30, AHCCCS shall pay for designated outpatient procedures provided to AHCCCS members according to the AHCCCS Outpatient Capped Fee-For-Service Schedule as defined in R9-22-712.20.
- C. Data. AHCCCS shall use Medicare Cost Report and adjudicated claim and encounter data from non-IHS acute care hospitals located in the state of Arizona to develop fees for the AHCCCS Outpatient Capped Fee-For-Service Schedule.
- D. Hospital Services Subject To Fees. AHCCCS shall reimburse services, in the following outpatient hospital categories under the AHCCCS Outpatient Capped Fee-For-Service Schedule:
  1. Surgery,
  2. Emergency Department,
  3. Laboratory,
  4. Radiology,
  5. Clinic, and
  6. Other services.
- E. Reimbursement. AHCCCS shall reimburse outpatient hospital services by procedure codes, in proper combination with revenue codes, as prescribed by AHCCCS.

**Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

**R9-22-712.11. Reserved**

**R9-22-712.12. Reserved**

**R9-22-712.13. Reserved**

**R9-22-712.14. Reserved**

**R9-22-712.15. Outpatient Hospital Reimbursement: Affected Hospitals**

Except as provided in R9-22-712(G), the AHCCCS Outpatient Capped Fee-For-Service Schedule shall apply to AHCCCS payments for outpatient services in all non-IHS acute hospitals.

**Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

**R9-22-712.16. Reserved**

**R9-22-712.17. Reserved**

**R9-22-712.18. Reserved**

**R9-22-712.19. Reserved**

**R9-22-712.20. Outpatient Hospital Reimbursement: Methodology for the AHCCCS Outpatient Capped Fee-For-Service Schedule**

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- A.** To establish the AHCCCS Outpatient Capped Fee-for-service Schedule for all claims with a begin date of service on or before September 30, 2011, AHCCCS shall:
1. Define the dataset of claims and encounters that shall be used to establish the AHCCCS Outpatient Capped Fee-for-service Schedule.
  2. Identify all the claims and encounters from non-IHS acute hospitals located in Arizona for services to be paid under the AHCCCS Outpatient Capped Fee-for-service Schedule.
  3. Match the revenue code on each detail of each claim and encounter to the ancillary line item CCR as reported on hospital-specific mapping documents and hospital-specific Medicare Cost Report for those hospitals that have submitted Medicare Cost Reports FYE 2002.
  4. Multiply the line item CCR from subsection (A)(3) by the covered billed charge for that revenue code to establish the cost for the service.
  5. Inflate the cost for the service from subsection (A)(4) using Global Insight Health-care Cost Review inflation factors from date of service month to the midpoint of the rate year in which the fees are initially effective.
  6. Include associated costs under R9-22-712.25 to calculate the rates for emergency room and surgery services.
  7. Combine data from all Arizona hospitals identified in subsection (A)(3) for each procedure code to establish the statewide median cost for each procedure.
  8. Group procedure codes according to the Ambulatory Payment Classification (APC) System groups as listed in 69 FR 65682, November 15, 2004, and establish a statewide median cost for each APC. Multiply each statewide median APC cost by 116 percent to establish the AHCCCS-based fee for each procedure in that specific APC group. AHCCCS shall assign each procedure in the group the same fee.
  9. For those procedure codes that are not grouped into any APC, establish a procedure-specific fee using either:
    - a. The AHCCCS Non-hospital Capped Fee-for-service Fee Schedule,
    - b. 116 percent of the procedure-specific median cost AHCCCS-based fee, or
    - c. The Medicare Clinical Laboratory Fee Schedule for laboratory services.
  10. Compare the AHCCCS-based fee established in subsections (A)(8) and (9) against the comparable Medicare fee established for the Medicare APC group as listed in the 69 FR 65682, November 15, 2004. The fee for each procedure shall be the greater of the AHCCCS-based fee or the Medicare fee but no more than 150 percent of the AHCCCS-based fee; however, for those laboratory services for which a limit is established in the Medicare Clinical Laboratory Fee Schedule, the fee shall not exceed that limit.
  11. Assign the 2005 Medicare fee in the AHCCCS Outpatient Capped Fee-for-service Schedule for those procedures for which there are fewer than 20 occurrences of the procedure code in the dataset, either independently, or, if applicable, for all procedure codes within an APC Group.
- B.** For all claims with a begin date of service on or after October 1, 2011, the AHCCCS Outpatient Capped Fee-for-Service Schedule shall be derived from the CMS Medicare Outpatient Prospective Payment System (OPPS) fee schedule modified by an Arizona conversion factor determined annually.
1. When clinic services are billed using 51X revenue codes, the reimbursement to the hospital is the difference between the facility and non-facility rates payable to the practitioner for the procedures listed in the Administration's Capped Fee-for-service Schedule under R9-22-710.
  2. Observation services, when not billed in conjunction with a service for which a single payment is made under R9-22-712.25, are reimbursed at an hourly rate published in the Outpatient Capped Fee-for-service Schedule. This hourly rate includes reimbursement for associated services.
- C.** The AHCCCS Outpatient Capped Fee-for-service Schedule including the effective date of any changes to the listing are on file and posted on AHCCCS' web site.
- Historical Note**
- New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4).
- R9-22-712.21. Reserved**
- R9-22-712.22. Reserved**
- R9-22-712.23. Reserved**
- R9-22-712.24. Reserved**
- R9-22-712.25. Outpatient Hospital Fee Schedule Calculations: Associated Service Costs**
- A.** AHCCCS shall include the costs of associated services, as defined by revenue codes and procedure codes, when determining the specific fees for the outpatient hospital procedures for emergency department and surgery services.
- B.** Payment made under subsection (A) or R9-22-712.20(B)(2) is inclusive of all services on the claim regardless of whether the services are provided on one or more days.
- C.** A complete listing of the revenue codes and procedure codes for associated costs included in the payment for emergency and surgery services including the effective date of any changes to the listing are on file and posted on AHCCCS' web site.
- Historical Note**
- New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3).
- R9-22-712.26. Reserved**
- R9-22-712.27. Reserved**
- R9-22-712.28. Reserved**
- R9-22-712.29. Reserved**
- R9-22-712.30. Outpatient Hospital Reimbursement: Payment for a Service Not Listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule**
- A.** AHCCCS shall calculate a statewide CCR for a service where a specific fee cannot be determined under R9-22-712.20.
- B.** For claims with a begin date of service on or before September 30, 2011, the statewide CCR shall be calculated based on the costs and covered charges associated with a service under sub-

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section (A) for all Arizona hospitals, using the method specified in R9-22-712.20(A)(3).

- C. For all claims with a begin date of service on or after October 1, 2011, the statewide CCR calculation shall equal either the CMS Medicare Outpatient Urban Cost-to-charge Ratio or the CMS Medicare Outpatient Rural Cost-to-charge Ratio published by CMS for the state of Arizona. AHCCCS shall use the urban cost-to-charge ratio for hospitals located in a county of 500,000 residents or more and for out-of-state hospitals. AHCCCS shall use the rural cost-to-charge ratio for hospitals located in a county of fewer than 500,000 residents. On October 1st of each year, AHCCCS shall adjust urban and rural CCRs to the CCRs as published by CMS in the *Federal Register* on or before August 1st of that year.
- D. To determine the payment amount for procedures where a specific fee is not determined under R9-22-712.20, the statewide CCR is multiplied by the covered charges.
- E. Reductions to payments for outpatient hospital services not listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule. Outpatient hospital services not listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rate published by CMS pursuant to subsection (C) of this Section.

**Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4).

**R9-22-712.31. Reserved**

**R9-22-712.32. Reserved**

**R9-22-712.33. Reserved**

**R9-22-712.34. Reserved**

**R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees**

- A. For all claims with a begin date of service on or before September 30, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule established under R9-22-712.20 (except for laboratory services and out-of-state hospital services) for the following hospitals submitting any claims:
- By 48 percent for public hospitals on July 1, 2005, and hospitals that were public anytime during the calendar year 2004;
  - By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
  - By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
  - By 115 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the criteria during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
  - By 113 percent for a Freestanding Children's Hospital with at least 110 pediatric beds during the contract year in

which the Outpatient Capped Fee-for-service Schedule rates are effective; or

- By 14 percent for a University Affiliated Hospital which is a hospital that has a majority of the members of its board of directors appointed by the Board of Regents during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective.
- B. For all claims with a begin date of service on or after October 1, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services) for the following hospitals. A hospital shall receive an increase from only one of the following categories:
- By 73 percent for public hospitals;
  - By 31 percent for hospitals in counties other than Maricopa and Pima with more than 100 licensed beds as of October 1 of that contract year;
  - By 37 percent for hospitals in counties other than Maricopa and Pima with 100 or fewer licensed beds as of October 1 of that contract year;
  - By 100 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the critical access criteria;
  - By 78 percent for a Freestanding Children's Hospital with at least 110 pediatric beds as of October 1 of that contract year; or
  - By 41 percent for a University Affiliated Hospital, this is a hospital that has a majority of the members of its board of directors appointed by the Arizona Board of Regents.
- C. In addition to subsections (A) and (B), an Arizona Level 1 trauma center as defined by R9-22-2101 shall receive a 50 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services and out-of-state hospital services) for Level 2 and 3 emergency department procedures.
- D. Hospitals with greater than 100 pediatric beds not receiving an increase under subsection (B) shall receive an 18 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services).
- E. For outpatient services with dates of service from October 1, 2022 through September 30, 2023, the payment otherwise required for outpatient hospital services provided by qualifying hospitals shall be increased by a percentage established by the administration. The percentage is published on the Administration's public website as part of its fee schedule subsequent to the public notice published no later than September 1, 2022. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.
- A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in (1)(a), (b), (c) or (d):
    - By April 1, 2022, the hospital must have submitted a Letter of Intent (LOI) to the Health Information Exchange (HIE) in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved.
      - No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to the HIE, in which it agrees to achieve the following milestones by the specified dates

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- or maintain its participation in the milestone activities if they have already been achieved.
- ii. No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
    - (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE organization to ensure proper processing of lab results within the HIE system.
    - (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
    - (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
  - iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf.
  - iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
  - v. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
  - vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization.
  - vii. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
  - viii. No later than January 1, 2023, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
  - ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
  - x. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below:
    - (1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on October 2021 data, to the final data quality profile, based on March 2022 data.
    - (2) Meet a minimum performance standard of at least 60% based on March 2022 data.
    - (3) If performance meets or exceeds an upper threshold of 90% based on March 2022 data, the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.
  - xi. DAP HIE Data Quality Standards CYE 2023 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 0.5% DAP increase for each category of the five measure categories, for a total potential increase of 2.5% if criteria are met for all categories.
    - (1) Data source and data site information must be submitted on all ADT transactions. (0.5%)
    - (2) Event type must be properly coded on all ADT transactions. (0%)
    - (3) Patient class must be properly coded on all appropriate ADT transactions. (0%)
    - (4) Patient demographic information must be submitted on all ADT transactions. (0%)
    - (5) Race must be submitted on all ADT transactions. (0.5%)
    - (6) Ethnicity must be submitted on all ADT transactions. (0.5%)
    - (7) Diagnosis must be submitted on all ADT transactions. (0.5%)
    - (8) Overall completeness of the ADT message. (0%)
- b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates;
    - i. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.
    - ii. No later than April 1, 2022:
      - (1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH

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Closed-Loop Referral Platform.

- (2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
  - (3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.
- iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.
  - c. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2022, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:
    - i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
    - ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.
    - iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.
    - iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.
    - v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.
    - vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.
  - d. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:
    - i. Number of ICU beds in use,
    - ii. Number of ICU beds available for use,
    - iii. Number of Medical-Surgical beds in use,
    - iv. Number of Medical-Surgical beds available for use,
    - v. Number of Telemetry beds in use,
    - vi. Number of Telemetry beds available for use.
2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets this criteria specified in (2)(a),(b), (c) or (d):
    - a. By April 1, 2022 the hospital must have submitted a LOI to the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:
      - i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
      - ii. No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
        - (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
        - (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
        - (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
      - iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all out-

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- sourced lab test results flow to the qualifying HIE organization on their behalf.
- iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
  - v. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
  - vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization.
  - vii. No later than November 1, 2022, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
  - viii. No later than January 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
  - ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
  - x. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below:
    - (1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on October 2021 data, to the final data quality profile, based on March 2022 data.
    - (2) Meet a minimum performance standard of at least 60% based on March 2022 data.
    - (3) If performance meets or exceeds an upper threshold of 90% based on March 2022 data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.
  - xi. DAP HIE Data Quality Standards CYE 2023 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a DAP increase for select Data Quality Measures for a total of 8.0% if criteria are met for all categories indicating a DAP.
    - (1) Data source and data site information must be submitted on all ADT transactions. (1.0%)
    - (2) Event type must be properly coded on all ADT transactions. (1.0%)
    - (3) Patient class must be properly coded on all appropriate ADT transactions. (0%)
    - (4) Patient demographic information must be submitted on all ADT transactions. (0%)
    - (5) Race must be submitted on all ADT transactions. (2.0%)
    - (6) Ethnicity must be submitted on all ADT transactions. (2.0%)
    - (7) Diagnosis must be submitted on all ADT transactions. (2.0%)
    - (8) Overall completeness of the ADT message. (0%)
- b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates;
    - i. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.
    - ii. No later than April 1, 2022:
      - (1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
      - (2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
      - (3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.
    - iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.
  - c. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2022, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The

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- facility agrees to achieve and maintain participation in the following activities:
- i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
  - ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.
  - iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.
  - iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.
  - v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.
  - vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.
- d. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:
    - i. Number of ICU beds in use,
    - ii. Number of ICU beds available for use,
    - iii. Number of Medical-Surgical beds in use,
    - iv. Number of Medical-Surgical beds available for use,
    - v. Number of Telemetry beds in use, and
    - vi. Number of Telemetry beds available for use.
3. A hospital designated as type: hospital, subtype: long term, psychiatric, or rehabilitation by the Arizona Department of Health Services Division of Licensing Services will qualify for an increase if it meets the criteria specified in (3)(a), (b), (c), (d), (e), or (f):
    - a. In order to qualify, by April 1, 2022 the hospital must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:
      - i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
      - ii. No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
        - (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
        - (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
        - (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
      - iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf.
      - iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the facility has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
      - v. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
      - vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization or

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- an Advance Directives Registry platform operated by the qualifying HIE organization.
- vii. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
  - viii. No later than January 1, 2023, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
  - ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
  - x. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to DAP increases described below.
    - (1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on October 2021 data, to the final data quality profile, based on March 2022 data.
    - (2) Meet a minimum performance standard of at least 60% based on March 2022 data.
    - (3) If performance meets or exceeds an upper threshold of 90% based on March 2022 data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.
  - xi. DAP HIE Data Quality Standards CYE 2022 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 0.5% DAP increase for each category of the five measure categories, for a total potential increase of 2.0% if criteria are met for all categories.
    - (1) Data source and data site information must be submitted on all ADT transactions. (0.5%)
    - (2) Event type must be properly coded on all ADT transactions. (0%)
    - (3) Patient class must be properly coded on all appropriate ADT transactions. (0%)
    - (4) Patient demographic information must be submitted on all ADT transactions. (0%)
    - (5) Race must be submitted on all ADT transactions. (0.5%)
    - (6) Ethnicity must be submitted on all ADT transactions. (0.5%)
    - (7) Diagnosis must be submitted on all ADT transactions. (0.5%)
    - (8) Overall completeness of the ADT message. (0%)
  - b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates;
    - i. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.
    - ii. No later than April 1, 2022:
      - (1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
      - (2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
      - (3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.
    - iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.
    - c. On March 15, 2022 is identified as a Medicare Annual Payment Update recipients on the QualityNet.org website. APU recipients are those facilities that satisfactorily met the requirements for the IPFQR program, which includes multiple clinical quality measures. Facilities identified as APU recipients will qualify for the DAP increase.
    - d. On March 15, 2022 meets or falls below the national average for the rate of pressure ulcers that are new or worsened from the Medicare Provider Data Catalog website for long-term care hospitals. Facility results will be compared to the national average results for the measure. Hospitals that meet or fall below the national average percentage will qualify for the DAP increase.
    - e. On March 15, 2022 meets or falls below the national average for the rate of pressure ulcers that are new or worsened from the Medicare Provider Data Catalog website for rehabilitation hospitals. Facility results will be compared to the national average results for the measure. Hospitals that meet or fall below the national average percentage will qualify for the DAP increase.
    - f. By April 30, 2022, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:
      - i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
      - ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for

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- requesting services to be performed by the non-IHS/Tribal 638 facility.
- iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.
  - iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.
  - v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022, through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.
  - vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.
4. A hospital designated as type: hospital, subtype: long term or rehabilitation by the Arizona Department of Health Services Division of Licensing Services will qualify for an increase if it meets the following criteria. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:
    - i. Number of ICU beds in use,
    - ii. Number of ICU beds available for use,
    - iii. Number of Medical-Surgical beds in use,
    - iv. Number of Medical-Surgical beds available for use,
    - v. Number of Telemetry beds in use, and
    - vi. Number of Telemetry beds available for use.
  5. A hospital designated as type: hospital by the Arizona Department of Health Services Division of Licensing Services and is owned and/or operated by Indian Health Services (IHS) or under Tribal authority will qualify for an increase if it meets these criteria specified in (5)(a) or (b);
    - a. By April 1, 2022 the hospital must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:
      - i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
        - ii. No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
          - (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
          - (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
          - (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
      - iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf.
      - iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the facility has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If the hospital has ambulatory and/or behavioral health practices, then the facility must submit the following actual patient identifiable information to the production environment of a qualifying HIE: registration, encounter summary, and SMI data elements as defined by the qualifying HIE organization. For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.
      - v. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

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- vi. No later than January 1, 2023, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
- vii. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
- viii. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below:
  - (1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on October 2021 data, to the final data quality profile, based on March 2022 data.
  - (2) Meet a minimum performance standard of at least 60% based on March 2022 data.
  - (3) If performance meets or exceeds an upper threshold of 90% based on March 2022 data, the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.
- ix. DAP HIE Data Quality Standards CYE 2022 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a DAP increase for select Data Quality Measures for a total of 2.5% if criteria are met for all categories indicating a DAP.
  - (1) Data source and data site information must be submitted on all ADT transactions. (0.5%)
  - (2) Event type must be properly coded on all ADT transactions. (0.5%)
  - (3) Patient class must be properly coded on all appropriate ADT transactions. (0.5%)
  - (4) Patient demographic information must be submitted on all ADT transactions. (0.5%)
  - (5) Overall completeness of the ADT message. (0.5%)
- b. By March 15, 2022, the facility must submit a LOI to enter into a CCA with a non-IHS/638 facility (a fully signed copy of a CCA with a non-IHS/Tribal 638 facility is also acceptable). By April 30, 2021, the facility must have entered into a CCA with a non-IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities: The IHS/Tribal 638 facility will have in place a signed CCA with a non-IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
  - i. The IHS/Tribal 638 facility will have a valid referral template in place for requesting services to be performed by the non-IHS/Tribal 638 facility.
  - ii. The IHS/Tribal 638 facility will continue to assume responsibility of the referred member, maintaining records and release of information protocol including clinical documentation of services provided by the non-IHS/Tribal 638 facility.
  - iii. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the IHS/Tribal 638 facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2021.
  - iv. The IHS/638 facility will submit a minimum of one referral and any supporting medical documentation to the non-IHS/Tribal 638 facility by September 1, 2022. During CYE 2023, from October 1, 2022, through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA referrals per month to the non-IHS/Tribal 638 facility.
  - v. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA referrals to the non-IHS/Tribal 638 facility by March 15, 2022, and submit an average of 5 CCA referrals per month by May 31, 2022.

**Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 3584, effective October 1, 2007 (Supp. 07-4). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2338, effective October 1, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2851, effective October 1, 2018 (Supp. 18-3). Amended by final rulemaking at 25 A.A.R. 3114, effective October 1, 2019 (Supp. 19-4). Amended by final rulemaking at 26 A.A.R. 3025, with an immediate effective date of November 3, 2020 (Supp 20-4). AHCCCS filed an incorrect version of a final rulemaking which made amendments to this Section published at 27 A.A.R. 2501 (October 29, 2021); AHCCCS filed the correct version of its final rulemaking on December 3, 2021, with this Section amended by final rulemaking at 27 A.A.R. 3015 (December 31, 2021), effective October 1, 2021 (Supp. 21-4). Amended by final rulemaking at 28 A.A.R. 3283 (October 14, 2022), with an immediate effective date of September 23, 2022 (Supp. 22-3).

- R9-22-712.36. Reserved**
- R9-22-712.37. Reserved**
- R9-22-712.38. Reserved**
- R9-22-712.39. Reserved**
- R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update**
- A.** Procedure codes. When procedure codes are issued by CMS and added to the Current Procedural Terminology published by the American Medical Association, AHCCCS shall add to the Outpatient Capped Fee-for-Service Schedule the new procedure codes for covered outpatient services and shall either assign the default CCR under R9-22-712.40(F)(2), the Medicare rate, or calculate an appropriate fee.

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- B.** APC changes. AHCCCS may reassign procedure codes to new or different APC groups when APC groups are revised by CMS. AHCCCS may reassign procedure codes to a different APC group than Medicare. If AHCCCS determines that utilization of a procedure code within the Medicare program is substantially different from utilization of the procedure code in the AHCCCS program, AHCCCS may choose not to assign the procedure code to any APC group. For procedure codes not grouped into an APC by Medicare, AHCCCS may assign the code to an APC group when AHCCCS determines that the cost and resources associated with the non-assigned code are substantially similar to those in the APC group.
- C.** Annual update for Outpatient Hospital Fee Schedule. Beginning October 1, 2006, through September 30, 2011, AHCCCS shall adjust outpatient fee schedule rates:
1. Annually by multiplying the rates effective during the prior year by the Global Insight Prospective Hospital Market Basket Inflation Index; or
  2. In a particular year the director may substitute the increases in subsection (C)(1) by calculating the dollar value associated with the inflation index in subsection (C)(1), and applying the dollar value to adjust rates at varying levels.
- D.** Reductions to the Outpatient Capped Fee-For-Service Schedule. Claims paid using the Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rates in effect on September 30, 2011, subject to the annual adjustments to procedure codes and APCs under this Section.
- E.** Rebase. AHCCCS shall rebase the outpatient fees every five years.
- F.** Statewide CCR:
1. For begin dates of service on or before September 30, 2011, the statewide CCR calculated in R9-22-712.30 shall be recalculated at the time of rebasing. When rebasing, AHCCCS may recalculate the statewide CCR based on the costs and charges for services excluded from the outpatient hospital fee schedule.
  2. For begin dates of service on or after October 1, 2011, the statewide CCR shall be set under R9-22-712.30(C).
- G.** Other Updates. In addition to the other updates provided for in this Section, the Administration may adjust the Outpatient Capped Fee-For-Service Fee Schedule and the Statewide CCR to the extent necessary to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

**Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 3584, effective October 1, 2007 (Supp. 07-4). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4).

Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.41. Reserved**

**R9-22-712.42. Reserved**

**R9-22-712.43. Reserved**

**R9-22-712.44. Reserved**

**R9-22-712.45. Outpatient Hospital Reimbursement: Outpatient Payment Restrictions**

- A.** AHCCCS shall not reimburse hospitals for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis if the member is admitted as an inpatient to the same hospital directly from the emergency room, observation, or other outpatient department.
- B.** AHCCCS shall include payment for the emergency room, observation, and other outpatient hospital services provided to the member before the hospital admission in the AHCCCS Inpatient Tiered Per Diem Capped Fee-For-Service Schedule under Article 7 of this Chapter.
- C.** Same day admit and discharge.
1. For discharges before September 30, 2014. Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.
  2. For discharge dates on and after October 1, 2014. Same day admit and discharge claims are paid for through the outpatient fee schedule.

**Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.46. Reserved**

**R9-22-712.47. Reserved**

**R9-22-712.48. Reserved**

**R9-22-712.49. Reserved**

**R9-22-712.50. Outpatient Hospital Reimbursement: Billing**

To receive appropriate reimbursement, hospitals shall:

1. Bill outpatient hospital services on the CMS approved Uniform Billing Form or in electronic format using the appropriate HIPAA transaction.
2. Follow the UB Manual Guidelines, as published by the National Uniform Billing Committee, and use the appropriate revenue code and procedure code combination as prescribed by AHCCCS and on file and online with AHCCCS.

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**Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

- R9-22-712.51. **Reserved**
- R9-22-712.52. **Reserved**
- R9-22-712.53. **Reserved**
- R9-22-712.54. **Reserved**
- R9-22-712.55. **Reserved**
- R9-22-712.56. **Reserved**
- R9-22-712.57. **Reserved**
- R9-22-712.58. **Reserved**
- R9-22-712.59. **Reserved**

**R9-22-712.60. Diagnosis Related Group Payments**

- A. Inpatient hospital services with discharge dates on or after October 1, 2014, shall be reimbursed using the diagnosis related group (DRG) payment methodology described in this Section and R9-22-712.61 through R9-22-712.81.
- B. Payments made using the DRG methodology shall be the sole reimbursement to the hospital for all inpatient hospital services and related supplies provided by the hospital. Services provided in the emergency room, observation area, or other outpatient departments that are directly followed by an inpatient admission to the same hospital are not reimbursed separately. Are reimbursed through the DRG methodology and not reimbursed separately.
- C. Each claim for an inpatient hospital stay shall be assigned a DRG code and a DRG relative weight based on the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health Information Systems. The applicable version of the APR-DRG classification system shall be available on the agency's website.
- D. Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to quick pay discounts and slow pay penalties under A.R.S. 36-2904.
- E. Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to the Urban Hospital Reimbursement Program under R9-22-718.
- F. For purposes of this Section and Sections R9-22-712.61 through R9-22-712.81:
  1. "DRG National Average length of stay" means the national arithmetic mean length of stay published in the All Patient Refined Diagnosis Related Group (APR-DRG) classification established by 3M Health Information Systems.
  2. "Length of stay" means the total number of calendar days of an inpatient stay beginning with the date of admission through discharge, but not including the date of discharge (including the date of a discharge to another hospital, i.e., a transfer) unless the member expires.
  3. "Medicare" means Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.
  4. "Medicare labor share" means a hospital's labor costs as a percentage of its total costs as determined by CMS for purposes of the Medicare Inpatient Prospective Payment System.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016

(Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

**R9-22-712.61. DRG Payments: Exceptions**

- A. Notwithstanding section R9-22-712.60, claims for inpatient services from the following hospitals shall be paid on a per diem basis, including provisions for outlier payments, where rates and outlier thresholds are included in the capped fee schedule published by the Administration on its website and available for inspection during normal business hours at 801 E. Jefferson, Phoenix, Arizona. If the covered costs per day on a claim exceed the published threshold for a day, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the outlier CCR. The outlier CCR will be the sum of the urban or rural default operating CCR appropriate to the location of the hospital and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS. The resulting amount will be the total reimbursement for the claim. There is no provision for outlier payments for hospitals described under subsection (A)(3).
  1. Hospitals designated as type: hospital, subtype; rehabilitation in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website in March of each year;
  2. Hospitals designated as type: hospital, subtype: long term in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;
  3. Hospitals designated as type: hospital, subtype; psychiatric in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year.
- B. Notwithstanding Section R9-22-712.60, claims for inpatient services that are covered by a RBHA or TRBHA, where the principal diagnosis on the claim is a behavioral health diagnosis, shall be reimbursed as prescribed by a per diem rate described by a fee schedule established by the Administration; however, if the principal diagnosis is a physical health diagnosis, the claim shall be processed under the DRG methodology described in this Section, even if behavioral health services are provided during the inpatient stay.
- C. Notwithstanding Section R9-22-712.60, claims for services associated with transplant services shall be paid in accordance with the contract between the AHCCCS administration and the transplant facility.
- D. Notwithstanding Section R9-22-712.60, claims from an IHS facility or 638 Tribal provider shall be paid the all-inclusive rate on a per visit basis in accordance with the rates published annually by IHS in the federal register.
- E. For hospitals that have contracts with the Administration for the provision of transplant services, inpatient days associated with transplant services are paid in accordance with the terms of the contract.
- F. For inpatient services with a date of admission from October 1, 2022 through September 30, 2023, provided by a hospital in subsection (A) that qualifies, the administration shall pay the hospital an Inpatient Differential Adjusted Payment equal to the sum of the payment otherwise provided for in subsection (A) plus the product of the amount otherwise provided for in subsection (A) and a percentage published on the Administration's public website as part of its fee schedule, subsequent to

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a public notice published no later than September 1, 2022. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.

- I. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (1)(a), (b), (c), or (d):
  - a. By April 1, 2022, a hospital the hospital must have submitted a Letter of Intent (LOI) to AHCCCS and the Health Information Exchange (HIE), in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved.
    - i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
    - ii. No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
      - (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE organization to ensure proper processing of lab results within the HIE system.
      - (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
      - (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
    - iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf.
    - iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
    - v. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
    - vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization.
    - vii. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
    - viii. No later than January 1, 2023, the hospital must complete the data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
    - ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
    - x. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below:
      - (1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on October 2022 data, to the final data quality profile, based on March 2022 data.
      - (2) Meet a minimum performance standard of at least 60% based on March 2022 data.
      - (3) If performance meets or exceeds an upper threshold of 90% based on March 2022 data, the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.
    - xi. DAP HIE Data Quality Standards CYE 2022 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 0.5% DAP increase for each category of the five measure categories, for a total potential increase of 2.0% if criteria are met for all categories.
      - (1) Data source and data site information must be submitted on all ADT transactions. (0.5%)
      - (2) Event type must be properly coded on all ADT transactions. (0%)
      - (3) Patient class must be properly coded on all appropriate ADT transactions. (0%)
      - (4) Patient demographic information must be submitted on all ADT transactions. (0%)
      - (5) Race must be submitted on all ADT trans-

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- actions. (0.5%)
- (6) Ethnicity must be submitted on all ADT transactions. (0.5%)
- (7) Diagnosis must be submitted on all ADT transactions. (0.5%)
- (8) Overall completeness of the ADT message. (0%)
- b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates;
- i. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.
  - ii. No later than April 1, 2022:
    - (1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
    - (2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
    - (3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.
  - iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.
- c. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2022, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:
- i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
  - ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.
  - iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.
  - iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.
  - v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.
  - vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.
- d. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:
- i. Number of ICU beds in use,
  - ii. Number of ICU beds available for use,
  - iii. Number of Medical-Surgical beds in use,
  - iv. Number of Medical-Surgical beds available for use,
  - v. Number of Telemetry beds in use, and
  - vi. Number of Telemetry beds available for use.
2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets the criteria specified in subsection (2)(a), (b), (c), or (d):
- a. By April 1, 2022 the hospital must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:
    - i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
    - ii. No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:

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- (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
- (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
- (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
- iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf.
- iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
- v. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
- vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization.
- vii. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
- viii. No later than January 1, 2023, the hospital must complete the data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
- ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
- x. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below.
  - (1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on October 2021 data, to the final data quality profile, based on March 2022 data.
  - (2) Meet a minimum performance standard of at least 60% based on March 2022 data.
  - (3) If performance meets or exceeds an upper threshold of 90% based on March 2022 data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.
- xi. DAP HIE Data Quality Standards CYE 2022 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a DAP increase for select Data Quality Measures for a total of 8.0% if criteria are met for all categories indicating a DAP.
  - (1) Data source and data site information must be submitted on all ADT transactions. (2.0%)
  - (2) Event type must be properly coded on all ADT transactions. (0%)
  - (3) Patient class must be properly coded on all appropriate ADT transactions. (0%)
  - (4) Patient demographic information must be submitted on all ADT transactions. (0%)
  - (5) Race must be submitted on all ADT transactions. (2.0%)
  - (6) Ethnicity must be submitted on all ADT transactions. (2.0%)
  - (7) Diagnosis must be submitted on all ADT transactions. (2.0%)
  - (8) Overall completeness of the ADT message. (0%)
- b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates.
  - i. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.
  - ii. No later than April 1, 2022:
    - (1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
    - (2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
    - (3) For hospitals that have not participated in

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DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.

- iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.
- c. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2022, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:
  - i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
  - ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.
  - iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.
  - iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.
  - v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.
  - vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.
- d. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through

an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:

- i. Number of ICU beds in use,
- ii. Number of ICU beds available for use,
- iii. Number of Medical-Surgical beds in use,
- iv. Number of Medical-Surgical beds available for use,
- v. Number of Telemetry beds in use, and
- vi. Number of Telemetry beds available for use.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2338, effective October 1, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2851, effective October 1, 2018 (Supp. 18-3). Amended by final rulemaking at 25 A.A.R. 3111 and at 25 A.A.R. 3114, effective October 1, 2019 (Supp. 19-4). Amended by final rulemaking at 26 A.A.R. 3025, with an immediate effective date of November 3, 2020 (Supp 20-4). AHCCCS filed an incorrect version of a final rulemaking which made amendments to this Section published at 27 A.A.R. 2501 (October 29, 2021); AHCCCS filed the correct version of its final rulemaking on December 3, 2021, with this Section amended by final rulemaking at 27 A.A.R. 3015 (December 31, 2021), effective October 1, 2021 (Supp. 21-4). Amended by final rulemaking at 28 A.A.R. 3283 (October 14, 2022), with an immediate effective date of September 23, 2022 (Supp. 22-3).

**R9-22-712.62. DRG Base Payment**

- A. The initial DRG base payment is the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code assigned to the claim, and any applicable provider and service policy adjusters.
- B. The DRG base rate for each hospital is the statewide standardized amount of which the hospital's labor-related share of that amount is adjusted by the hospital's wage index. The hospital's labor share is determined based on the labor share for the Medicare inpatient prospective payment system published in 85 Fed. Reg. 59060 through 59061 (September 18, 2020). The hospital's wage index is determined based on the wage index tables reference in 85 Fed. Reg. 59059 (September 18, 2020). The statewide standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.
- C. Claims shall be assigned both a DRG code derived from all diagnosis and surgical procedure codes included on the claim (the "pre-HCAC" DRG code) and a DRG code derived excluding diagnosis and surgical procedure codes associated with the health care acquired conditions that were not present on admission or any other provider-preventable conditions (the "post-HCAC" DRG code). The DRG code with the lower relative weight shall be used to process claims using the DRG methodology.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4). Amended by final rulemaking at 27 A.A.R. 2512 (October 29, 2021), with an immediate effective date of October 6, 2021 (Supp. 21-4).

**R9-22-712.63. DRG Base Payments Not Based on the State-**

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**wide Standardized Amount**

- A.** Notwithstanding Section R9-22-712.62, a select specialty hospital standardized amount shall be used in place of the statewide standardized amount in subsection R9-22-712.62(B) to calculate the DRG base rate for the following hospitals:
1. Hospitals located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2011 Medicare Cost Report are reimbursed by Medicare.
  2. Hospitals designated as type: hospital, subtype: short-term that has a license number beginning "SH" in the Provider & Facility Database for Arizona Medical Facilities posted by the ADHS Division of Licensing Services on its website for March of each year.
- B.** The select specialty hospital standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

**R9-22-712.64. DRG Base Payments and Outlier CCR for Out-of-State Hospitals**

- A.** DRG Base payment:
1. For high volume out-of-state hospitals defined in subsection (C), the wage adjusted DRG base payment is determined as described in R9-22-712.62.
  2. Notwithstanding subsection R9-22-712.62 the wage adjusted DRG base rate for out-of-state hospitals that are not high volume hospitals shall be included in the AHCCCS capped fee schedule available on the agency's website.
- B.** Outlier CCR:
1. Notwithstanding subsection R9-22-712.68, the CCR used for the outlier calculation for out-of-state hospitals that are not high volume hospitals shall be the sum of the statewide urban default operating cost-to-charge ratio and the statewide capital CCR in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS.
  2. The CCR used for the outlier calculation for high volume out-of-state hospitals is the same as in-state hospitals as described in R9-22-712.68.
- C.** A high volume out-of-state hospital is a hospital not otherwise excluded under R9-22-712.61, that is located in a county that borders the State of Arizona and had 500 or more AHCCCS covered inpatient days for the fiscal year beginning October 1, 2015.
- D.** Other than as required by this Section, DRG reimbursement for out-of-state hospitals is determined under R9-22-712.60 through R9-22-712.81.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

**R9-22-712.65. DRG Provider Policy Adjustor**

- A.** After calculating the DRG base payment as required in R9-22-712.62, R9-22-712.63, or R9-22-712.64, for claims from a high-utilization hospital, the product of the DRG base rate and

the DRG relative weight for the post-HCAC DRG code shall be multiplied by a provider policy adjustor that is included in the AHCCCS capped fee schedule available on the agency's website.

- B.** A hospital is a high-utilization hospital if the hospital had:
1. Covered inpatient days subject to DRG reimbursement, determined using adjudicated claim and encounter data during the fiscal year beginning October 1, 2015, equal to at least four hundred percent of the statewide average number of AHCCCS-covered inpatient days at all hospitals;
  2. A Medicaid inpatient utilization rate greater than 30 percent calculated as the ratio of AHCCCS-covered inpatient days to total inpatient days as reported in the hospital's Medicare Cost Report for the fiscal year ending 2016; and,
  3. Received less than \$2 million in add-on payment for outliers under R9-22-712.68, based on adjudicated claims and encounters for fiscal year beginning October 1, 2015.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

**R9-22-712.66. DRG Service Policy Adjustor**

In addition to Section R9-22-712.65, for claims with DRG codes in the following categories, the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code, and the DRG provider policy adjustor shall be multiplied by the service policy adjustor listed in the AHCCCS capped fee schedule, available on the agency's website, corresponding to the following DRG codes:

1. Normal newborn DRG codes,
2. Neonates DRG codes,
3. Obstetrics DRG codes,
4. Psychiatric DRG codes,
5. Rehabilitation DRG codes,
6. Burn DRG codes.
7. Claims for members under age 19 assigned DRG codes other than listed above:
  - a. For dates of discharge occurring on or after October 1, 2014 and ending no later than December 31, 2015 regardless of severity of illness level,
  - b. For dates of discharge on or after January 1, 2016, for severity of illness levels 1 and 2,
  - c. For dates of discharge on or after January 1, 2016 and before January 1, 2017, for severity of illness levels 3 and 4.
  - d. For dates of discharge on or after January 1, 2017, and before January 1, 2018 for severity of illness levels 3 and 4.
  - e. For dates of discharge on or after January 1, 2018, for severity of illness levels 3 and 4.
8. Claims for members assigned DRG codes other than listed above.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

**R9-22-712.67. DRG Reimbursement: Transfers**

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- A. For purposes of this Section a “transfer” means the transfer of a member from a hospital to a short-term general hospital for inpatient care, a designated cancer center, children’s hospital, or a critical access hospital except when a member is moved for the purpose of receiving sub-acute services.
- B. Designated cancer center or children’s hospitals are those hospitals identified as such in the UB-04 billing manual published by the National Uniform Billing Committee.
- C. The hospital the member is transferred from shall be reimbursed either the initial DRG base payment or the transfer DRG base payment, whichever is less.
- D. The transfer DRG base payment is an amount equal to the initial DRG base payment, as determined after making any provider or service policy adjustors, divided by the DRG National Average length of stay for the DRG code multiplied by the sum of one plus the length of stay.
- E. The hospital the member is transferred to shall be reimbursed under the DRG payment methodology without a reduction due to the transfer.
- F. Unadjusted DRG base payment. The unadjusted DRG base payment is either the initial DRG base payment, as determined after making any provider or service policy adjustors, or the transfer DRG base payment, whichever is less.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4).

**R9-22-712.68. DRG Reimbursement: Unadjusted Outlier Add-on Payment**

- A. Claims for inpatient hospital services qualify for an outlier add-on payment if the claim cost exceeds the outlier cost threshold.
- B. The claim cost is determined by multiplying covered charges by an outlier CCR as described by the following subsections:
  1. For hospitals designated as type: hospital, subtype: children’s in the Provider & Facility Database for Arizona Medical Facilities posted by the ADHS Division of Licensing Services on its website for March of each year. The outlier CCR will be calculated by dividing the hospital total costs by the total charges using the most recent Medicare Cost Report available as of September 1 of that year.
  2. For Critical Access Hospitals the outlier CCR will be the sum of the statewide rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS.
  3. For all other hospitals the outlier CCR will be the sum of the operating cost-to-charge ratio and the capital cost-to-charge ratio established for each hospital in the impact file established as part of the Medicare Inpatient Prospective Payment System by CMS.
- C. AHCCCS shall update the CCRs described in subsection (B) to conform to the most recent CCRs established by CMS as of September 1 of each year, and the CCRs so updated shall be used for claims with dates of discharge on or after October 1 of that year.
- D. The outlier threshold is equal to the sum of the unadjusted DRG base payment plus the fixed loss amount. The fixed loss amount for critical access hospitals and for all other hospitals are included in the AHCCCS capped fee schedule available on the agency’s website.

- E. For those inpatient hospital claims that qualify for an outlier add-on payment, the payment is calculated by subtracting the outlier threshold from the claim cost and multiplying the result by the DRG marginal cost percentage. The DRG marginal cost percentage for claims assigned DRG codes associated with the treatment of burns and for all other claims are included in the AHCCCS capped fee schedule available on the agency’s website.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

**R9-22-712.69. DRG Reimbursement: Covered Day Adjusted DRG Base Payment and Covered Day Adjusted Outlier Add-on Payment**

Adjustments to the payments are made to account for days not covered by AHCCCS as follows:

1. A covered day reduction factor unadjusted is determined if the member is not eligible on the first day of the inpatient stay but is eligible for subsequent days during the inpatient stay. In this case, a covered day reduction factor unadjusted is calculated by dividing the number of AHCCCS covered days by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of days the member is eligible during the inpatient stay.
2. A covered day reduction factor unadjusted is also determined if the member is eligible on the first day of the inpatient stay but is determined ineligible for one or more days prior to the date of discharge. In this case, a covered day reduction factor unadjusted is calculated by adding one to the number of AHCCCS covered days and dividing the result by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of days the member is eligible during the inpatient stay.
3. If the covered day reduction factor unadjusted is greater than one, then the covered day reduction factor final is one; otherwise, the covered day reduction factor final is equal to the covered day reduction factor unadjusted.
4. The covered day adjusted DRG base payment is an amount equal to the product of the unadjusted DRG base payment and the covered day reduction factor final.
5. The covered day adjusted DRG outlier add-on payment is an amount equal to the product of the unadjusted DRG outlier add-on payment and the covered day reduction factor final.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.70. Covered Day Adjusted DRG Base Payment and Covered Day Adjusted Outlier Add-on Payment for FES members**

In addition to the covered day reduction factor in R9-22-712.69, a covered day reduction factor unadjusted is determined for an inpatient stay during which an FES member receives services for the treatment of an emergency medical condition and also receives services once the condition no longer meets the criteria as an emergency medical condition described in R9-22-217.

1. A covered day reduction factor unadjusted is calculated by adding one to the AHCCCS covered days and dividing

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the result by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of inpatient days during which an FES member receives services for an emergency medical condition as described in R9-22-217. For purposes of this adjustment, any portion of a day during which the FES member receives treatment for an emergency medical condition is counted as an AHCCCS covered day.

2. If the covered day reduction factor unadjusted is greater than one, then the covered day reduction factor final is one; otherwise, the covered day reduction factor final is equal to the covered day reduction factor unadjusted.
3. The covered day adjusted DRG base payment is an amount equal to the product of the unadjusted DRG base payment and the covered day reduction factor final.
4. The covered day adjusted DRG outlier add-on payment is an amount equal to the product of the unadjusted DRG outlier add-on payment and the covered day reduction factor final.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.71. Final DRG Payment**

- A. The final DRG payment is the sum of the final DRG base payment, the final DRG outlier add-on payment, and the Differential Adjusted Payment.
- B. The final DRG base payment is an amount equal to the product of the covered day adjusted DRG base payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.
- C. The final DRG outlier add-on payment is an amount equal to the product of the covered day adjusted DRG outlier add-on payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.
- D. The factor for each hospital and for each federal fiscal year is published as part of the AHCCCS capped fee schedule and is available on the AHCCCS administration's website and is on file for public inspection at the AHCCCS administration located at 801 E. Jefferson Street, Phoenix, Arizona.
- E. For inpatient services with a date of discharge from October 1, 2022 through September 30, 2023, the Inpatient Differential Adjusted Payment is the sum of the final DRG base payment and the final DRG outlier add-on payment multiplied by a percentage published on the Administration's public website as part of its fee schedule, subsequent to the public notice published no later than September 1, 2022. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.
  1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria:
    - a. By April 1, 2022, a hospital the hospital must have submitted a Letter of Intent (LOI) to AHCCCS and the Health Information Exchange (HIE), in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved.
      - i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
      - ii. No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
        - (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE organization to ensure proper processing of lab results within the HIE system.
        - (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
        - (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
      - iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf.
      - iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
      - v. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

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- vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization.
- vii. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
- viii. No later than January 1, 2023, the hospital must complete the data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
- ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
- x. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below.
  - (1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on October 2021 data, to the final data quality profile, based on March 2022 data.
  - (2) Meet a minimum performance standard of at least 60% based on March 2022 data.
  - (3) If performance meets or exceeds an upper threshold of 90% based on March 2022 data, the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.
- xi. DAP HIE Data Quality Standards CYE 2023 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 0.5% DAP increase for each category of the five measure categories, for a total potential increase of 2.0% if criteria are met for all categories.
  - (1) Data source and data site information must be submitted on all ADT transactions. (0.5%)
  - (2) Event type must be properly coded on all ADT transactions. (0%)
  - (3) Patient class must be properly coded on all appropriate ADT transactions. (0%)
  - (4) Patient demographic information must be submitted on all ADT transactions. (0%)
  - (5) Race must be submitted on all ADT transactions. (0.5%)
  - (6) Ethnicity must be submitted on all ADT transactions. (0.5%)
  - (7) Diagnosis must be submitted on all ADT transactions. (0.5%)
  - (8) Overall completeness of the ADT message. (0%)
- b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates.
  - i. No later than April 1, 2022, submit registration form or forms for participation using the form or forms on the website of the qualifying HIE organization.
  - ii. No later than April 1, 2022:
    - (1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
    - (2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
    - (3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.
  - iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.
  - c. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2022, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:
    - i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
    - ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.
    - iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.
    - iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.
    - v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming

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- guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.
- vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.
  - d. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:
    - i. Number of ICU beds in use,
    - ii. Number of ICU beds available for use,
    - iii. Number of Medical-Surgical beds in use,
    - iv. Number of Medical-Surgical beds available for use,
    - v. Number of Telemetry beds in use,
    - vi. Number of Telemetry beds available for use.
  2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets the criteria specified;
    - a. By April 1, 2022 the hospital must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:
      - i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
        - (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
        - (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
        - (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
      - iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf.
      - iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
      - v. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
      - vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization.
      - vii. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
      - viii. No later than January 1, 2023, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
      - ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
      - x. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below.
        - (1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on October 2021 data, to the final data quality profile, based on March 2022 data.
        - (2) Meet a minimum performance standard of at least 60% based on March 2022 data.
        - (3) If performance meets or exceeds an upper threshold of 90% based on March 2022

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- data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.
- xi. DAP HIE Data Quality Standards CYE 2023 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a DAP increase for select Data Quality Measures for a total of 8.0% if criteria are met for all categories indicating a DAP.
    - (1) Data source and data site information must be submitted on all ADT transactions. (1.0%)
    - (2) Event type must be properly coded on all ADT transactions. (1.0%)
    - (3) Patient class must be properly coded on all appropriate ADT transactions. (0%)
    - (4) Patient demographic information must be submitted on all ADT transactions. (0%)
    - (5) Race must be submitted on all ADT transactions. (2.0%)
    - (6) Ethnicity must be submitted on all ADT transactions. (2.0%)
    - (7) Diagnosis must be submitted on all ADT transactions. (2.0%)
    - (8) Overall completeness of the ADT message. (0%)
  - b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates;
    - i. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.
    - ii. No later than April 1, 2022:
      - (1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
      - (2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
      - (3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.
    - iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.
  - c. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2022, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:
    - i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
    - ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.
    - iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.
    - iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.
    - v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.
    - vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.
  - d. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:
    - i. Number of ICU beds in use,
    - ii. Number of ICU beds available for use,
    - iii. Number of Medical-Surgical beds in use,
    - iv. Number of Medical-Surgical beds available for use,
    - v. Number of Telemetry beds in use, and
    - vi. Number of Telemetry beds available for use.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2338, effective October 1, 2017 (Supp. 17-3). Amended

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by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4). Amended by final rulemaking at 24 A.A.R. 2851, effective October 1, 2018 (Supp. 18-3). Amended by final rulemaking at 25 A.A.R. 3114, effective October 31, 2019 (Supp. 19-4). Amended by final rulemaking at 26 A.A.R. 3025, with an immediate effective date of November 3, 2020 (Supp 20-4). AHCCCS filed an incorrect version of a final rulemaking which made amendments to this Section published at 27 A.A.R. 2501 (October 29, 2021); AHCCCS filed the correct version of its final rulemaking on December 3, 2021, with this Section amended by final rulemaking at 27 A.A.R. 3015 (December 31, 2021), effective October 1, 2021 (Supp. 21-4). Amended by final rulemaking at 28 A.A.R. 3283 (October 14, 2022), with an immediate effective date of September 23, 2022 (Supp. 22-3).

**R9-22-712.72. DRG Reimbursement: Enrollment Changes During an Inpatient Stay**

- A. If a member's enrollment changes during an inpatient stay, including changing enrollment from fee-for-service to a contractor, or vice versa, or changing from one contractor to another contractor, the contractor with whom the member is enrolled on the date of discharge shall be responsible for reimbursing the hospital for the entire length of stay under the DRG payment rules in Sections R9-22-712.60 through R9-22-712.81. If the member is eligible but not enrolled with a contractor on the date of discharge, then the AHCCCS administration shall be responsible for reimbursing the hospital for the entire length of stay under the DRG payment rules in Sections R9-22-712.60 through R9-22-712.81.
- B. When a member's enrollment changes during an inpatient stay, the hospital shall use the date of enrollment with the payer responsible on the date of discharge as the "from" date of service on the claim regardless of the date of admission.
- C. Interim claims submitted to a payer other than the payer responsible on the day of discharge shall be processed in the same manner as other interim claims as described in R9-22-712.76.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

**R9-22-712.73. DRG Reimbursement: Inpatient Stays for Members Eligible for Medicare**

If the hospital receives less than the full Medicare payment for a member eligible for benefits under Part A of Medicare because the member has exceeded the maximum benefit permitted under Part A of Medicare, the hospital shall submit a separate claim for services performed after the date the maximum Medicare Part A benefit is exceeded. The claim may include all diagnosis codes for the entire inpatient stay, but the hospital is only required to include revenue codes, surgical procedure codes, service units, and charges for services performed after the date the Medicare Part A benefit is exceeded. A claim so submitted shall be reimbursed using the DRG payment methodology.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.74. DRG Reimbursement: Third Party Liability**  
DRG payments are subject to reduction based on cost avoidance under Section R9-22-1003 and other rules regarding first-and third-

party liability under Article 10 of this Chapter including cost avoidance for claims for ancillary services covered under Part B of Medicare.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.75. DRG Reimbursement: Payment for Administrative Days**

- A. Categories of Administrative Days. Administrative days fall into one of two categories, either subsection (A)(1) or (A)(2).
1. Administrative days due to lack of appropriate placement options and not meeting inpatient medical criteria. Administrative days are days in which a member is admitted as an inpatient to an acute care hospital, does not meet the criteria for an acute inpatient stay, but is admitted or not discharged because; (1) an appropriate placement outside the hospital is not available, (2) the member cannot be safely discharged or transferred, or (3) the Administration or the contractor failed to provide for the appropriate placement outside the hospital in a timely manner.
    - a. Administrative days may occur prior to an acute care episode, for example, when a woman with a high-risk pregnancy is admitted to a hospital while awaiting delivery.
    - b. Administrative days may also occur at the end of an acute care episode, for example, when a member is not discharged while awaiting placement in a nursing facility or other sub-acute or post-acute setting.
    - c. Administrative days may also include days in a receiving hospital when the member has been discharged from one acute care hospital for the purpose of receiving sub-acute services at the receiving hospital.
    - d. Administrative days do not include days when the member is awaiting appropriate placement or services that are currently available but the hospital has not transferred or discharged the member because of the hospital's administrative or operational delays.
    - e. Administrative days include inpatient claims covered by a RBHA or TRBHA that otherwise meet the criteria in subsection (A)(1).
  2. Administrative days for claims with the principal diagnosis of behavioral health meeting inpatient medical criteria. Administrative days are days with dates of discharge on or after October 1, 2018, in which a member is admitted as an inpatient to an acute care hospital, meets the criteria for an acute inpatient stay, and the principal diagnosis on the hospital claim is a behavioral health diagnosis. Inpatient claims covered by a RBHA or TRBHA are not considered administrative days under subsection (A)(2) regardless of the principal diagnosis on the hospital claim.
- B. Reimbursement of Administrative Days.
1. Administrative days under subsection (A)(1) are reimbursed at the rate the claim would have paid had the services not been provided in an inpatient hospital setting but had been provided at the appropriate level of care such as the rate paid for stays at a nursing facility.
  2. Administrative days under subsection (A)(2) are reimbursed at the daily rate found on the Inpatient Behavioral Health Capped Fee-For-Service Schedule meeting the

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criteria of "Service Description – Psychiatric Stay," regardless of revenue code.

- C. Prior authorization is required for administrative days.
- D. A hospital shall submit a claim for administrative days separate from any claim for reimbursement for the inpatient stay otherwise reimbursable under the DRG payment methodology.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 25 A.A.R. 3111, effective October 1, 2019 (Supp. 19-4).

**R9-22-712.76. DRG Reimbursement: Interim Claims**

- A. For inpatient stays with a length of stay greater than 29 days, a hospital may submit interim claims for each 30 day period during the inpatient stay.
- B. Hospitals shall be reimbursed for interim claims at a per diem rate of \$500 per day.
- C. Following discharge, the hospital shall void all interim claims. In such circumstances, the hospital shall submit a claim to the payer with whom the member is enrolled on the date of discharge, whether the Administration or a contractor, for the entire inpatient stay for which the final claim shall be reimbursed under the DRG payment methodology. Interim claims will be recouped.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.77. DRG Reimbursement: Admissions and Discharges on the Same Day**

- A. Except as provided for in subsection (B), for any claim for inpatient services with an admission date and discharge date that are the same calendar date, the contractor or the Administration shall process the claim as an outpatient claim and the hospital shall be reimbursed under R9-22-712.10 through R9-22-712.50.
- B. Claims with an admission date and discharge date that are the same calendar date that also indicate that the member expired on the date of discharge shall be reimbursed under the DRG methodology.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.78. DRG Reimbursement: Readmissions**

If a member is readmitted without prior authorization to the same hospital that the member was discharged from within 72 hours and the DRG code assigned to the claim for the prior admission has the same first three digits as the DRG code assigned to the claim for the readmission, then payment for the claim for the readmission will be disallowed only if the readmission could have been prevented by the hospital.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.79. DRG Reimbursement: Change of Ownership**

The administration shall not change any of the components of the calculation of reimbursement for inpatient services using the DRG methodology based upon a change in the hospital's ownership except to the extent those components would change under the

methodology had the hospital not changed ownership (e.g., updating the hospital's cost-to-charge ratio as of September 1 of each year under R9-22-712.68).

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.80. DRG Reimbursement: New Hospitals**

- A. DRG base payment for new hospitals. For any hospital that does not have a labor share or wage index published by CMS as described in subsection R9-22-712.62(B) because the hospital was not in operation, the DRG base rate described in subsection R9-22-712.62(B) shall be calculated as the statewide standardized amount after adjusting that amount for the labor-related share and the wage index published by CMS as described in subsection R9-22-712.62(B) that is appropriate to the location of the hospital published by CMS as described in subsection R9-22-712.62(B).
- B. Outlier calculations for new hospitals. For any hospital that does not have an operating cost-to-charge ratio listed in the impact file described in subsection R9-22-712.68(B) because the hospital was not in operation prior to the publication of the impact file, the statewide urban or rural default operating cost-to-charge ratio appropriate to the location of the hospital and the statewide capital cost-to-charge ratio shall be used to determine the unadjusted outlier add-on payment. The statewide urban or rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio shall be based on the ratios published by CMS and updated by the Administration as described in subsection R9-22-712.68(C).
- C. In addition to the requirement of this Section, DRG reimbursement for new hospitals is determined under R9-22-712.60 through R9-22-712.79.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

**R9-22-712.81. DRG Reimbursement: Updates**

In addition to the other updates provided for in Sections R9-22-712.60 through R9-22-712.80, the Administration may update the version of the APR-DRG classification system established by 3M Health Information Systems, adjust the statewide standardized amount in Section R9-22-712.62, the base payments in R9-22-712.63 and R9-22-712.64, the provider policy adjustor in R9-22-712.65, service policy adjustors in R9-22-712.66, and the fixed loss amounts and marginal cost percentages used to calculate the outlier threshold in R9-22-712.68 to the extent necessary to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. The Administration shall publish any proposed classification system on the agency's website at least 30 days prior to the effective date, to ensure a sufficient period for public comment, as required by 42 C.F.R. § 447.205. In addition, the public notice shall be available for inspection during normal business hours at 701 E. Jefferson, Phoenix, Arizona. The requirements of 42 CFR § 447.205 as of November 2, 2015 are incorporated by reference and do not include any later amendments.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final

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rulemaking at 23 A.A.R. 2896, effective January 1, 2018  
(Supp. 17-4).

**R9-22-712.90. Reimbursement of Hospital-based Freestanding Emergency Departments**

- A.** “Hospital-based freestanding emergency department” (hospital-based FSED) means an outpatient treatment center, as defined in R9-10-101, that: (1) provides emergency room services under R9-10-1019, (2) is subject to the requirements of 42 CFR 489.24, and (3) shares an ownership interest with a hospital, regardless of whether the outpatient treatment center operates under a hospital’s single group license as described in A.R.S. § 36-422.
- B.** A hospital-based FSED shall register with the Administration separately from the hospital with which an ownership interest is shared and shall obtain a separate provider identification number. The Administration shall not charge a separate provider enrollment fee for registration of a hospital-based FSED. The Administration shall accept a hospital’s compliance with the provider screening and enrollment requirements of 42 CFR Part 455 as compliance by the hospital-based FSED.
- C.** For dates of service on and after March 1, 2017, and except as provided in subsection (D), services provided by a hospital-based FSED for evaluation and management CPT codes 99281 through 99285 shall be reimbursed at the following percentages of the amounts otherwise reimbursable under R9-22-712.20 through R9-22-712.30. All other covered codes shall be reimbursed in accordance with R9-22-712.20 through R9-22-712.30 without a percentage reduction.
1. 60 percent for a level 1 emergency department visit as indicated by CPT 99281.
  2. 80 percent for a level 2 emergency department visit as indicated by CPT 99282.
  3. 90 percent for a level 3 emergency department visit as indicated by CPT 99283.
  4. 100 percent for a level 4 or 5 emergency department visit as indicated by CPT codes 99284 and 99285.
- D.** A hospital-based FSED located in a city or town in a county with less than 500,000 residents, where the only hospital in the city or town operating an emergency department closed on or after January 1, 2015, shall be reimbursed under R9-22-712.20 through R9-22-712.35 using the adjustment in R9-22-712.35 associated with the nearest hospital with which the freestanding emergency department shares an ownership interest.
- E.** Services provided by an outpatient treatment center that provides emergency room services under R9-10-1019, but does not otherwise meet the criteria in subsection A, shall be reimbursed based on the non-hospital AHCCCS capped fee-for-service schedule under R9-22-710.
- F.** The Administration shall not reimburse a hospital for services provided at a hospital-based FSED if the member is admitted directly from a hospital-based FSED to a hospital with an ownership interest in the hospital-based FSED. As provided in R9-22-712.60(B), payments made for the inpatient stay using the DRG methodology shall be the sole reimbursement.

**Historical Note**

New Section made by final rulemaking at 23 A.A.R. 22,  
February 11, 2017 (Supp. 16-4).

**R9-22-713. Overpayment and Recovery of Indebtedness**

- A.** If a contractor or a subcontracting provider receives an overpayment from the Administration or otherwise becomes indebted to the Administration, the contractor or subcontracting provider shall immediately remit the amount of the indebtedness or overpayment to the Administration for deposit in the AHCCCS fund.

- B.** If the funds described in subsection (A) are not remitted, the Administration may recover the funds paid by the Administration to a contractor or subcontracting provider through:
1. A repayment agreement executed with the Administration;
  2. Withholding or offsetting against current or future payments to be paid to the contractor or subcontracting provider; or
  3. Enforcement of, or collection against, the performance bond, financial reserve, or other financial security under A.R.S. § 36-2903.

**Historical Note**

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to the emergency (Supp. 83-3). Former Section R9-22-713 repealed, new Section R9-22-713 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-713 renumbered and amended as Section R9-22-714, former Section R9-22-709 renumbered and amended as Section R9-22-713 effective October 1, 1985 (Supp. 85-5). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

**R9-22-714. Payments to Providers**

- A.** Provider agreement. The Administration or a contractor shall not reimburse a covered service provided to a member unless the provider has signed a provider agreement with the Administration that establishes the terms and conditions of participation and payment under A.R.S. § 36-2904.
- B.** Provider reimbursement. The Administration or a contractor shall reimburse a provider for a service furnished to a member only if:
1. The provider personally furnishes the service to a specific member. For purposes of this Section, services personally furnished by a provider include:
    - a. Services provided by medical residents or dental students in a teaching environment; or
    - b. Services provided by a licensed or certified assistant under the general supervision of a licensed practitioner in accordance with 4 A.A.C. 24, 9 A.A.C. 16, 4 A.A.C. 43, or 4 A.A.C. 45;
  2. The provider verifies that individuals who have provided services described in subsection (B)(1) have not been placed on the List of Excluded Individuals/Entities (LEIE) maintained by the United States Department of Health and Human Services Office of the Inspector General (OIG), located at OIG’s web site;
  3. The service contributes directly to the diagnosis or treatment of the member; and
  4. The service ordinarily requires performance by the type of provider seeking reimbursement.
- C.** The Administration or a contractor may make a payment for covered services only:
1. To the provider;
  2. To anyone specified in a reassignment from the provider to a government agency or reassignment by a court order;
  3. To a business agent, if the agent’s compensation for the service is:
    - a. Related to the cost of processing the billing;

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- b. Not related on a percentage or other basis to the amount that is billed or collected; and
  - c. Not dependent upon collection of the payment;
  - 4. To the employer of the provider, if the provider is required as a condition of employment to turn over the provider's fees to the employer;
  - 5. To the inpatient facility in which the service is provided, if the provider has a contract under which the inpatient facility submits the claim; or
  - 6. To a foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the foundation, plan or similar organization submits the claim.
- D.** The Administration or a contractor shall not make a payment to or through a factor, either directly or by power of attorney, for a covered service furnished to a member by a provider.
- E.** Reimbursement for a pathology service. Unless otherwise specified in a contract, the Administration or a contractor shall reimburse a pathologist for a pathology service furnished to a member only if the other requirements in this Section are met and the service is:
- 1. A surgical pathology service;
  - 2. A specific cytopathology, hematology, or blood banking pathology service that requires performance by a physician and is listed in the capped fee-for-service schedule;
  - 3. A clinical consultation service that:
    - a. Is requested by the member's attending physician or primary care physician,
    - b. Is related to a test result that is outside the clinically significant normal or expected range in view of the condition of the member,
    - c. Results in a written narrative report included in the member's medical record,
    - d. Requires the exercise of medical judgment by the consultant pathologist, and
    - e. Is listed in the capped fee-for-service schedule; or
  - 4. A clinical laboratory interpretative service that:
    - a. Is requested by the member's attending physician or primary care physician,
    - b. Results in a written narrative report included in the member's medical record,
    - c. Requires the exercise of medical judgment by the consultant pathologist, and
    - d. Is listed in the capped fee-for-service schedule.

**Historical Note**

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule is similar to the emergency (Supp. 83-3). Repealed effective October 1, 1983 (Supp. 83-5). Former Section R9-22-713 renumbered and amended as Section R9-22-714 effective October 1, 1985 (Supp. 85-5). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 9 A.A.R. 3800, effective October 4, 2003 (Supp. 03-3). Amended by final rulemaking at 13 A.A.R. 662, 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 this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.*

*ation in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.*

**R9-22-715. Hospital Rate Negotiations**

- A.** A contractor that negotiates with hospitals for inpatient or outpatient services shall reimburse hospitals for services rendered on or after March 1, 1993, as described in A.R.S. § 36-2903.01 and this Article, or at the negotiated rate that, in the aggregate, does not exceed reimbursement levels that would have been paid under A.R.S. § 36-2903.01, and this Article. This subsection does not apply to urban hospitals described under R9-22-718. Contractors may engage in rate negotiations with a hospital at any time during the contract period.
- B.** The Administration may negotiate or contract with a hospital on behalf of a contractor for discounted hospital rates and may require that the negotiated discounted rates be included in a subcontract between the contractor and hospital.

**Historical Note**

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to the emergency (Supp. 83-3). Repealed effective October 1, 1983 (Supp. 83-5). New Section R9-22-715 adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective January 14, 1997 (Supp. 97-1). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

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

**R9-22-716. Repealed****Historical Note**

Adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Section repealed by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

**R9-22-717. Repealed****Historical Note**

Adopted effective July 30, 1993 (Supp. 93-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3).

*Editor's Note: The following Section was originally adopted under an exemption from the provisions of the Administrative*

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*Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council. The agency was required to submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and was required to hold a public hearing. It has since been amended under the regular rulemaking process.*

**R9-22-718. Urban Hospital Inpatient Reimbursement Program**

**A. Definitions.** The following definitions apply to this Section:

1. "Contractor" has the same meaning as set forth in A.R.S. § 36-2901, and includes all contractors regardless of whether the GSA's served by the contractor includes urban or rural counties.
2. "Noncontracted Hospital" means an urban hospital, including psychiatric hospitals, which does not have a contract under this Section with a contractor.
3. "Urban Hospital" means a hospital that is not a rural hospital, as defined in R9-22-712.07, and that is physically located in Maricopa or Pima County.

**B. General Provisions.**

1. This Section applies to an urban hospital who receives payment for inpatient hospital services under A.R.S. §§ 36-2903.01 and 36-2904.
2. AHCCCS shall operate an inpatient hospital reimbursement program under A.R.S. § 36-2905.01 and this Section.
3. Residency of the member receiving inpatient AHCCCS covered services is not a factor in determining which hospitals are required to contract with which contractors.
4. A contractor shall enter into a contract for reimbursement for inpatient AHCCCS covered services with one or more urban hospitals located in the same county as the contractor.
5. A noncontracted urban hospital shall be reimbursed for inpatient services by a contractor at 95 percent of the amount calculated as defined in A.R.S. § 36-2903.01 and this Article, unless otherwise negotiated by both parties.

**C. Contract Begin Date.** A contract under this Article shall cover inpatient acute care hospital services for members with hospital admissions on and after October 1, 2003.

**D. Outpatient urban hospital services.** Outpatient urban hospital services, including observation days and emergency room treatments that do not result in an admission, shall be reimbursed either through an urban hospital contract negotiated between a contractor and an urban hospital, or the reimbursement rates set forth in A.R.S. § 36-2903.01. Outpatient services in an urban hospital that result in an admission shall be paid as inpatient services in accordance with this Section.

**E. Urban Hospital Contract.**

1. Provisions of an urban hospital contracts. The urban hospital contract shall contain but is not limited to the following provisions:
  - a. Required provisions as described in the Request for Proposals (RFP);
  - b. Dispute settlement procedures. If the AHCCCS Grievance System prescribed in A.R.S. § 36-2903.01(B) and rule is not used, then arbitration shall be used;
  - c. Arbitration procedure. If arbitration is used, the urban hospital contract shall identify:
    - i. The parties' agreement on arbitrating claims arising from the contract,
    - ii. Whether arbitration is nonbinding or binding,
    - iii. Timeliness of arbitration,

- iv. What contract provisions may be appealed,
  - v. What rules will govern arbitrations,
  - vi. The number of arbitrators that shall be used,
  - vii. How arbitrators shall be selected, and
  - viii. How arbitrators shall be compensated.
- d. Timeliness of claims submission and payment;
  - e. Prior authorization;
  - f. Concurrent review;
  - g. Electronic submission of claims;
  - h. Claims review criteria;
  - i. Payment of discounts or penalties such as quick-pay and slow-pay provisions;
  - j. Payment of outliers;
  - k. Claim documentation specifications under A.R.S. § 36-2904.
    - l. Treatment and payment of emergency room services; and
    - m. Provisions for rate changes and adjustments.
2. AHCCCS review and approval of urban hospital contracts:
- a. AHCCCS may review, approve, or disapprove the hospital contract rates, terms, conditions, and amendments to the contract;
  - b. The AHCCCS evaluation of each urban hospital contract shall include but not be limited to the following areas:
    - i. Availability and accessibility of services to members,
    - ii. Related party interests,
    - iii. Inclusion of required terms pursuant to this Section, and
    - iv. Reasonableness of the rates.
- F. Quick-Pay/Slow-Pay.** A payment made by a contractor to a noncontracted hospital shall be subject to quick-pay discounts and slow-pay penalties under A.R.S. § 36-2904.

**Historical Note**

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective January 29, 1997; pursuant to Laws 1996, Ch. 288, § 24 (Supp. 97-1). Amended by exempt rulemaking at 10 A.A.R. 500, effective February 1, 2004 (Supp. 04-1). Amended by exempt rulemaking at 13 A.A.R. 3190, effective October 1, 2007 (Supp. 07-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 24 A.A.R. 1515, effective June 30, 2018 (Supp. 18-2).

**R9-22-719. Contractor Performance Measure Outcomes**

The Administration may retain a specified percentage of capitation reimbursement to distribute to contractors based on their performance measure outcomes under A.R.S. § 36-2904. The Administration shall notify contractors 60 days prior to a new contract year if this methodology is implemented. The Administration shall specify the details of the reimbursement methodology in contract.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-720. Reinsurance**

**A.** Reinsurance is a stop-loss program provided by the Administration to a contractor for partial reimbursement of the cost of covered services for a member with an acute medical condition when the cost of covered services exceeds a pre-determined deductible level amount within a contract year. The

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Administration self-insures the reinsurance program through a reduction to capitation rates. The reinsurance program also includes a catastrophic reinsurance program for members diagnosed with specific medical conditions.

- B. The Administration shall specify in contract guidelines for claims submission, processing, payment, and the types of care and services that are provided to a member whose care is covered by reinsurance.
- C. When the Administration determines that a contractor does not follow the specified guidelines for care or services and the care or services could have been provided at a lower cost according to the guidelines, the Administration shall reimburse the contractor as if the care or services had been provided as specified in the guidelines.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

**R9-22-721. Behavioral Health Inpatient Facilities**

“Behavioral health inpatient facility” means a health care institution, other than Arizona State Hospital, that meets the following requirements:

1. Provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:
  - a. Have a limited or reduced ability to meet the individual’s basic physical needs;
  - b. Suffer harm that significantly impairs the individual’s judgment, reason, behavior, or capacity to recognize reality;
  - c. Be a danger to self;
  - d. Be a danger to others;
  - e. Be persistently or acutely disabled as defined in A.R.S. § 36-501; or
  - f. Be gravely disabled; and
2. Is one of the following facility types:
  - a. Psychiatric hospitals;
  - b. Mental health residential treatment centers;
  - c. Secure residential treatment centers with 17 or more beds;
  - d. Non-secure residential treatment centers with 1-16 beds;
  - e. Non-secure residential treatment centers with 17 or more beds;
  - f. Sub-acute facilities with 1-16 beds;
  - g. Sub-acute facilities with 17 or more beds.

**Historical Note**

New Section made by final rulemaking at 25 A.A.R. 3120, effective October 1, 2019 (Supp. 19-4).

**R9-22-722. Reserved**

**R9-22-723. Reserved**

**R9-22-724. Reserved**

**R9-22-725. Reserved**

**R9-22-726. Reserved**

**R9-22-727. Reserved**

**R9-22-728. Reserved**

**R9-22-729. Reserved**

*Editor’s Note: Amendments to Section R9-22-730 were filed*

*as a final exempt rulemaking. AHCCCS provided an opportunity for public comment on the amended rules under Laws 2013, 1st Special Session, Ch. 10. A proposed exempt rulemaking was published in the Arizona Administrative Register at 21 A.A.R. 1041 (Supp. 15-3).*

*Editor’s Note: Amendments to Section R9-22-730 were filed as a final exempt rulemaking. AHCCCS provided an opportunity for public comment on the amended rules under Laws 2013, 1st Special Session, Ch. 10. A proposed exempt rulemaking was published in the Arizona Administrative Register at 21 A.A.R. 491 (Supp. 15-2).*

**R9-22-730. Hospital Assessment Fund - Hospital Assessment**

A. For purposes of this Section, the following terms are defined as provided below unless the context specifically requires another meaning:

1. “2019 Medicare Cost Report” means The Medicare Cost Report for the hospital fiscal year ending in calendar year 2019 as reported in the CMS Healthcare Provider Cost Reporting Information System (HCRIS) release dated October 9, 2020.
2. “2019 Uniform Accounting Report” means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of December 10, 2020 for the hospital’s fiscal year ending in calendar year 2019.
3. “Quarter” means the three month period beginning January 1, April 1, July 1, and October 1 of each year.
4. A “new hospital” means a licensed hospital that did not hold a license from the Arizona Department of Health Services prior to January 2, 2022.
5. “Outpatient Net Patient Revenues” means an amount, calculated using data in the hospital’s 2019 Uniform Accounting Report, that is equal to the hospital’s 2019 total net patient revenue multiplied by the ratio of the hospital’s 2019 gross outpatient revenue to the hospital’s 2019 total gross patient revenue.

B. Beginning January 1, 2014, for each Arizona licensed hospital not excluded under subsection (I) shall be subject to an assessment payable on a quarterly basis. The assessment shall be levied against the legal owner of each hospital as of the first day of the quarter, and except as otherwise required by subsections (D), (E) and (F). For the period beginning October 1, 2022, the assessment for each hospital shall be amount equal to the sum of: (1) the number of discharges reported on the hospital’s 2019 Medicare Cost Report, excluding discharges reported on the Medicare Cost Report as “Other Long Term Care Discharges,” multiplied by the following rates appropriate to the hospital’s peer group; and (2) the amount of outpatient net patient revenues multiplied by the following rate appropriate to the hospital’s peer group:

1. \$829.50 per discharge and 1.5314% of outpatient net patient revenues for hospitals located in a county with a population less than 500,000 that are designated as type: hospital, subtype: short-term.
2. \$829.50 per discharge and 0.6381% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.
3. \$207.50 per discharge and 0.6381% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.
4. \$207.50 per discharge and 0.6381% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.

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- tal, subtype: psychiatric, that reported 2,500 or more discharges on the 2019 Medicare Cost Report.
5. \$663.50 per discharge and 1.6590% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's 2019 Uniform Accounting Report.
  6. \$746.50 per discharge and 1.9142% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with at least 10% but less than 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's 2019 Uniform Accounting Report.
  7. \$166.00 per discharge and 0.5105% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: children's.
  8. \$829.50 per discharge and 2.5523% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term not included in another peer group.
- C. Peer groups for the four quarters beginning October 1 of each year are established based on hospital license type and subtype designated in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website January, 2022.
  - D. Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's 2019 Medicare Cost Report, are assessed a rate of \$207.50 for each discharge from the psychiatric sub-provider as reported in the 2019 Medicare Cost Report. All discharges other than those reported as discharges from the psychiatric sub-provider are assessed at the rate required by subsection (B).
  - E. Notwithstanding subsection (B), rehabilitative discharges from a hospital that reported having a rehabilitative sub-provider in the hospital's 2019 Medicare Cost Report, are assessed a rate of \$0 for each discharge from the rehabilitative sub-provider as reported in the 2019 Medicare Cost Report. All discharges other than those reported as discharges from the rehabilitative sub-provider are assessed at the rate required by subsection (B).
  - F. Notwithstanding subsection (B), for any hospital that reported more than 24,000 discharges on the hospital's 2019 Medicare Cost Report, discharges in excess of 24,000 are assessed a rate of \$83.00 for each discharge in excess of 24,000. The initial 24,000 discharges are assessed at the rate required by subsection (B).
  - G. Assessment notice. On or before the 15th day of the first month of the quarter or upon CMS approval, whichever is later, the Administration shall send to each hospital a notification that the Hospital Assessment Fund assessment invoice is available to be viewed on a secure website. The invoice shall include the hospital's peer group assignment and the assessment due for the quarter.
  - H. Assessment due date. The Hospital Assessment Fund assessment must be received by the Administration no later than:
    1. The 15th day of the second month of the quarter or
    2. In the event CMS approves the assessment after the 15th day of the first month of the quarter, 30 days after notification by the Administration that the assessment invoice is available.
  - I. Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital's 2019 Medicare Cost Report and Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for January 2, 2022:
    1. Hospitals owned and operated by the state, the United States, or an Indian tribe.
    2. Hospitals designated as type: hospital, subtype: short-term that have a license number beginning "SH".
    3. Hospitals designated as type: hospital, subtype: psychiatric that reported fewer than 2,500 discharges on the 2019 Medicare Cost Report.
    4. Hospitals designated as type: hospital, subtype; rehabilitation.
    5. Hospitals designated as type: med-hospital, subtype: special hospitals.
    6. Hospitals designated as type: hospital, subtype: short-term located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2019 Medicare Cost Report are reimbursed by Medicare.
    7. Hospitals designated as type: hospital, subtype: short-term that have at least 25 percent Medicare swing beds as percentage of total Medicare days, per the 2019 Medicare Cost Report.
    8. Hospitals designated as type: hospital, subtype: short-term that are an urban public acute care hospital.
  - J. New hospitals. For hospitals that did not file a 2019 Medicare Cost Report because of the date the hospital began operations:
    1. If the hospital was open on the January 2 preceding the October assessment start date, the hospital assessment will begin on October 1 following the date the hospital began operating.
    2. If the hospital began operating between January 3 and June 30, the assessment will begin on October 1 of the following calendar year.
    3. A hospital is not considered a new hospital based on a change in ownership.
    4. The assessment will be based on the discharges reported in the hospital's first Medicare Cost Report and Uniform Accounting Report, which includes 12 months-worth of data, except when any of the following apply;
      - a. If there is not a complete 12 months-worth of data available, the assessment will be based on the annualized number of discharges from the date hospital operations began through December 31 preceding the October assessment start date. The hospital shall self-report the discharge data and all other data requested by the Administration necessary to determine the appropriate assessment to the Administration no later than January preceding the assessment start date for the new hospitals. "Annualized" means divided by a ratio equal to the number of months of data divided by 12 months.
      - b. If more than 12 months of data is available, the assessment will be based on the most recent 12 months of self-reported data, as of December 31;
    5. For purposes of calculating subpart 4, if a new hospital shares a Medicare Identification Number with an existing hospital, the assessment amount will be based on self-reported data from the new hospital instead of the Medicare Cost Report. The data shall include the number of

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discharges and all other data requested by the Administration necessary to determine the appropriate assessment.

6. For hospitals providing self-reported data, described in subpart 4 and 5:
  - a. Psychiatric discharges will be annualized to determine if subsections (B)(4) or (I)(3) apply to the assessment amount.
  - b. Discharges will be annualized to determine if subsection (F) applies to the assessment amount.
- K. Changes of ownership. The parties to a change of ownership shall promptly provide written notice to the Administration of a change of ownership and any agreement regarding the payment of the assessment. The assessed amount will continue at the same amount applied to the prior owner. Assessments are the responsibility of the owner of record as of the first day of the quarter; however, this rule is not intended to prohibit the parties to a change of ownership from entering into an agreement for a new owner to assume the assessment responsibility of the owner of record as of the first day of the prior quarter.
- L. Hospital closures. Hospitals that close shall pay a proportion of the quarterly assessment equal to that portion of the quarter during which the hospital operated.
- M. Required information for the inpatient assessment. For any hospital that has not filed a 2019 Medicare Cost report, or if the 2019 Medicare Cost report does not include the reliable information sufficient for the Administration to calculate the inpatient assessment, the Administration shall use data reported on the 2019 Uniform Accounting Report filed by the hospital in place of the 2019 Medicare Cost report to calculate the assessment. If the 2019 Uniform Accounting Report filed by the hospital does not include reliable information sufficient for the Administration to calculate the inpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2019 Medicare Cost report to calculate the assessment.
- N. Required information for the outpatient assessment. For any hospital that has not filed a 2019 Uniform Accounting Report, or if the 2019 Uniform Accounting Report does not reconcile to 2019 Audited Financial Statements, the Administration shall use the data reported on 2019 Audited Financial Statements to calculate the outpatient assessment. If the 2019 Audited Financial Statements do not include the reliable information sufficient for the Administration to calculate the outpatient assessment, the Administration all use data reported on the 2019 Medicare Cost report. If the Medicare Cost report does not include reliable information sufficient for the Administration to calculate the outpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2019 Medicare Cost report to calculate the outpatient assessment.
- O. The Administration will review and update as necessary rates and peer groups periodically to ensure the assessment is sufficient to fund the state match obligation to cover the cost of the populations as specified in A.R.S. § 36-2901.08.
- P. Enforcement. If a hospital does not comply with this Section, the director may suspend or revoke the hospital's provider agreement. If the hospital does not comply within 180 days after the hospital's provider agreement is suspended or revoked, the director shall notify the director of the Department of Health Services who shall suspend or revoke the hospital's license.

**Historical Note**

New Section R9-22-730 made by exempt rulemaking at 20 A.A.R. 281, effective January 15, 2014 (Supp. 14-1).

Amended by exempt rulemaking at 20 A.A.R. 1833, effective July 1, 2014 (Supp. 14-2). Amended by final exempt rulemaking at 21 A.A.R. 637, effective April 15, 2015 (Supp. 15-2). Amended by final exempt rulemaking at 21 A.A.R. 1486, effective July 16, 2015 (Supp. 15-3). Amended by final exempt rulemaking at 22 A.A.R. 2050, effective July 14, 2016 (Supp. 16-4). Amended by final exempt rulemaking at 23 A.A.R. 1945, effective July 1, 2017 (Supp. 17-2). Amended by final exempt rulemaking at 24 A.A.R. 2229, effective July 10, 2018 (Supp. 18-3). Amended by final exempt rulemaking at 25 A.A.R. 1938, effective July 1, 2019 (Supp. 19-3). Amended by final exempt rulemaking at 26 A.A.R. 1702, effective July 1, 2020 (Supp. 20-3). Amended by final exempt rulemaking at 26 A.A.R. 2984, effective October 1, 2020 (Supp. 20-4). Amended by final exempt rulemaking at 27 A.A.R. 2370, effective October 1, 2021 (Supp. 21-3). Amended by final exempt rulemaking 28 A.A.R. 2213 (September 2, 2022), effective October 1, 2022 (Supp. 22-3).

**R9-22-731. Health Care Investment Fund - Hospital Assessment**

- A. For purposes of this Section, terms are the same as defined in A.A.C. R9-22-730 as provided below unless the context specifically requires another meaning.
- B. Beginning October 1, 2022, for each Arizona licensed hospital not excluded under subsection (I) shall be subject to an assessment payable on a quarterly basis. The assessment shall be levied against the legal owner of each hospital as of the first day of the quarter, and except as otherwise required by subsections (D), (E) and (F). For the period beginning October 1, 2022, the assessment for each hospital shall be amount equal to the sum of: (1) the number of discharges reported on the hospital's 2019 Medicare Cost Report, excluding discharges reported on the Medicare Cost Report as "Other Long Term Care Discharges," multiplied by the following rates appropriate to the hospital's peer group; and (2) the amount of outpatient net patient revenues multiplied by the following rate appropriate to the hospital's peer group:
  1. \$211.50 per discharge and 3.5149% of outpatient net patient revenues for hospitals located in a county with a population less than 500,000 that are designated as type: hospital, subtype: short-term.
  2. \$211.50 per discharge and 1.645% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.
  3. \$53.00 per discharge and 1.645% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.
  4. \$53.00 per discharge and 1.645% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the 2019 Medicare Cost Report.
  5. \$169.25 per discharge and 3.8078% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's 2019 Uniform Accounting Report.
  6. \$190.50 per discharge and 4.3936% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with at least 10% but less than 20%

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- of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's 2019 Uniform Accounting Report.
7. \$42.50 per discharge and 1.1716% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: children's.
  8. \$211.50 per discharge and 5.8581% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term not included in another peer group.
- C.** Peer groups for the four quarters beginning October 1 of each year are established based on hospital license type and subtype designated in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website January 2, 2022.
- D.** Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's 2019 Medicare Cost Report, are assessed a rate of \$53.00 for each discharge from the psychiatric sub-provider as reported in the 2019 Medicare Cost Report. All discharges other than those reported as discharges from the psychiatric sub-provider are assessed at the rate required by subsection (B).
- E.** Notwithstanding subsection (B), rehabilitative discharges from a hospital that reported having a rehabilitative sub-provider in the hospital's 2019 Medicare Cost Report, are assessed a rate of \$0 for each discharge from the rehabilitative sub-provider as reported in the 2019 Medicare Cost Report. All discharges other than those reported as discharges from the rehabilitative sub-provider are assessed at the rate required by subsection (B).
- F.** Notwithstanding subsection (B), for any hospital that reported more than 24,000 discharges on the hospital's 2019 Medicare Cost Report, discharges in excess of 24,000 are assessed a rate of \$21.25 for each discharge in excess of 24,000. The initial 24,000 discharges are assessed at the rate required by subsection (B).
- G.** Assessment notice. On or before the 10th day of the first month of the quarter or upon CMS approval, whichever is later, the Administration shall send to each hospital a notification that the assessment invoice is available to be viewed on a secure website. The invoice shall include the hospital's peer group assignment and the assessment due for the quarter.
- H.** Assessment due date. The assessment must be received by the Administration no later than the 10<sup>th</sup> day of the second month of the quarter.
- I.** Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital's 2019 Medicare Cost Report and Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for January 2, 2022:
1. Hospitals owned and operated by the state, the United States, or an Indian tribe.
  2. Hospitals designated as type: hospital, subtype: short-term that have a license number beginning "SH".
  3. Hospitals designated as type: hospital, subtype: psychiatric that reported fewer than 2,500 discharges on the 2019 Medicare Cost Report.
  4. Hospitals designated as type: hospital, subtype: rehabilitation.
  5. Hospitals designated as type: med-hospital, subtype: special hospitals.
  6. Hospitals designated as type: hospital, subtype: short-term located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2019 Medicare Cost Report are reimbursed by Medicare.
  7. Hospitals designated as type: hospital, subtype: short-term that have at least 25 percent Medicare swing beds as percentage of total Medicare days, per the 2019 Medicare Cost Report.
  8. Hospitals designated as type: hospital, subtype: short-term that are an urban public acute care hospital.
- J.** New hospitals. For hospitals that did not file a 2019 Medicare Cost Report because of the date the hospital began operations:
1. If the hospital was open on the January 2 preceding the October assessment start date, the hospital assessment will begin on October 1 following the date the hospital began operating.
  2. If the hospital began operating between January 3 and June 30, the assessment will begin on October 1 of the following calendar year.
  3. A hospital is not considered a new hospital based on a change in ownership.
  4. The assessment will be based on the discharges reported in the hospital's first Medicare Cost Report and Uniform Accounting Report, which includes 12 months-worth of data, except when any of the following apply:
    - a. If there is not a complete 12 months-worth of data available, the assessment will be based on the annualized number of discharges from the date hospital operations began through December 31 preceding the October assessment start date. The hospital shall self-report the discharge data and all other data requested by the Administration necessary to determine the appropriate assessment to the Administration no later than January preceding the assessment start date for the new hospitals. "Annualized" means divided by a ratio equal to the number of months of data divided by 12 months.
    - b. If more than 12 months of data is available, the assessment will be based on the most recent 12 months of self-reported data, as of December 31;
  5. For purposes of calculating subpart 4, if a new hospital shares a Medicare Identification Number with an existing hospital, the assessment amount will be based on self-reported data from the new hospital instead of the Medicare Cost Report. The data shall include the number of discharges and all other data requested by the Administration necessary to determine the appropriate assessment.
  6. For hospitals providing self-reported data, described in subpart 4 and 5:
    - a. Psychiatric discharges will be annualized to determine if subsections (B)(4) or (I)(3) apply to the assessment amount.
    - b. Discharges will be annualized to determine if subsection (F) applies to the assessment amount.
- L.** Changes of ownership. The parties to a change of ownership shall promptly provide written notice to the Administration of a change of ownership and any agreement regarding the payment of the assessment. The assessed amount will continue at the same amount applied to the prior owner. Assessments are the responsibility of the owner of record as of the first day of the quarter; however, this rule is not intended to prohibit the parties to a change of ownership from entering into an agree-

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ment for a new owner to assume the assessment responsibility of the owner of record as of the first day of the prior quarter.

- M.** Hospital closures. Hospitals that close shall pay a proportion of the quarterly assessment equal to that portion of the quarter during which the hospital operated.
- N.** Required information for the inpatient assessment. For any hospital that has not filed a 2019 Medicare Cost report, or if the 2019 Medicare Cost report does not include the reliable information sufficient for the Administration to calculate the inpatient assessment, the Administration shall use data reported on the 2019 Uniform Accounting Report filed by the hospital in place of the 2019 Medicare Cost report to calculate the assessment. If the 2019 Uniform Accounting Report filed by the hospital does not include reliable information sufficient for the Administration to calculate the inpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2019 Medicare Cost report to calculate the assessment.
- O.** Required information for the outpatient assessment. For any hospital that has not filed a 2019 Uniform Accounting Report, or if the 2019 Uniform Accounting Report does not reconcile to 2019 Audited Financial Statements, the Administration shall use the data reported on 2019 Audited Financial Statements to calculate the outpatient assessment. If the 2019 Audited Financial Statements do not include the reliable information sufficient for the Administration to calculate the outpatient assessment, the Administration all use data reported on the 2019 Medicare Cost report. If the Medicare Cost report does not include reliable information sufficient for the Administration to calculate the outpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2019 Medicare Cost report to calculate the outpatient assessment.
- P.** Enforcement. If a hospital does not comply with this Section, the director may suspend or revoke the hospital's provider agreement. If the hospital does not comply within 180 days after the hospital's provider agreement is suspended or revoked, the director shall notify the director of the Department of Health Services who shall suspend or revoke the hospital's license.

**Historical Note**

New Section made by final exempt rulemaking at 26 A.A.R. 2984, effective October 1, 2020 (Supp. 20-4). Amended by final rulemaking at 27 A.A.R. 2514 (October 29, 2021), with an immediate effective date of October 6, 2021 (Supp. 21-4). Amended by final exempt rulemaking at 28 A.A.R. 3351 (October 21, 2022), effective October 1, 2022 (Supp. 22-3).

**ARTICLE 8. REPEALED**

*Article 8, consisting of R9-22-801 through R9-22-804 and Exhibit A, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).*

**R9-22-801. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-801 adopted as an emergency adoption now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-801 repealed, new Section R9-22-801 adopted effective October 29, 1985 (Supp. 85-5). Amended sub-

sections (C), (F), (H), (I), and (K) effective October 1, 1986 (Supp. 86-5). Change of heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (H) effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Section heading amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-801 repealed, new Section R9-22-801 adopted January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-802. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-802 adopted as an emergency adoption now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 29, 1985 (Supp. 85-5). Amended subsections (A), (B), (C) and (D) effective October 14, 1988 (Supp. 88-4). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-802 repealed, new Section R9-22-802 adopted effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-803. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-803 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-803 repealed, new Section R9-22-803 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-803 renumbered and amended as Section R9-22-804. Adopted effective January 31, 1986 (Supp. 86-1). Amended effective September 29, 1992 (Supp. 92-3). Former Section R9-22-803 repealed, new Section R9-22-803 adopted January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-804. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-804 adopted as an emergency adoption now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Former Section R9-22-804 repealed, former Section R9-22-803 renumbered and amended as Section R9-22-804 effective October 29, 1985 (Supp. 85-5). Amended effective October 14, 1988

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(Supp.88-4). Amended subsections (B) and (C) effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-804 repealed, new Section R9-22-804 adopted effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**Exhibit A. Repealed****Historical Note**

New Exhibit adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Exhibit repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-805. Repealed****Historical Note**

Former Section R9-22-805 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective January 31, 1986 (Supp. 86-1).

**ARTICLE 9. REPEALED****R9-22-901. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-901 adopted as an emergency adoption now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective August 29, 1985 (Supp. 85-4). Amended effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

**R9-22-902. Repealed****Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-902 renumbered and amended as Section R9-22-904, former Section R9-22-903 renumbered and amended as Section R9-22-902 effective October 1, 1986 (Supp. 86-5). Former Section R9-22-902 repealed, new Section R9-22-902 adopted effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed, new

Section adopted by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

**R9-22-903. Repealed****Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-903 renumbered and amended as Section R9-22-902, former Section R9-22-904 renumbered and amended as Section R9-22-903 effective October 1, 1986 (Supp. 86-5). Former Section R9-22-903 repealed, new Section R9-22-903 adopted effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

**R9-22-904. Repealed****Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-904 renumbered and amended as Section R9-22-903, former Section R9-22-902 renumbered and amended as Section R9-22-904 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

**R9-22-905. Repealed****Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-905 renumbered without change as Section R9-22-908, former Section R9-22-907 renumbered and amended as Section R9-22-905 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

**R9-22-906. Repealed****Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Amended effective October 1, 1986 (Supp. 86-5). Amended effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemak-

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ing at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

**R9-22-907. Repealed****Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-907 renumbered and amended as Section R9-22-905, former Section R9-22-908 renumbered and amended as Section R9-22-907 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

**R9-22-908. Repealed****Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-908 renumbered and amended as Section R9-22-907, former Section R9-22-905 renumbered without change as Section R9-22-908 effective October 1, 1986 (Supp. 86-5). Former R9-22-908 repealed effective May 30, 1989 (Supp. 89-2). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

**R9-22-909. Repealed****Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

**ARTICLE 10. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES****R9-22-1001. Definitions**

In addition to the definitions in A.R.S. §§ 36-2901, 36-2923 and 9 A.A.C. 22, Article 1, the following definitions apply to this Article: "Absent parent" means an individual who is absent from the home and is legally responsible for providing financial and/or medical support for a dependent child.

"Cost avoid" means to deny a claim and return the claim to the provider for a determination of the amount of first- or third-party liability.

"First-party liability" means the obligation of any insurance plan or other coverage obtained directly or indirectly by a member that provides benefits directly to the member to pay all or part of the expenses for medical services incurred by AHCCCS or a member.

"Third-party" means a person, entity, or program that is, or may be, liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member.

"Third-party liability" means any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished to a member under a state plan.

**Historical Note**

Former Section R9-22-712 renumbered and amended as Section R9-22-1001 effective October 1, 1985 (Supp. 85-5). Amended subsections (E) through (H) effective October 1, 1986 (Supp. 86-5). Amended subsections (B), (C), (E), and (F) effective December 22, 1987 (Supp. 87-4). Section repealed; new Section adopted effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 21 A.A.R. 1237, effective July 7, 2015 (Supp. 15-3).

**R9-22-1002. General Provisions**

AHCCCS is the payor of last resort unless specifically prohibited by applicable state or federal law. AHCCCS is not the payor of last resort when the following entities are the third-party:

1. Indian Health Services (IHS/638), contract health,
2. Title IV-E,
3. Arizona Early Intervention Program (AZEIP),
4. Local educational agencies providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300,
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 USC 300ff et seq., and
6. The Arizona Refugee Resettlement Program operated under 45 CFR Part 400, Subpart (G).

**Historical Note**

Section R9-22-529 adopted effective October 1, 1985, then renumbered as Section R9-22-1002 effective October 1, 1985 (Supp. 85-5). Amended subsections (C) and (D) effective October 1, 1986 (Supp. 86-5). Amended effective December 22, 1987 (Supp. 87-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed; new Section adopted effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 21 A.A.R. 1237, effective July 7, 2015 (Supp. 15-3).

**R9-22-1003. Cost Avoidance**

- A.** The Administration's reimbursement responsibility.
1. The Administration shall pay no more than the difference between the Capped Fee-For-Service schedule and the amount of the third-party liability, unless Medicare is the third-party.
  2. If Medicare is the third-party that is liable, the Administration shall pay the Medicare copayment, coinsurance, and deductible regardless of the Capped Fee-For-Service Schedule, as described under 9 A.A.C. 29, Article 3.
- B.** The Contractor's reimbursement responsibility.
1. If the contract between the contractor and the provider does not state otherwise, a contractor shall pay no more than the difference between the contracted rate and the amount of the third-party liability.
  2. If the provider does not have a contract with the contractor, a contractor shall pay no more than the difference between the Capped Fee-For-Service rate and the amount of the third-party liability.

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- C. The following parties shall take reasonable measures to identify potentially legally liable first- or third-party sources:
1. AHCCCS, the Administration, or a contractor;
  2. A provider;
  3. A noncontracting provider; and
  4. A member.
- D. Except as specified under subsection (E), the Administration or a contractor shall cost avoid a claim for AHCCCS covered services under Article 2 if the Administration or a contractor has established the probable existence of a liable party at the time the claim is filed. Establishing liability takes place when the Administration or the contractor receives confirmation that another party is legally responsible for payment of a health care service under Article 2.
- E. The Administration or contractor shall pay the full amount of the claim according to the Capped-Fee-For-Service Schedule or the contracted rate as described under subsection (B), and then seek reimbursement from any liable parties if the claim is for:
1. Prenatal care for pregnant women,
  2. Preventive pediatric services, including E.P.S.D.T. and administration of vaccines to children under the Vaccines for Children (VFC) program; or
  3. Services covered by third-party liability that is derived from an absent parent whose obligation to pay support is being enforced by the Division of Child Support Enforcement.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 3012, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 21 A.A.R. 1237, effective July 7, 2015 (Supp. 15-3).

**R9-22-1004. Member Participation**

A member shall cooperate in identifying potentially legally liable first- or third-parties and timely assist the Administration and a contractor, provider, or noncontracting provider in pursuing any first- or third-party who may be liable to pay for covered services.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

**R9-22-1005. Collections**

- A. Parties that notify AHCCCS. A provider or noncontracting provider shall cooperate with AHCCCS by identifying all potential sources of first- or third-party liability and notify AHCCCS of these sources.
- B. Parties that pursue collection or reimbursement. AHCCCS, a provider, or noncontracting provider shall pursue collection or reimbursement from all potential sources of first- or third-party liability.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

**R9-22-1006. AHCCCS Monitoring Responsibilities**

AHCCCS shall monitor first- or third-party liability payments to a provider or noncontracting provider, which include but are not limited to payments by or for:

1. Private health insurance;
2. Employment-related disability and health insurance;
3. Long-term care insurance;
4. Other federal programs not excluded by statute from recovery;
5. Court ordered or non-court ordered medical support from an absent parent;
6. State worker's compensation;
7. Automobile insurance, including underinsured and uninsured motorists insurance;
8. Court judgment or settlement from a liability insurer including settlement proceeds placed in a trust;
9. First-party probate estate recovery;
10. Adoption-related payment; or
11. A tortfeasor.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

**R9-22-1007. Notification for Perfection, Recording, and Assignment of AHCCCS Liens**

- A. Hospital requirements. A hospital providing medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a first- or third-party shall within 30 days after a member's discharge:
1. Notify AHCCCS via facsimile or mail under R9-22-1008, or
  2. Mail AHCCCS a copy of the lien the hospital proposes to record or has recorded under A.R.S. § 33-932.
- B. Provider and noncontracting provider requirements. A provider or noncontracting provider, other than a hospital, rendering medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a first- or third-party shall notify AHCCCS via facsimile or mail under R9-22-1008 within 30 days after providing the service.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

**R9-22-1008. Notification Information for Liens**

- A. Except as provided in subsection (B), a hospital, provider, and noncontracting provider identified in R9-22-1007 shall provide the following information to AHCCCS in writing:
1. Name of the hospital, provider or noncontracting provider;
  2. Address of the hospital, provider or noncontracting provider;
  3. Name of member;
  4. Member's Social Security Number or AHCCCS identification number;
  5. Address of member;
  6. Date of member's admission or date service is provided;
  7. Amount estimated to be due for care of member;
  8. Date of discharge, if member has been discharged;
  9. Name of county in which injuries were sustained; and
  10. Name and address of all persons, firms, and corporations and their insurance carriers identified by the member or legal representative as being liable for damages.
- B. If the date of discharge is not known at the time the information in subsection (A) is provided, a party identified in subsection (A) is provided,

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tion (A) shall notify AHCCCS of the date of discharge within 30 days after the member has been discharged.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

**R9-22-1009. Notification of Health Insurance Information**

A provider or noncontracting provider shall notify AHCCCS, in writing, of the following health insurance information within 10 days of receipt of the health insurance information:

1. Name of member,
2. Member's Social Security Number or AHCCCS identification number,
3. Insurance carrier name,
4. Insurance carrier address,
5. Policy number or insurance holder's Social Security Number,
6. Policy begin and end dates, and
7. Insurance holder's name.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

**ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS****R9-22-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims; Definitions**

- A. Scope. This Article applies to prohibited acts as described under A.R.S. § 36-2918(A), and submissions of encounters to the Administration. The Administration considers a person who aids and abets a prohibited act affecting any of the AHCCCS programs or Health Care Group to be engaging in a prohibited act under A.R.S. § 36-2918(A).
- B. Purpose. This Article describes the circumstances AHCCCS considers and the process that AHCCCS uses to determine the amount of a penalty, assessment, or penalty and assessment as required under A.R.S. § 36-2918. This Article includes the process and time-frames used by a person to request a State Fair Hearing.
- C. Definitions. The following definitions apply to this Article:
  1. "Assessment" means a monetary amount that does not exceed twice the dollar amount claimed by the person for each service.
  2. "Claim" means a request for payment submitted by a person for payment for a service or line item of service, including a submission of an encounter.
  3. "Day" means calendar day unless otherwise specified.
  4. "File" means the date that AHCCCS receives a written acceptance, request for compromise, request for a counter proposal, or a request for a State Fair Hearing as established by a date stamp on the written document or other record of receipt.
  5. "Penalty" means a monetary amount, based on the number of items of service claimed or reported, that does not exceed \$2,000 times the number of line items of service.
  6. "Person" means an individual or entity as described under A.R.S. § 1-215.
  7. "Reason to know" or "had reason to know" means that a person, acts in deliberate ignorance of the truth or falsity of, or with reckless disregard of the truth or falsity of

information. No proof of specific intent to defraud is required.

**Historical Note**

Adopted effective October 1, 1986 (Supp. 86-5). Amended subsection A. effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective June 9, 1998 (Supp. 98-2). Amended by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

**R9-22-1102. Determining the Amount of a Penalty and an Assessment**

- A. AHCCCS shall determine the amount of a penalty and assessment according to A.R.S. § 36-2918(B) and (C), R9-22-1104, and R9-22-1105.
- B. AHCCCS shall include in the amount of the penalty and assessment the cost incurred by AHCCCS for conducting the following:
  1. An investigation,
  2. Audit, or
  3. Inquiry.

**Historical Note**

Adopted effective October 1, 1986 (Supp. 86-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

**R9-22-1103. Repealed****Historical Note**

Adopted effective October 1, 1986 (Supp. 86-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Section repealed by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

**R9-22-1104. Mitigating Circumstances**

AHCCCS shall consider any of the following to be mitigating circumstances when determining the amount of a penalty, assessment, or penalty and assessment.

1. Nature and circumstances of a claim. The following are mitigating circumstances:
  - a. All the services are of the same type,
  - b. All the dates of services occurred within six months or less,
  - c. The number of claims submitted is less than 25,
  - d. The nature and circumstances do not indicate a pattern of inappropriate claims for the services, and
  - e. The total amount claimed for the services is less than \$1,000.
2. Degree of culpability. The degree of culpability of a person who presents or causes to present a claim is a mitigating circumstance if:
  - a. Each service is the result of an unintentional and unrecognized error in the process that the person followed in presenting or in causing to present the service,

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- b. Corrective steps were taken promptly by the person after the error was discovered, and
  - c. The person had a fraud and abuse control plan that was operating effectively at the time each claim was presented or caused to be presented.
3. Financial condition. The financial condition of a person who presents or causes to present a claim is a mitigating circumstance if the imposition of a penalty, assessment, or penalty and assessment without reduction will render the provider incapable to continue providing services. AHCCCS shall consider the resources available to the person when determining the amount of the penalty, assessment, or penalty and assessment.
  4. Other matters as justice may require. AHCCCS shall take into account other circumstances of a mitigating nature, if in the interest of justice, the circumstances require a reduction of the penalty, assessment, or penalty and assessment.
- b. The person had received an administrative sanction in connection with:
    - i. A Medicaid program,
    - ii. A Medicare program, or
    - iii. Any other public or private program of reimbursement for medical services.
4. Effect on patient care. The adverse effect on patient care that resulted, or could have resulted, from the failure to provide medically necessary care by a person in connection with a claim.
  5. Other matters as justice may require. AHCCCS shall take into account other circumstances of an aggravating nature, if in the interest of justice, the circumstances require an increase of the penalty, assessment, or penalty and assessment.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).  
Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

**Historical Note**

Adopted effective October 1, 1986 (Supp. 86-5).  
Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).  
Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

**R9-22-1105. Aggravating Circumstances**

AHCCCS shall consider any of the following to be aggravating circumstances when determining the amount of a penalty, assessment, or penalty and assessment.

1. Nature and circumstances of each claim. The nature and circumstances of each claim and the circumstances under which the claim is presented or caused to be presented are aggravating circumstances if:
  - a. A person has forged, altered, recreated, or destroyed records;
  - b. The person refuses to provide pertinent documentation to AHCCCS for a claim or refuses to cooperate with investigators;
  - c. The services are of several types;
  - d. All the dates of services did not occur within six months or less;
  - e. The number of claims submitted is greater than 25;
  - f. The nature and circumstances indicate a pattern of inappropriate claims for the services; and
  - g. The total amount claimed for the services is \$5,000 or greater.
2. Degree of culpability. The degree of culpability of a person who presents or causes to present each claim is an aggravating circumstance if:
  - a. The person knows or had reason to know that each service was not provided as claimed,
  - b. The person knows or had reason to know that no payment could be made because the person had been excluded from reimbursement by AHCCCS, or
  - c. The person knows or had reason to know that the payment would violate the terms of an agreement between the person and AHCCCS system.
3. Prior offenses. The prior offenses of a person who presents or causes to present each claim are an aggravating circumstance if:
  - a. At any time before the submittal of the claim the person was held criminally or civilly liable for any act, or

**R9-22-1106. Notice of Intent**

If AHCCCS imposes a penalty, assessment, or a penalty and assessment, AHCCCS shall hand deliver or send by certified mail return receipt requested or Federal Express to the person, a written Notice of Intent to impose a penalty, assessment, or a penalty and assessment. The Notice of Intent shall include:

1. The statutory basis for the penalty, assessment, or the penalty and assessment;
2. Identification of the state or federal regulation and state or federal law that AHCCCS alleges has been violated;
3. The factual basis for AHCCCS' determination that the penalty, assessment, or the penalty and assessment should be imposed;
4. The amount of the penalty, assessment, or penalty and assessment;
5. The process for the person to accept or request a compromise of the penalty, assessment, or penalty and assessment; and
6. The process for requesting a State Fair Hearing.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).  
Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

**R9-22-1107. Reserved****R9-22-1108. Request for a Compromise**

- A. To request a compromise, the person shall file a written request with AHCCCS within 30 days from the date of receipt of the Notice of Intent. The written request for compromise shall contain the person's reasons for the reduction or modification of the penalty, assessment, or penalty and assessment.
- B. Within 30 days from the date of receipt of the request for compromise from the person, AHCCCS shall send a Notice of Compromise Decision that accepts, denies, or offers a counter proposal to the person's request for compromise. If AHCCCS offers a counter proposal the amount of the counter proposal shall represent the penalty, assessment, or penalty and assessment.
  1. If AHCCCS does not withdraw the Notice of Intent under R9-22-1112 or denies the request for compromise the original penalty, assessment, or penalty and assessment is upheld.

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2. To dispute the Compromise Decision, the person shall file a request for a State Fair Hearing under R9-22-1110 within 30 days from the date of receipt of the Notice of Compromise Decision.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).

Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

**R9-22-1109. Failure to Respond to the Notice of Intent**

If a person fails to respond timely to the Notice of Intent, AHCCCS shall uphold the original penalty, assessment, or penalty and assessment.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).

Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

**R9-22-1110. Request for State Fair Hearing**

- A. To request a State Fair Hearing regarding a dispute concerning a penalty, assessment, or penalty and assessment, the person shall file a written request for a State Fair Hearing with AHCCCS within 60 days from the date of the receipt of the Notice of Intent under R9-22-1106 or within 30 days from the date of receipt of the Notice of Compromise Decision under R9-22-1108, if applicable.
- B. AHCCCS shall mail a Notice of Hearing under A.R.S. § 41-1092.05 if AHCCCS receives a timely request for a State Fair Hearing from the person.
- C. AHCCCS shall mail a Director's Decision to the person no later than 30 days after the date the Administrative Law Judge sends the decision of the Office of Administrative Hearings (OAH) to AHCCCS.
- D. AHCCCS shall accept a written request for withdrawal of a hearing request if the written request for withdrawal is received from the person before AHCCCS mails a Notice of Hearing under A.R.S. § 41-1092 et seq. If AHCCCS mailed a Notice of Hearing under A.R.S. § 41-1092 et seq., a person may withdraw the hearing request only by sending a written request for withdrawal to OAH.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).

Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

**R9-22-1111. Issues and Burden of Proof**

- A. Preponderance of evidence. In any State Fair Hearing conducted under R9-22-1110, AHCCCS shall prove by a preponderance of the evidence that a person presented or caused to be presented each claim in violation of this Article and any aggravating circumstances under R9-22-1105. A person shall bear the burden of producing and proving by a preponderance of the evidence any circumstance that would justify reducing the amount of the penalty, assessment, or penalty and assessment.
- B. Statistical sampling.
  1. In meeting the burden of proof described in subsection (A), AHCCCS may introduce the results of a statistical sampling study as evidence of the number and amount of claims that were presented or caused to be presented by the person. A statistical sampling study constitutes prima

facie evidence of the number and amount of claims if computed by valid statistical methods.

2. The burden of proof shall shift to the person to produce evidence reasonably calculated to rebut the findings of the statistical sampling study once AHCCCS has made a prima facie case as described in subsection (B)(1). AHCCCS shall be given the opportunity to rebut this evidence.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).

Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

**R9-22-1112. Withdrawal and Continuances**

AHCCCS may withdraw the Notice of Intent at any time. Prior to referring a matter to the Office of Administrative Hearings the parties may mutually agree to a continuance.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).

**ARTICLE 12. BEHAVIORAL HEALTH SERVICES****R9-22-1201. Definitions**

Definitions. The following definitions apply to this Article:

"Adult behavioral health therapeutic home" as defined in 9 A.A.C. 10, Article 1.

"Agency" for the purposes of this Article means a behavioral health facility, a classification of a health care institution, including a mental health treatment agency defined in A.R.S. § 36-501, that is licensed to provide behavioral health services according to A.R.S. Title 36, Chapter 4.

"Assessment" means an analysis of a patient's need for physical health services or behavioral health services to determine which services a health care institution will provide to the patient.

"Behavior management services" means services that assist the member in carrying out daily living tasks and other activities essential for living in the community, including personal care services.

"Behavioral health therapeutic home care services" means interactions that teach the client living, social, and communication skills to maximize the client's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services indicated by the client's treatment plan, as appropriate.

"Behavioral health services" means medical services, nursing services, health-related services, or ancillary services provided to an individual to address the individual's behavioral health issue.

"Behavioral health technician" means an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and

Are provided with clinical oversight by a behavioral health professional.

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“Case management” for the purposes of this Article, means services and activities that enhance treatment, compliance, and effectiveness of treatment.

“Certified psychiatric nurse practitioner” means a registered nurse practitioner who meets the psychiatric specialty area requirements under A.A.C. R4-19-505(C).

“Clinical oversight” means as described under 9 A.A.C. 10.

“Cost avoid” means to avoid payment of a third-party liability claim when the probable existence of third-party liability has been established under 42 CFR 433.139(b).

“Court-ordered evaluation” has the same meaning as “evaluation” in A.R.S. § 36-501.

“Court-ordered pre-petition screening” has the same meaning as “pre-petition screening” in A.R.S. § 36-501.

“Court-ordered treatment” means treatment provided according to A.R.S. Title 36, Chapter 5.

“Crisis services” means immediate and unscheduled behavioral health services provided to a patient to address an acute behavioral health issue affecting the patient.

“Direct supervision” has the same meaning as “supervision” in A.R.S. § 36-401.

“Emergency medical services provider” has the same meaning as in A.R.S. § 36-2201.

“Health care institution” has the same meaning as defined in A.R.S. § 36-401.

“Health care practitioner” means a:

Physician;

Physician assistant;

Nurse practitioner; or

Other individual licensed and authorized by law to use and prescribe medication and devices, as defined in A.R.S. § 32-1901.

“Licensee” means the same as in 9 A.A.C. 10, Article 1.

“Medical practitioner” means a physician, physician assistant, or nurse practitioner.

“Partial care” means a day program of services provided to individual members or groups that is designed to improve the ability of a person to function in a community, and includes basic, therapeutic, and medical day programs.

“Physician assistant” means the same as in A.R.S. § 32-2501 except that when providing a behavioral health service, the physician assistant shall be supervised by an AHCCCS-registered psychiatrist.

“Psychiatrist” means a physician who meets the licensing requirements under A.R.S. § 32-1401 or a doctor of osteopathy who meets the licensing requirements under A.R.S. § 32-1800, and meets the additional requirements of a psychiatrist under A.R.S. § 36-501.

“Psychologist” means a person who meets the licensing requirements under A.R.S. §§ 32-2061 and 36-501.

“Qualified behavioral health service provider” means a behavioral health service provider that meets the requirements of R9-22-1206.

“Respite” means a period of care and supervision of a member to provide rest or relief to a family member or other person caring for the member. Respite provides activities and services to meet the social, emotional, and physical needs of the member during respite.

“TRBHA” or “Tribal Regional Behavioral Health Authority” means a Native American tribe under contract with ADHS/DBHS to coordinate the delivery of behavioral health services to eligible and enrolled members of the federally-recognized tribal nation.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Ch. 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, Ch. 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, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

**R9-22-1202. ADHS, Contractor, Administration and CRS Responsibilities**

- A.** ADHS responsibilities. ADHS is responsible for payment of behavioral health services provided to members, except as specified under subsection (D). ADHS’ responsibility for payment of behavioral health services includes claims for inpatient hospital services, which may include physical health services, when the principal diagnosis on the hospital claim is a behavioral health diagnosis. Behavioral health diagnoses are identified as “mental disorders” in the latest International Classification of Diseases (ICD) code set as required by AHC-CCS claims and encounters.
- B.** ADHS/DBHS may contract with a TRBHA for the provision of behavioral health services for American Indian members. American Indian members may receive covered behavioral health services:
1. From an IHS or tribally operated 638 facility,
  2. From a TRBHA, or
  3. From a RBHA.
- C.** Contractor responsibilities. A contractor shall:
1. Refer a member to a RBHA under the contract terms;
  2. Provide EPSDT developmental and behavioral health screening as specified in R9-22-213;
  3. Coordinate a member’s transition of care and medical records; and
  4. Be responsible for providing covered inpatient hospital services, which may include behavioral health inpatient hospital services, when the principal diagnosis on the hospital claim is not a behavioral health diagnosis.
- D.** Administration and CRS responsibilities.
1. The Administration shall be responsible for payment of behavioral health services provided to an ALTCS FFS or an FES member and for behavioral health services provided by IHS and tribally operated 638 facilities. The Administration is also responsible for payment of behav-

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ioral health services provided to these members during prior quarter coverage.

2. CRS shall be responsible for payment of behavioral health services provided to members enrolled with CRS.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Ch. 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, Ch. 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, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended to correct typographical errors, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4). Amended by final rulemaking at 21 A.A.R. 1225, effective July 7, 2015 (Supp. 15-3).

**R9-22-1203. Eligibility for Covered Services**

Title XIX members. A member determined eligible under A.R.S. § 36-2901(6)(a) or (g) except for the failure to meet U.S. citizenship or qualified alien status requirements, shall receive medically necessary covered services under Article 12 and Article 2.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Ch. 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, Ch. 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, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

**R9-22-1204. General Service Requirements**

- A. Services. Behavioral health services include mental health, substance abuse, and physical services. Medically necessary services shall be covered and service requirements met as described under Article 2 and Article 5.
- B. Notification to Administration for American Indians enrolled with a tribal contractor. A provider shall notify the Administration no later than 72 hours after an American Indian member enrolled with a tribal contractor presents to a behavioral health hospital for inpatient emergency behavioral health services.

- C. Restrictions and limitations. Room and board is not a covered service unless provided in a behavioral health inpatient facility under R9-22-1205.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Ch. 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, Ch. 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, Ch. 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, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective January 1, 1996; filed with the Secretary of State December 22, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

**R9-22-1205. Scope and Coverage of Behavioral Health Services**

- A. Inpatient behavioral health services. The following inpatient services are covered subject to the limitations and exclusions in this Article and Article 2.
  1. Covered inpatient behavioral health services include all behavioral health services, medical detoxification, accommodations and staffing, supplies, and equipment, if the service is provided under the direction of a physician in a Medicare-certified:
    - a. General acute care hospital,
    - b. Inpatient psychiatric unit in a general acute care hospital, or
    - c. Behavioral health hospital.
  2. Inpatient service limitations:
    - a. Inpatient services, other than emergency services specified in this Section, are not covered unless prior authorization is obtained.
    - b. Inpatient services and room and board are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
      - i. A licensed psychiatrist,
      - ii. A certified psychiatric nurse practitioner,
      - iii. A licensed physician assistant,
      - iv. A licensed psychologist,
      - v. A licensed clinical social worker,
      - vi. A licensed marriage and family therapist,
      - vii. A licensed professional counselor,
      - viii. A licensed independent substance abuse counselor, and
      - ix. A medical practitioner.
- B. Behavioral Health Inpatient facility for children. Services provided in a Behavioral Health Inpatient facility for children as defined in 9 A.A.C. 10, Article 3 are covered subject to the limitations and exclusions under this Article.

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1. Behavioral Health Inpatient facility for children services are not covered unless provided under the direction of a licensed physician in a licensed Behavioral Health Inpatient facility for children accredited by an AHCCCS-approved accrediting body as specified in contract.
  2. Covered Behavioral Health Inpatient facility for children services include room and board and treatment services for behavioral health and substance abuse conditions.
  3. Inpatient Behavioral Health Inpatient facility for children service limitations.
    - a. Services are not covered unless prior authorized, except for emergency services as specified in this Section.
    - b. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
      - i. A licensed psychiatrist,
      - ii. A certified psychiatric nurse practitioner,
      - iii. A licensed physician assistant,
      - iv. A licensed psychologist,
      - v. A licensed clinical social worker,
      - vi. A licensed marriage and family therapist,
      - vii. A licensed professional counselor,
      - viii. A licensed independent substance abuse counselor, and
      - ix. A medical practitioner.
  4. The following may be billed independently if prescribed by a provider as specified in this Section who is operating within the scope of practice:
    - a. Laboratory services, and
    - b. Radiology services.
- C. Covered Inpatient sub-acute agency services.** Services provided in a inpatient sub-acute facility as defined in 9 A.A.C. 10, Article 1 are covered subject to the limitations and exclusions under this Article.
1. Inpatient sub-acute facility services are not covered unless provided under the direction of a licensed physician in a licensed inpatient sub-acute facility that is accredited by an AHCCCS-approved accrediting body.
  2. Covered Inpatient sub-acute facility services include room and board and treatment services for behavioral health and substance abuse conditions.
  3. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
    - a. A licensed psychiatrist,
    - b. A certified psychiatric nurse practitioner,
    - c. A licensed physician assistant,
    - d. A licensed psychologist,
    - e. A licensed clinical social worker,
    - f. A licensed marriage and family therapist,
    - g. A licensed professional counselor,
    - h. A licensed independent substance abuse counselor, and
    - i. A medical practitioner.
  4. The following may be billed independently if prescribed by a provider specified in this Section who is operating within the scope of practice:
    - a. Laboratory services, and
    - b. Radiology services.
- D. Behavioral health residential facility services.** Services provided in a licensed behavioral health residential facility as defined in 9 A.A.C. 10, Article 1 are covered subject to the limitations and exclusions under this Article.
1. Behavioral health residential facility services are not covered unless provided by a licensed behavioral health residential facility.
  2. Covered services include all non-prescription drugs as defined in A.R.S. § 32-1901, non-customized medical supplies, and clinical oversight or direct supervision of the behavioral health residential facility staff, whichever is applicable. Room and board are not covered services.
  3. The following licensed and certified providers may bill independently for services:
    - a. A licensed psychiatrist,
    - b. A certified psychiatric nurse practitioner,
    - c. A licensed physician assistant,
    - d. A licensed psychologist,
    - e. A licensed clinical social worker,
    - f. A licensed marriage and family therapist,
    - g. A licensed professional counselor,
    - h. A licensed independent substance abuse counselor, and
- E. Partial care.** Partial care services are covered subject to the limitations and exclusions in this Article.
1. Partial care services are not covered unless provided by a licensed and AHCCCS-registered behavioral health agency that provides a regularly scheduled day program of individual member, group, or family activities that are designed to improve the ability of the member to function in the community. Partial care services include basic, therapeutic, and medical day programs.
  2. Partial care services. Educational services that are therapeutic and are included in the member's behavioral health treatment plan are included in per diem reimbursement for partial care services.
- F. Outpatient services.** Outpatient services are covered subject to the limitations and exclusions in this Article and Article 2.
1. Outpatient services include the following:
    - a. Screening provided by a behavioral health professional or a behavioral health technician as defined in R9-22-1201;
    - b. A behavioral health assessment provided by a behavioral health professional or a behavioral health technician;
    - c. Counseling including individual therapy, group therapy, and family therapy provided by a behavioral health professional or a behavioral health technician;
    - d. Behavior management services as defined in R9-22-1201; and
    - e. Psychosocial rehabilitation services as defined in R9-22-201.
  2. Outpatient service limitations.
    - a. The following licensed or certified providers may bill independently for outpatient services:
      - i. A licensed psychiatrist;
      - ii. A certified psychiatric nurse practitioner;
      - iii. A licensed physician assistant as defined in R9-22-1201;
      - iv. A licensed psychologist;
      - v. A licensed clinical social worker;
      - vi. A licensed professional counselor;
      - vii. A licensed marriage and family therapist;
      - viii. A licensed independent substance abuse counselor;
      - ix. A medical practitioner; and

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- x. An outpatient treatment center or substance abuse transitional facility licensed under 9 A.A.C. 10, Article 14, that is an AHCCCS-registered provider.
  - b. A behavioral health practitioner not specified in subsections (F)(2)(a)(i) through (x), who is contracted with or employed by an AHCCCS-registered behavioral health agency shall not bill independently.
- G.** Emergency behavioral health services are covered subject to the limitations and exclusions under this Article. In order to be covered, behavioral health services shall be provided by qualified service providers under R9-22-1206. ADHS/DBHS shall ensure that emergency behavioral health services are available 24 hours per day, seven days per week in each GSA for an emergency behavioral health condition for a non-FES member as defined in R9-22-201.
- H.** Other covered behavioral health services. Other covered behavioral health services include:
1. Case management as defined in 9 A.A.C. 10, Article 1;
  2. Laboratory and radiology services for behavioral health diagnosis and medication management;
  3. Medication;
  4. Monitoring, administration, and adjustment for psychotropic medication and related medications;
  5. Respite care as described within subsection (J);
  6. Behavioral health therapeutic home care services provided by a RBHA in a professional foster home defined in 6 A.A.C. 5, Article 58 or in an adult behavioral health therapeutic home as defined in 9 A.A.C. 10, Article 1;
  7. Other support services to maintain or increase the member's self-sufficiency and ability to live outside an institution.
- I.** Transportation services. Transportation services are covered under R9-22-211.
- J.** Limited Behavioral Health services. Respite services are limited to no more than 600 hours per benefit year.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Ch. 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, Ch. 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, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by exempt rulemaking at 17 A.A.R. 1870, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

**R9-22-1206. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective Novem-

ber 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, Ch. 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, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Repealed by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

**R9-22-1207. General Provisions for Payment****A. Claims submissions.**

1. A provider of behavioral health services shall submit a claim for non-emergency behavioral health services provided to a member to the appropriate RBHA.
2. A provider of behavioral health services shall submit a claim for non-inpatient emergency behavioral health services provided to a member to the appropriate RBHA.
3. A provider of behavioral health services shall submit a claim for non-inpatient emergency behavioral health services provided to a member enrolled in a TRBHA to the Administration.
4. A provider of behavioral health services shall submit a claim for non-emergency behavioral health services provided to a member enrolled in a TRBHA to the Administration.
5. A provider of emergency behavioral health services, that are the responsibility of ADHS/DBHS or a contractor, shall submit a claim to the entity responsible for emergency behavioral health services under R9-22-210.01(A).
6. A provider shall comply with the time-frames and other payment procedures in Article 7 of this Chapter, if applicable, and A.R.S. § 36-2904.
7. ADHS/DBHS or a contractor, whichever entity is responsible for covering behavioral health services, shall cost avoid any behavioral health service claims if it establishes the existence or probable existence of first-party liability or third-party liability.

- B.** Prior authorization. Payment to a provider for behavioral health services or items requiring prior authorization may be denied if a provider does not obtain prior authorization from a RBHA, ADHS/DBHS, a TRBHA, the Administration or a contractor.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Ch. 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, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

**R9-22-1208. Repealed**

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**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4).

**ARTICLE 13. CHILDREN'S REHABILITATIVE SERVICES (CRS)**

*Article 13, consisting of Sections R9-22-1301 through R9-22-1306, made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3).*

*Article 13, consisting of Sections R9-22-1301 through R9-22-1306, made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Exemption to promulgate rules repealed under Laws 2012, Chapter 299, Section 7 (Supp. 13-3).*

*Article 13, consisting of Sections R9-22-1301 through R9-22-1309, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 13 is now in 9 A.A.C. 34 (Supp. 04-1).*

**R9-22-1301. Children's Rehabilitative Services (CRS) related Definitions**

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Article have the following meanings unless the context explicitly requires another meaning:

"Active treatment" means there is a current need for treatment of the CRS qualifying condition(s) or it is anticipated that treatment or evaluation for continuing treatment of the CRS qualifying condition(s) will be needed within the next 18 months from the last date of service for treatment of any CRS qualifying condition.

"CRS application" means a submitted form with any additional documentation required by the Administration to determine whether an individual is medically eligible for CRS.

"CRS condition" means a list of medical condition(s) in R9-22-1303 and which are referred to as covered conditions in A.R.S. § 36-2912.

"Functionally limiting" means a restriction having a significant effect on an individual's ability to perform an activity of daily living as determined by a provider.

"Medically eligible" means meeting the medical eligibility requirements of R9-22-1303.

"Redetermination" means a decision made by the Administration regarding whether a member continues to meet the requirements in R9-22-1302.

**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 21 A.A.R. 2022, effective October 1, 2015 (Supp. 15-3).

**R9-22-1302. Children's Rehabilitative Services (CRS)****Eligibility Requirements**

Beginning October 1, 2013, an AHCCCS member who needs active treatment for one or more of the qualifying medical condition(s) in R9-22-1303 shall be given a CRS Designation. An American Indian member can choose to receive CRS services through an American Indian Health Plan or a contractor. A member enrolled in CMDP shall obtain CRS services through CMDP. The contractor shall provide covered services necessary to treat the condition(s) and other services described within the contract. The effective date of the CRS Designation shall be as specified in contract.

**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

**R9-22-1303. Medical Eligibility**

The following lists identify those medical condition(s) that do qualify for CRS services as well as those that do not qualify for CRS services. The list of condition(s) that qualify for a CRS Designation is all inclusive. The list of condition(s) that do not qualify for a CRS Designation is not an all-inclusive list.

1. Cardiovascular System
  - a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. Arrhythmia,
    - ii. Arteriovenous fistula,
    - iii. Cardiomyopathy,
    - iv. Conduction defect,
    - v. Congenital heart defect other than isolated small Ventricular Septal Defects (VSD), Patent Ductus Arteriosus (PDA), Atrial Septal Defects (ASD),
    - vi. Coronary artery and aortic aneurysm,
    - vii. Renal vascular hypertension,
    - viii. Rheumatic heart disease, and
    - ix. Valvular disorder.
  - b. Condition(s) not medically eligible for CRS:
    - i. Arteriovenous fistula that is not expected to cause cardiac failure or threaten loss of function;
    - ii. Benign heart murmur;
    - iii. Branch artery pulmonary stenosis;
    - iv. Essential hypertension;
    - v. Patent foramen ovale (PFO);
    - vi. Peripheral pulmonary stenosis;
    - vii. Postural orthopedic tachycardia; and
    - viii. Premature atrial, nodal or ventricular contractions that are of no hemodynamic significance.
2. Endocrine system:
  - a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. Addison's disease,
    - ii. Adrenogenital syndrome,
    - iii. Cystic fibrosis (including atypical cystic fibrosis),
    - iv. Diabetes insipidus,

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- v. Hyperparathyroidism,
- vi. Hyperthyroidism,
- vii. Hypoparathyroidism, and
- viii. Panhypopituitarism.
- b. Condition(s) not medically eligible for CRS
  - i. Diabetes mellitus,
  - ii. Hypopituitarism associated with a malignancy and requiring treatment of less than 90 days,
  - iii. Isolated growth hormone deficiency, and
  - iv. Precocious puberty.
- 3. Genitourinary system medical condition(s):
  - a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. Ambiguous genitalia,
    - ii. Bladder extrophy,
    - iii. Deformity and dysfunction of the genitourinary system secondary to trauma 90 days or more after the trauma occurred,
    - iv. Ectopic ureter,
    - v. Hydronephrosis, that is not resolved with antibiotics,
    - vi. Polycystic and multicystic kidneys,
    - vii. Pyelonephritis when treatment with drugs or biologicals has failed to cure or ameliorate and surgical intervention is required,
    - viii. Ureteral stricture, and
    - ix. Vesicoureteral reflux, at a grade 3 or higher.
  - b. Condition(s) not medically eligible for CRS:
    - i. Enuresis,
    - ii. Hydrocele,
    - iii. Hypospadias,
    - iv. Meatal stenosis,
    - v. Nephritis, infectious or noninfectious,
    - vi. Nephrosis,
    - vii. Phimosis, and
    - viii. Undescended testicle.
- 4. Ear, nose, or throat medical condition(s):
  - a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. Cholesteatoma,
    - ii. Congenital/Craniofacial anomaly that is functionally limiting,
    - iii. Deformity and dysfunction of the ear, nose, or throat secondary to trauma, 90 days or more after the trauma occurred,
    - iv. Mastoiditis that continues 90 days or more after the first diagnosis of the condition,
    - v. Microtia that requires multiple surgical interventions,
    - vi. Neurosensory hearing loss, and
    - vii. Significant conductive hearing loss due to an anomaly in one ear or both ears equal to or greater than a pure tone average of 30 decibels that despite medical treatment, requires a hearing aid.
  - b. Condition(s) not medically eligible for CRS:
    - i. A craniofacial anomaly that is not functionally limiting,
    - ii. Adenoiditis,
    - iii. Cranial or temporal mandibular joint syndrome,
    - iv. Hypertrophic lingual frenum,
    - v. Isolated preauricular tag or pit,
    - vi. Nasal polyp,
    - vii. Obstructive apnea,
    - viii. Perforation of the tympanic membrane,
    - ix. Recurrent otitis media,
    - x. Simple deviated nasal septum,
    - xi. Sinusitis,
    - xii. Tonsillitis, and
    - xiii. Uncontrolled salivation.
- 5. Musculoskeletal system medical condition(s):
  - a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. Achondroplasia,
    - ii. Arthrogyrosis (multiple joint contractures),
    - iii. Bone infection that continues 90 days or more after the initial diagnosis,
    - iv. Chondrodysplasia,
    - v. Chondroectodermal dysplasia,
    - vi. Clubfoot,
    - vii. Collagen vascular disease, including but not limited to, ankylosis spondylitis, polymyositis, dermatomyositis, polyarteritis nodosa, psoriatic arthritis, scleroderma, rheumatoid arthritis and lupus,
    - viii. Congenital or developmental cervical spine abnormality,
    - ix. Congenital spinal deformity,
    - x. Diastrophic dysplasia,
    - xi. Enchondromatosis,
    - xii. Femoral anteversion and tibial torsion,
    - xiii. Fibrous dysplasia,
    - xiv. Hip dysplasia,
    - xv. Hypochondroplasia,
    - xvi. Joint infection that continues 90 days or more after the initial diagnosis,
    - xvii. Juvenile rheumatoid arthritis,
    - xviii. Kyphosis (Scheurmann's Kyphosis) 50 degrees or over,
    - xix. Larsen syndrome,
    - xx. Leg length discrepancy of two centimeters or more,
    - xxi. Legg-Calve-Perthes disease,
    - xxii. Limb amputation or limb malformation,
    - xxiii. Metaphyseal and epiphyseal dysplasia,
    - xxiv. Metatarsus adductus,
    - xxv. Muscular dystrophy,
    - xxvi. Orthopedic complications of hemophilia,
    - xxvii. Osgood Schlatter's disease that requires surgical intervention,
    - xxviii. Osteogenesis imperfecta,
    - xxix. Rickets,
    - xxx. Scoliosis when 25 degrees or greater, or when there is a need for bracing or surgery,
    - xxxi. Seronegative spondyloarthropathy such as Reiters, psoriatic arthritis, and ankylosing spondylitis,
    - xxxii. Slipped capital femoral epiphysis,
    - xxxiii. Spinal muscle atrophy,
    - xxxiv. Spondyloepiphyseal dysplasia, and
    - xxxv. Syndactyly.
  - b. Condition(s) not medically eligible for CRS:
    - i. Back pain with no structural abnormality,
    - ii. Benign bone tumor,
    - iii. Bunion,
    - iv. Carpal tunnel syndrome,

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- v. Deformity and dysfunction secondary to trauma or injury,
  - vi. Ehlers Danlos,
  - vii. Flat foot,
  - viii. Fracture,
  - ix. Ganglion cyst,
  - x. Ingrown toenail,
  - xi. Kyphosis under 50 degrees,
  - xii. Leg length discrepancy of less than two centimeters at skeletal maturity,
  - xiii. Polydactyly without bone involvement,
  - xiv. Popliteal cyst,
  - xv. Trigger finger, and
  - xvi. Varus and valgus deformities.
6. Gastrointestinal system medical condition(s):
- a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. Anorectal atresia,
    - ii. Biliary atresia,
    - iii. Cleft lip,
    - iv. Cleft palate,
    - v. Congenital atresia, stenosis, fistula, or rotational abnormalities of the gastrointestinal tract,
    - vi. Deformity and dysfunction of the gastrointestinal system secondary to trauma, 90 days or more after the trauma occurred,
    - vii. Diaphragmatic hernia,
    - viii. Gastroschisis,
    - ix. Hirschsprung's disease,
    - x. Omphalocele, and
    - xi. Tracheoesophageal fistula.
  - b. Condition(s) not medically eligible for CRS:
    - i. Celiac disease,
    - ii. Crohn's disease,
    - iii. Hernia other than a diaphragmatic hernia,
    - iv. Intestinal polyp,
    - v. Malabsorption syndrome, also known as short bowel syndrome,
    - vi. Pyloric stenosis,
    - vii. Ulcer disease, and
    - viii. Ulcerative colitis.
7. Nervous system medical condition(s):
- a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. Benign intracranial tumor,
    - ii. Benign intraspinal tumor,
    - iii. Central nervous system degenerative disease,
    - iv. Central nervous system malformation or structural abnormality,
    - v. Cerebral palsy,
    - vi. Craniosynostosis requiring surgery,
    - vii. Deformity and dysfunction secondary to trauma in an individual that continues 90 days or more after the incident,
    - viii. Hydrocephalus,
    - ix. Muscular dystrophy or other myopathy,
    - x. Myelomeningocele, also known as spina bifida,
    - xi. Myoneural disorder, including but not limited to, amyotrophic Lateral Sclerosis or ALS, myasthenia gravis, Eaton-Lambert syndrome, muscular dystrophy, troyer sclerosis, polymyositis, dermatomyositis, progressive bulbar palsy, polio,
    - xii. Neurofibromatosis,
    - xiii. Neuropathy/polyneuropathy, hereditary or idiopathic,
    - xiv. Residual dysfunction that continues 90 days or more after a vascular accident, inflammatory condition, or infection of the central nervous system,
    - xv. Residual dysfunction that continues 90 days or more after near drowning,
    - xvi. Residual dysfunction that continues 90 days or more after the spinal cord injury, and
    - xvii. Uncontrolled seizure disorder, in which there have been more than two seizures with documented compliance of one or more medications.
  - b. Condition(s) not medically eligible for CRS:
    - i. Central apnea secondary to prematurity,
    - ii. Febrile seizures,
    - iii. Headaches,
    - iv. Near sudden infant death syndrome,
    - v. Plagiocephaly, and
    - vi. Spina bifida occulta.
8. Ophthalmology:
- a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. Cataracts,
    - ii. Disorder of the iris, ciliary bodies, retina, lens, or cornea,
    - iii. Disorder of the optic nerve,
    - iv. Glaucoma,
    - v. Non-malignant enucleation and post-enucleation reconstruction, and
    - vi. Retinopathy of prematurity.
  - b. Condition(s) not medically eligible for CRS:
    - i. Astigmatism,
    - ii. Ptosis,
    - iii. Simple refraction error, and
    - iv. Strabismus.
9. Respiratory system medical condition(s):
- a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. Anomaly of the larynx, trachea, or bronchi that requires surgery, and
    - ii. Nonmalignant obstructive lesion of the larynx, trachea, or bronchi.
  - b. Condition(s) not medically eligible for CRS:
    - i. Allergies,
    - ii. Asthma,
    - iii. Bronchopulmonary dysplasia,
    - iv. Chronic obstructive pulmonary disease,
    - v. Emphysema, and
    - vi. Respiratory distress syndrome.
10. Dermatological system medical condition(s):
- a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. A burn scar that is functionally limiting,
    - ii. A hemangioma that is functionally limiting that requires laser or surgery,
    - iii. Complicated nevi requiring multiple procedures,
    - iv. Cystic hygroma such as lymphangioma, and
    - v. Malocclusion that is functionally limiting.

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- b. Condition(s) not medically eligible for CRS:
  - i. A deformity that is not functionally limiting,
  - ii. Ectodermal dysplasia,
  - iii. Isolated malocclusion that is not functionally limiting,
  - iv. Pilonidal cyst,
  - v. Port wine stain,
  - vi. Sebaceous cyst,
  - vii. Simple nevi, and
  - viii. Skin tag.
- 11. Metabolic CRS condition(s) that qualify for CRS medical eligibility:
  - a. Amino acid or organic acidopathy,
  - b. Biotinidase deficiency,
  - c. Homocystinuria,
  - d. Inborn error of metabolism,
  - e. Maple syrup urine disease,
  - f. Phenylketonuria, and
  - g. Storage disease.
- 12. Hemoglobinopathies CRS condition(s) that qualify for CRS medical eligibility:
  - a. Sickle cell anemia, and
  - b. Thalassemia.
- 13. Additional medical/behavioral condition(s) which are not medically eligible for CRS:
  - a. Allergies,
  - b. Anorexia nervosa or obesity,
  - c. Attention deficit disorder,
  - d. Autism,
  - e. Cancer,
  - f. Depression or other mental illness,
  - g. Developmental delay,
  - h. Dyslexia or other learning disabilities,
  - i. Failure to thrive,
  - j. Hyperactivity, and
  - k. Immunodeficiency, such as AIDS and HIV.

**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 21 A.A.R. 2022, effective October 1, 2015 (Supp. 15-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

**R9-22-1304. Referral and Disposition of CRS Medical Eligibility Determination**

- A. To refer an individual for a CRS medical eligibility determination a person shall submit to the Administration the following information:
  - 1. CRS application;
  - 2. Documentation from a specialist who diagnosed the individual, stating the individual's diagnosis;
  - 3. Diagnostic test results that support the individual's diagnosis; and
  - 4. Documentation of the individual's need for specialized treatment of the CRS condition through medical, surgical, or therapy modalities.

- B. The Administration shall notify the CRS applicant, member or authorized representative of the outcome of the determination within 60 days of receipt of information required under subsection (A). The member may appeal the determination under Chapter 34.

**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 21 A.A.R. 2022, effective October 1, 2015 (Supp. 15-3).

**R9-22-1305. CRS Redetermination**

- A. Continued eligibility for CRS services shall be redetermined by verifying active treatment status of the CRS qualifying medical condition(s) as follows:
  - 1. The contractor is responsible for notifying the AHCCCS Administration of the date when a member with a CRS Designation is no longer in active treatment for the qualifying condition(s).
  - 2. The Administration may request, at any time, that the contractor submit the medical documentation to the Administration for a CRS medical redetermination within the specified time-frames in contract.
  - 3. The Administration shall notify the member or authorized representative of the outcome of the redetermination.
- B. If the Administration determines that a member is no longer medically eligible for a CRS Designation, the Administration shall provide the member or authorized representative a written notice that informs the member that the Administration is ending the member's CRS Designation. The member may appeal the redetermination under A.A.C. Title 9, Chapter 34.
- C. Upon reaching his or her 21st birthday, the member's CRS Designation will be ended.

**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

**R9-22-1306. Repealed****Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Repealed by final

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rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

**R9-22-1307. Covered Services**

The Administration will cover medically necessary services as described within Article 2 unless otherwise specified in contract.

**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3).

**R9-22-1308. Repealed****Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-1309. Repealed****Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR HOUSEHOLDS****R9-22-1401. General Information**

A. Scope. This Article contains eligibility criteria to determine whether a household or individual is eligible for AHCCCS medical coverage. Eligibility criteria described under Article 3 applies to this Article.

B. Definitions. In addition to definitions contained in R9-22-101 and A.R.S. § 36-2901, the words and phrases in this Article, Article 3 and Article 15 have the following meanings unless the context explicitly requires another meaning:

“Burial plot” means a space reserved in a cemetery, crypt, vault, or mausoleum for the remains of a deceased person.

“Caretaker relative” means:

A parent of a dependent child with whom the child is living;

When the dependent child does not live with a parent or the parent in the home is incapacitated, another relative of the child by blood, adoption, or marriage in the home who assumes primary responsibility for the child’s care; or

A woman in her third trimester of pregnancy with no other dependent children.

“Cash assistance” means a program administered by the Department that provides assistance to needy families with dependent children under 42 U.S.C. 601 et seq.

“Dependent child” means a child under the age of 18, or if age 18 is a full-time student in secondary school or equivalent vocational or technical training, if reasonably expected to complete such school or training before turning age 19.

“MAGI – based income” means Modified Adjusted Gross Income as defined under 42 CFR 435.603(e).

“Medical expense deduction” or “MED” means the cost of the following expenses if incurred in the United States:

A medical service or supply that would be covered if provided to an AHCCCS member of any age under Articles 2 and 12 of this Chapter;

A medical service or supply that would be covered if provided to an Arizona Long-term Care System member under 9 A.A.C. 28, Articles 2 and 11;

Other necessary medical services provided by a licensed practitioner or physician;

Assistance with daily living if the assistance is documented in an individual plan of care by a nurse, social service worker, registered therapist, or dietician under the supervision of a physician except when provided by the spouse of an applicant or the parent of a minor child;

Medical services provided in a licensed nursing home or in an alternative HCBS setting under R9-28-101;

Purchasing and maintaining an animal guide or service animal for the assistance of a member of the MED family unit under R9-22-1436; and

Health insurance premiums, deductibles, and coinsurance, if the insured is a member of the MED family unit.

“Monthly income” means the gross countable income received or projected to be received during the month or the monthly equivalent.

“Monthly equivalent” means a monthly countable income amount established by averaging, prorating, or converting a person’s income.

“Spendthrift restriction” means a legal restriction on the use of a resource that prevents a payee or beneficiary from alienating the resource.

“Tax dependent” is described under 42 CFR 435.4.

“Taxpayer” means a person who expects to file a tax return, and does not expect to be claimed as a tax dependent by another person.

“Title IV-D” means Title IV-D of the Social Security Act, 42 U.S.C. 651-669, the statutes establishing the child support enforcement and paternity program.

“Title IV-E” means Title IV-E of the Social Security Act 42 U.S.C. 670-679, the statutes establishing the foster care and adoption assistance programs.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

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Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1). Punctuation error corrected with a parenthesis added at the beginning of the definition "Caretaker" (Supp. 20-4).

**R9-22-1402. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1403. Agency Responsible for Determining Eligibility**

The Administration or its designee shall determine eligibility under the provisions of this Article. The Administration or its designee shall not discriminate against an applicant or member because of race, color, creed, religion, ancestry, national origin, age, sex, or physical or mental disability.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1404. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1405. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1406. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section

repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1407. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 19 A.A.R. 3309, November 30, 2013 (Supp. 13-4). Section repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014; this Section was slated to be codified as repealed in Supp. 14-1. Due to a clerical error the Section wasn't repealed in this Chapter until Supp. 20-4.

**R9-22-1408. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1409. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1410. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R.

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192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1411. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1412. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by exempt rulemaking at 10 A.A.R. 23, effective December 9, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1413. Time-frames, Reinstatement of an Application**

- A.** The Administration or its designee shall complete an eligibility determination under R9-22-306(A)(1) unless:
1. The applicant is pregnant. The Administration or its designee shall complete an eligibility determination for a pregnant woman within 20 days after the application date unless additional information is required to determine eligibility; or
  2. The applicant is in a hospital as an inpatient at the time of application. Within seven days of the Administration or its designee's receipt of a signed application the Administration or its designee shall complete an eligibility determination if the Administration or its designee does not need additional information or verification to determine eligibility.
- B.** The Administration or its designee shall reopen or reinstate eligibility of an individual who is discontinued for failure to submit the renewal form or necessary information, without requiring a new application, if the individual submits the renewal form or necessary information within 90 days after the date of discontinuance.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Amended by final

rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1414. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1415. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1416. Effective Date of Eligibility**

- A.** Except as provided in R9-22-303 and subsections (B), (C) and (D), the effective date of eligibility is the first day of the month that the applicant files an application if the applicant is eligible that month, or the first day of the first eligible month following the application month except for:
1. The MED program under R9-22-1439, and
  2. Eligibility for a newborn under R9-22-1429.
- B.** The effective date of eligibility for an applicant who moves into Arizona is no sooner than the date Arizona residency is established.
- C.** The effective date of eligibility for an inmate applying for medical coverage is the date the applicant no longer meets the definition of an inmate of a public institution.
- D.** The effective date of eligibility for a newborn is no sooner than the date of birth.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1417. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192,

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with an immediate effective date of January 7, 2014  
(Supp. 14-1).

**R9-22-1418. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1419. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1419.01. Repealed****Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1419.02. Repealed****Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1419.03. Repealed****Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1419.04. Repealed****Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1420. Income Eligibility Criteria**

**A.** Evaluation of income. In determining eligibility, the Administration or its designee shall evaluate the following types of income received by a person identified in subsection (B):

1. Earned income, including in-kind income, before any deductions. For purposes of this Section, in-kind income means room, board, or provision for other needs in exchange for work performed. The person identified in

subsection (B) shall ensure that the provider of the in-kind income establishes and verifies the monetary value of the item provided. The provider may be, but is not limited to:

- a. A landlord who provides all or a portion of rent or utilities in exchange for services;
  - b. A store owner who gives goods such as groceries, clothes, or furniture in exchange for services; or
  - c. An individual who trades goods such as a car, tools, trailer, building material, or gasoline in exchange for services;
2. Self-employment income under R9-22-1424, including gross business receipts minus business expenses; and
  3. Unearned income, including deemed income under R9-22-317 from the sponsor of a non-citizen applicant.

**B.** MAGI income group. The Administration or its designee shall include the following persons in the MAGI income group:

1. When the applicant is a taxpayer include:
  - a. The applicant,
  - b. Everyone the applicant expects to claim as a tax dependent for the current year, and
  - c. The applicant's spouse, when living with the applicant.
2. Except as provided in subsection (B)(3), when the applicant expects to be claimed as a tax dependent for the current year include:
  - a. The taxpayer claiming the applicant,
  - b. Everyone else the taxpayer expects to claim as a tax dependent,
  - c. The taxpayer's spouse when living with the taxpayer, and
  - d. The applicant's spouse, when living with the applicant.
3. When any of the following apply, determine the persons whose income is included as described in subsection (4)(a) or (4)(b) based on the applicant's age:
  - a. The applicant expects to be claimed as a tax dependent by someone other than a spouse or natural, adopted or step-parent;
  - b. The applicant is under age 19, expects to be claimed as a tax dependent by a natural, adopted or step-parent, lives with more than one such parent and the parents do not expect to file a joint tax return; or
  - c. The applicant is under age 19 and expects to be claimed as a tax dependent by a non-custodial parent.
4. When the applicant is not a taxpayer, does not expect to be claimed as a tax dependent and is:
  - a. Under age 19. Include the income of the applicant and when living with the applicant, the applicant's:
    - i. Spouse;
    - ii. Natural, adopted and step-children;
    - iii. Natural, adopted and step-parents;
    - iv. Natural, adopted and step-siblings; and
  - b. Age 19 or older. Include the income of the applicant and when living with the applicant, the applicant's:
    - i. Spouse;
    - ii. Natural, adopted and step-children under age 19.
5. When the applicant is a pregnant woman, the Administration or its designee shall also include the number of expected babies only for the pregnant woman's income group.

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6. When the taxpayer cannot reasonably establish that a person is the taxpayer's tax dependent, inclusion of the person in the taxpayer's MAGI income group is determined as provided in subsection (B)(4).
- C. A person whose income is counted. The Administration or its designee shall count the MAGI-based income of all members of an applicant's MAGI income group with the following exceptions:
1. The income of an individual who is included in the MAGI income group of his or her natural, adoptive or step parent and is not expected to be required to file a tax return for the year in which eligibility for Medicaid is being determined, is not counted whether or not the individual files a tax return.
  2. The income of a tax dependent other than the taxpayer's spouse or biological, adopted or stepchild who is not expected to be required to file a tax return for the year in which eligibility for Medicaid is being determined is not counted when the tax dependent is included in the taxpayer's MAGI income group, whether or not the tax dependent files a tax return.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1421. MAGI based Income Eligibility**

- A. In determining eligibility, if an individual would otherwise be ineligible under this Article due to excess income, the Administration or its designee shall subtract an amount equivalent to five percentage points of the Federal Poverty Level (FPL) from the household income.
- B. A person is eligible under this Article when:
1. Subject to subsection (A), the monthly household income does not exceed the appropriate FPL;
  2. If ineligible under (B)(1), the household income determined in accordance with 26 CFR 1.36B-1(e) is below 100 percent FPL; or
  3. For eligibility under R9-22-1437, the person's income during the period defined in R9-22-1437(C) does not exceed the FPL under R9-22-1437(B).
- C. The Administration or its designee shall consider the following factors when determining the income period to use to determine monthly income:
1. Type of income,
  2. Frequency of income,
  3. If source of income is new or terminated, or
  4. Income fluctuation.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192,

with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1422. Methods for Calculating Monthly Income**

- A. Projecting income.
1. Description. Projecting income is a method of determining the amount of income that a person will receive.
  2. Calculation. The Administration or its designee shall project income by:
    - a. Converting income to a monthly equivalent,
    - b. Using unconverted income, or
    - c. Prorating income to determine a monthly equivalent.
  3. Exclusion. When calculating projected monthly income, the Administration or its designee shall exclude an unusual variation in income under R9-22-1424(E), except for a month in which the variation is anticipated to occur.
- B. Averaged income.
1. Description. Averaging income proportionally distributes the person's income received on a regular basis.
  2. Calculation. To average income, the Administration or its designee shall add the amount of the income and divide by the total number of pay periods. If the amount of income received per pay period fluctuates, and the fluctuation is expected to continue, the Administration or its designee shall:
    - a. Use the averaged weekly or bi-weekly amounts to convert weekly or bi-weekly income to a monthly equivalent;
    - b. Use the averaged monthly or semi-monthly amounts to project monthly income; and
    - c. Use the averaged hours worked and multiply the average by the current rate of pay. If there is a change in the rate of pay, use the new rate of pay when calculating projected income under subsection (A).
- C. Prorated income.
1. Description. Prorated income evenly distributes a person's income over the period the income is intended to cover to calculate a monthly equivalent.
  2. Calculation. To prorate income, the Administration or its designee shall divide the total amount of the person's income received during the period by the number of months that the income is intended to cover.
- D. Converted income.
1. Description. Converted income is income received weekly or biweekly that is changed to a monthly equivalent.
  2. Calculation.
    - a. The Administration or its designee shall average the weekly or bi-weekly income amounts before converting to the monthly equivalent if the person's past income fluctuates and the fluctuation is expected to recur.
    - b. To convert income paid weekly to a monthly equivalent, the Administration or its designee shall multiply the weekly average by 4.3 weeks.
    - c. To convert income paid bi-weekly to a monthly equivalent, the Administration or its designee shall multiply the bi-weekly average by 2.15 weeks.
- E. Unconverted income.
1. Description. Unconverted income is the actual amount of income received or projected to be received during a month.

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2. Calculation. The Administration or its designee shall sum the actual amount of income received or projected to be received during a month.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1423. Calculations and Use of Methods Listed in R9-22-1422 Based on Frequency of Income**

- A.** Monthly income. If otherwise countable income is received monthly or in a lump sum, the Administration or its designee shall use the unconverted method for calculating monthly income.
1. Lump sum means a nonrecurring payment that serves as a complete payment.
  2. Lump sum payments include but are not limited to: rebates or credits; inheritances; insurance settlements; and payments for prior months from such sources as Social Security, Railroad Retirement, or other benefits.
  3. A lump sum payment may include a portion intended for the current month.
- B.** Weekly income. If income is received weekly, the Administration or its designee shall convert the income to a monthly equivalent under R9-22-1422(D).
- C.** Bi-weekly income. If income is received bi-weekly, the Administration or its designee shall convert the income to a monthly equivalent under R9-22-1422(D).
- D.** Semi-monthly or daily income. If income is received semi-monthly or daily, the Administration or its designee shall use the unconverted method for calculating monthly income under R9-22-1422(E).
- E.** Bimonthly, quarterly, semi-annual, or annual income. If income is received bimonthly, quarterly, semi-annually, or annually, the Administration or its designee shall prorate the income received or projected to be received under R9-22-1422(C).

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1424. Use of Methods Listed in R9-22-1423 Based on Type of Income**

- A.** New income.
1. Description. New income is income received from a new source during the first calendar month that the income is received from the source.
  2. Calculating monthly income.
    - a. If a full month's income is received, the Administration or its designee shall use the appropriate method

described in R9-22-1423 to calculate the monthly income.

- b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.

**B.** Terminated income.

1. Terminated income is income received during the last calendar month when no more income is expected to be received from that source.

## 2. Calculating monthly income.

- a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
- b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.

**C.** Break in income.

1. Description. A break in income is a break in established frequency of income of one calendar month or more.

## 2. Calculating monthly income.

- a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
- b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.

**D.** Contract or regular seasonal income.

## 1. Descriptions.

- a. Contract income is income a person earns under a contract that specifies a length of time the contract covers, the amount of income to be paid, and the frequency of payment.
- b. Regular seasonal income is income that fluctuates based on season or is only received during a certain season, and can reasonably be anticipated based on history or other verification.

## 2. Calculating monthly income.

- a. When the contract or regular seasonal income will not fluctuate over the 12-month period beginning with the month the application or renewal is submitted, the Administration or its designee shall use the appropriate income calculation method in R9-22-1423 for the frequency of receipt.
- b. When the contract or regular seasonal income is anticipated to fluctuate over the 12-month period beginning with the month the application or renewal is submitted, the Administration or its designee shall calculate the monthly income as follows:
  - i. For a one-time contract that ends between the month the application or renewal is submitted and the end of the calendar year, divide the income that will be received from the application or renewal month through the end of the calendar year by the number of months in that period to get a monthly equivalent;
  - ii. For contracts that extend into the next calendar year, contracts that are anticipated to be renewed and regular seasonal income, the Administration or its designee shall divide the income that will be received in the 12-month period beginning with the application or

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renewal month by 12 to get the monthly equivalent.

- E. Unusual variation in the amount of income.**
1. Description. Unusual variation is an amount of income that is different from the established amount received and is not projected to continue or recur.
  2. Calculating monthly income.
    - a. When calculating income for the month in which an unusual variation in income occurs, the Administration or its designee shall include the unusual variation in the income calculation.
    - b. When an unusual variation in income occurs during the month, the Administration or its designee shall use the converted method for calculating monthly income if income is received weekly or bi-weekly.
    - c. When projecting income for the months following the month in which the unusual variation occurs, the Administration or its designee shall exclude the unusual variation in income from the income calculation.
- F. Self-employment income.**
1. Description. Self-employment income is income a person earns from the person's own trade or business less allowable expenses.
  2. Calculating monthly income. The Administration or its designee shall prorate the income under R9-22-1422.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1425. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1426. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1427. Eligibility Under MAGI**

- A. Caretaker Relatives.** An individual is eligible for AHCCCS medical coverage as a Caretaker Relative when the individual meets the following requirements:
1. Is a caretaker relative as defined in R9-22-1401.
  2. The total countable income under R9-22-1420(B) does not exceed 106 percent of the FPL for the number of people in the MAGI income group.
- B. Continued medical coverage.**
1. A caretaker relative eligible under subsection (A) and all dependent children eligible under subsection (D) in the caretaker relative's MAGI income group are entitled to continued AHCCCS coverage for up to 12 months if eligible under subsection (B)(1)(c)(i) and up to four months if eligible under subsection (B)(1)(c)(ii) if the MAGI income group's income exceeds the limit for the income group's size and the following conditions are met:
    - a. The caretaker relative still lives with a dependent child;
    - b. A caretaker relative in the income group received AHCCCS medical coverage under this Section for three calendar months out of the most recent six months; and
    - c. The loss of AHCCCS coverage under this Section is due to:
      - i. Increased earned income of a caretaker relative, or
      - ii. Increased spousal support.
  2. An applicant may be added to the continued medical coverage under subsection (B)(1), if the applicant did not reside in the household at the time continued medical coverage under this Section was determined and the applicant is:
    - a. The spouse or dependent child of a caretaker relative receiving continued medical coverage, or
    - b. The parent of a dependent child who is receiving continued medical coverage.
- C. Pregnant Women.** A pregnant woman is eligible for AHCCCS medical coverage when the total countable income under R9-22-1420(B) does not exceed 156 percent of the FPL for the number of people in the MAGI income group. A pregnant woman who applies for AHCCCS medical coverage during the pregnancy or postpartum period and is determined eligible, remains eligible throughout the postpartum period. The postpartum period begins the day the pregnancy terminates and ends the last day of the month in which the 60th day following pregnancy termination occurs.
- D. Children.** A child less than 19 years of age is eligible for AHCCCS medical coverage when the total countable income under R9-22-1420(B) does not exceed the following percentage of the FPL for the number of people in the MAGI income group:
1. 147 percent for a child under one year of age,
  2. 141 percent for a child age one through five years of age, or
  3. 133 percent for all other persons.
- E. Adults.** An individual is eligible for AHCCCS medical coverage when the individual meets the following eligibility requirements:
1. Is 19 years of age or older but less than 65 years of age;
  2. Is not pregnant;
  3. Is not eligible for AHCCCS Medical Coverage under any other coverage group listed in 42 U.S.C. 1396a(a)(10)(A)(i);
  4. Is not entitled to or enrolled for Medicare benefits under Part A or Part B;

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5. The total countable income under R9-22-1420(B) does not exceed 133 percent of the FPL for the number of people in the MAGI income group; and
6. When the individual is a caretaker relative, but has income exceeding the limit in subsection (A)(2), each child under age 19 living with the individual is receiving AHCCCS medical coverage or KidsCare, or is enrolled in minimum essential coverage as defined in 42 CFR 435.4.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Section R9-22-1427 repealed; new Section R9-22-1427 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1428. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1429. Eligibility for a Newborn**

A child born to a mother eligible for and receiving medical coverage under this Article, Article 15 of the Chapter, or 9 A.A.C. 28, is automatically eligible for AHCCCS medical coverage for a period not to exceed 12 months. Automatic eligibility begins on the child's date of birth and ends with the last day of the month in which the child turns age one.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1430. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1431. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 2633, effective July 10, 2007 (Supp. 07-3). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1). Repealed by final rulemaking at 21 A.A.R. 1241, effective September 5, 2015 (Supp. 15-3).

**R9-22-1432. Young Adult Transitional Insurance**

An individual is eligible for AHCCCS medical coverage when the individual meets all of the following eligibility requirements:

1. Is 18 through 25 years of age;
2. Was in the custody of the Department of Economic Security under A.R.S. Title 8, Chapter 5 or Chapter 10 on the individual's 18th birthday;
3. Was eligible for and receiving AHCCCS Medical Coverage on the individual's 18th birthday; and
4. Is not eligible for AHCCCS Medical Coverage under 42 U.S.C. 1396a(a)(10)(A)(i)(I) - (VII).

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1433. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1434. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Section repealed by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4).

**R9-22-1435. Eligibility for a Person With Medical Expenses Whose Income is Over 100 Percent FPL**

An applicant who is not eligible for AHCCCS medical coverage due to excess income may become AHCCCS eligible by deducting

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medical expenses from the applicant's income. This coverage is called Medical Expense Deduction (MED).

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1436. MED Family Unit**

- A. For the purpose of this Section, a child is an unmarried person under age 18.
- B. The Department shall consider each of the following to be a family when living together:
  1. A parent and the parent's children;
  2. A married couple without children;
  3. A married couple and the children of either or both spouses;
  4. Unmarried parents who live with at least one child in common, and the parents' other children, whether in common or not; and
  5. A person without children.
- C. If an applicant is pregnant, the family unit includes the number of unborn children.
- D. A child of the children included in subsections (B)(1), (B)(3), or (B)(4) is considered part of the family unit when living together.
- E. The Department shall not include a SSI-cash recipient in the MED family unit even if the SSI-cash recipient is a parent, spouse, or child.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1437. MED Income Eligibility Requirements**

- A. Income exclusions. The exclusions in R9-22-1420(C) apply to the MED family unit.
- B. Income standard.
  1. The Department shall divide the annual FPL for the MED family unit that is in effect during each month of the income period by 12 to determine the monthly FPL.
  2. The Department shall add the monthly FPLs for the income period and multiply the resulting amount by 40 percent.
  3. Changes to the annual FPL are implemented in April of each year.
- C. Income period. The income period is the month of application and the next two months. The Department shall add together the three months' income to establish the MED family unit's income amount.
- D. Medical expense deduction period. The medical expense deduction period is a three-month period consisting of:
  1. For a new application, the month before the application month, the month of application, and month following the application month; or
  2. For a MED eligibility review, the last month of the prior MED eligibility period and the following two months.
- E. The Department shall calculate the amount of countable monthly income as follows:

1. Subtract a \$90 cost of employment allowance from the gross amount of earned income for each person whose earned income is counted;
  2. Disregard from the remaining earned income an amount billed by the provider for the care of each dependent child under age 18 or incapacitated adult member of the MED family unit if the care is for the purpose of allowing the person to work. If more than one person in the household is responsible for and billed for the care of a dependent child, the disregard may be split between the wage earners if splitting the disregard is to the benefit of the family, but shall not exceed the maximum disregards as follows:
    - a. A maximum of \$200 for a child under age two and \$175 for other dependents for a wage-earner employed full-time (86 or more hours per month); and
    - b. A maximum of \$100 for a child under age two, and \$88 for other dependents for a wage earner employed part-time (less than 86 hours a month);
  3. Add the remaining earned income for each MED family member to the unearned income of all MED family members;
  4. Compare the MED family's unit countable income amount to the income standard in subsection (B). The difference is the amount of medical expenses the family shall incur during the medical expense deduction period to become eligible;
  5. Subtract allowable medical expense deductions that were incurred by:
    - a. A member of the MED family unit;
    - b. A deceased spouse or minor child of a MED family unit if this person would have been a member of the MED unit during the MED expense deduction period;
    - c. A person who was a minor child of a MED family unit member when the expense was incurred but who is no longer a minor child; or
    - d. A minor child, including a child who is a runaway, who left home before the date of application to live with someone other than a parent; and
  6. Compare the net MED family income to the income standard listed in subsection (B).
- F. The family is eligible if the net income in subsection (E)(6) does not exceed the income standard in subsection (B).

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1438. MED Resource Eligibility Requirements**

- A. Including countable resources. The Department shall include the resources not excluded that belong to and are available to members of the family of a qualified alien under A.R.S. § 36-2903.03 and the sponsor and sponsor's spouse of a person who is a qualified alien.
- B. Ownership and availability. The Department shall evaluate the ownership of resources to determine the availability of resources to a person listed in subsection (A).
  1. Jointly owned resources with ownership records containing the words "and" or "and/or" between the owners' names are available to each owner except if one of the owners refuses to sell. A consent to sale is not required if all owners are members of the MED family unit.
  2. Jointly owned resources with ownership records containing the word "or" between the owners' names are pre-

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sumed to be available in full to each owner. The applicant or member may rebut the presumption by providing clear and convincing evidence of intent to establish a different type of ownership. If the presumption is rebutted, the resource is available to the owners:

- a. Consistent with the intent of the owners, or
  - b. Based on each owner's proportionate net contribution if there is not clear and convincing evidence of a different allocation.
3. The Department shall establish availability of a trust under 42 U.S.C. 1396p(d)(4)(A) or (C).
- C. Unavailability.** The Department shall consider the following resources unavailable:
1. Property subject to spendthrift restriction, such as:
    - a. Accounts established by the SSA, Veteran's Administration, or similar sources that mandate that the funds in the account be used for the benefit of a person not residing with the MED family unit; or
    - b. Trusts established by a will or funded solely by the income and resources of someone other than a member of the MED family unit.
  2. A resource being disputed in a divorce proceeding or probate matter;
  3. Real property located on a Native American reservation;
  4. A resource held by a conservator to the extent court-imposed restrictions make the resource unavailable to the applicant, member, or member of the family unit for:
    - a. Medical care,
    - b. Food,
    - c. Clothing, or
    - d. Shelter.
- D. Resource exclusion.** The Department shall exclude the following resources from the calculation of resources under subsection (E):
1. One burial plot for each person listed in R9-22-1436;
  2. Household furnishings and personal items that are necessary for day-to-day living;
  3. Up to \$1500 of the value of one prepaid funeral plan for each person listed in R9-22-1436 that specifically covers only funeral-related expenses as evidenced by a written contract;
  4. The value of one motor vehicle regularly used for transportation. If the MED family unit owns more than one vehicle, the exclusion is applied to the vehicle with the highest equity value;
  5. The value of a vehicle used to earn income and not used simply for transportation to and from employment;
  6. The value of a vehicle in which a SSI-cash recipient has an ownership interest; and
  7. The value of any vehicle used for medical treatment, employment, or transportation of a SSI-cash disabled child, and that is excluded by SSI for that reason.
  8. Funds set aside in an Individual Development Account under 6 A.A.C. 12, Article 4; and
  9. Any other resource specifically excluded by federal law.
- E. Calculation of resources.** The Department shall determine the value of all household resources as follows:
1. Calculate the total amount of countable liquid resources;
  2. Calculate the equity value of each countable non-liquid resource. The Department shall determine the equity value of a countable non-liquid resource by subtracting the amount of valid encumbrances on that resource from:
    - a. The market value of real property if there is no assessor's evaluation of the property,
    - b. The market value of real property if the assessor's value of the real property does not include the value of permanent structures on that property,
    - c. The assessor's full cash value if subsections (E)(2)(a) and (E)(2)(b) do not apply, and
    - d. The market value of a non-liquid resource that is not real property;
  3. Not assign an equity value to a resource that is less than zero; and
  4. Determine the MED family unit's resources by adding the totals determined in subsections (1) and (2).
- F. Resource standard to be eligible for MED.** A person is not eligible for MED if the resources determined in subsection (E) exceed \$100,000 or if more than \$5,000 are liquid resources.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1439. MED Effective Date of Eligibility**

- A.** A MED family unit is eligible on the day the income and resource eligibility requirements are met but no earlier than the first day of the month of application. If the family unit meets the income requirements in the application month but does not meet the resource limit until the following month, the family unit's effective date of eligibility is the first day of the month following the month of application.
- B.** The Department shall adjust the effective date of eligibility under subsection (A) to an earlier date if:
1. A member presents verification of additional allowable medical expenses incurred on an earlier date during the medical expense deduction period that allow the member to meet the income requirements, and
  2. The member presents the verification within 60 days of approval of eligibility under this Section.
- C.** The Department shall not adjust an effective date of eligibility more than one time per application.
- D.** The Department shall adjust the effective date no later than 30 days after the end of the 60-day period under subsection (B)(2).
- E.** The Department shall deny an application and provide the applicant a denial notice when the applicant does not meet the MED requirements under this Article during the month of application or the month following the month of application.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1440. MED Eligibility Period**

The Department shall approve eligibility for six months. Changes in circumstances do not affect eligibility for the first three months.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1441. Eligibility Appeals**

- A.** Adverse actions. An applicant or member may appeal by requesting a hearing from the Department concerning any of the following adverse actions:
1. Complete or partial denial of eligibility under R9-22-1413;
  2. Suspension, termination, or reduction of AHCCCS medical coverage under R9-22-1415;
  3. Delay in the eligibility determination beyond the timeframes under this Article;

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4. The imposition of or increase in a premium or copayment; or
  5. The effective date of eligibility.
- B.** Notice of Adverse Action. The Department shall personally deliver or send, by regular mail, a Notice of Adverse Action to the person affected by the action. For the purpose of this Section, the date of the Notice of Adverse Action shall be the date of personal delivery to the applicant or the postmark date, if mailed.
- C.** Automatic change and hearing rights.
1. An applicant or a member is not entitled to a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.
  2. An applicant or a member is entitled to a hearing if a federal or state law requires an automatic change and the applicant or member timely files an appeal that alleges a misapplication of the facts to the law.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1442. Cessation of MED Coverage**

The Department shall not approve any individual or family who has applied on or after May 1, 2011 as eligible for MED coverage. With respect to any applications that are pending as of May 1, 2011, the Department shall not approve any individual or family as eligible for MED coverage who has not met all eligibility requirements prior to May 1, 2011.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 1028, effective May 1, 2011 (Supp. 11-2).

**R9-22-1443. Repealed****Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 1345, effective July 8, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 2624, effective July 8, 2011 (Supp. 11-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**ARTICLE 15. AHCCCS MEDICAL COVERAGE FOR PEOPLE WHO ARE AGED, BLIND, OR DISABLED****R9-22-1501. General Information**

**A.** General. The Administration shall determine eligibility for AHCCCS medical coverage for the following applicants or members using the eligibility criteria and requirements in this Article and Article 3:

1. A person who is aged, blind, or disabled and does not receive SSI cash; and
2. A person terminated from the SSI cash program under R9-22-1505.

**B.** Definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“Aged” means a person who is 65 years of age or older as specified in 42 U.S.C. 1382c(a)(1)(A).

“Blind” means a person who has been determined blind by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(2) and 42 CFR 435.530 as of October 1, 2012, which are incorporated by reference and on file with the Administration, and available

from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

“Disabled” means a person who has been determined disabled by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E) and 42 CFR 435.540 as of October 1, 2012, which are incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

**C. Eligibility effective date.**

1. Eligibility is effective on the first day of the month that all eligibility requirements are met, including the period described under R9-22-303.
2. The effective date of eligibility for an applicant who moves into Arizona is no sooner than the date Arizona residency is established.
3. The effective date of eligibility for an inmate applying for medical coverage is the date the applicant no longer meets the definition of an inmate of a public institution.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 23, effective December 9, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1). Amended by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4). Section amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014; amendments to this Section were slated to be codified in Supp. 14-1 but due to a clerical error, were not published. The amendments to this Section were published in Supp. 20-4 and no additional amendments have been made to this Section since January 7, 2014 (Supp. 20-4).

**R9-22-1502. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1503. Financial Eligibility Criteria**

- A.** General income eligibility. Except as provided under subsection (B) of this rule, the Administration or its designee shall count the identified income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K.
- B.** Exceptions.

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1. In-kind support and maintenance under 42 U.S.C. 1382a(a)(2)(A) is excluded.
2. For a person living with a spouse, the Administration or its designee calculates net income for an eligible couple under 20 CFR 416.1160 as of April 1, 2013, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments, even if the spouse is not eligible for or applying for SSI or coverage under this Article.
3. In determining the net income of a married couple living with a child or the net income of a person who is not living with a spouse but living with a child, a child allocation is allowed as a deduction from the combined net income of the couple for each child regardless of whether the child is ineligible or eligible. For the purposes of this Section, a child means a person who is unmarried, natural or adopted, and under age 18 or under age 22 if a full-time student. Each child's allocation deduction is reduced by that child's income, including public income maintenance payments, using the methodology under 20 CFR 416.1163(b)(1) and (2) as of April 1, 2013, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
4. In determining the income deemed available to an applicant who is a child from an ineligible parent or parents, an allocation for each eligible or ineligible child of the parent is allowed as a deduction from the parent's income under 20 CFR 416.1165(b). The child's allocation is reduced by that child's income, including public income maintenance payments.
5. In determining the income of a person who receives an annual Title II Cost of Living Allowance (COLA) increase, the COLA amount is disregarded from January until the Administration applies the effective income limits under R9-22-1504 based on the FPL for the calendar year.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1504. Eligibility For A Person Who is Aged, Blind, or Disabled**

- A. To be eligible for AHCCCS medical coverage, an applicant shall meet the conditions of eligibility and requirements in this Article and:
  1. Meet one of the income tests described in subsection (B) or (C), or
  2. The special requirements in R9-22-1505.
- B. The Administration shall determine whether the applicant's countable income, as described in R9-22-1503, is less than or equal to 100 percent of the SSI FBR, as adjusted annually.

- C. The Administration shall determine whether the applicant's countable income, as described in R9-22-1503, without deducting the amount from earned income under 42 U.S.C. 1382a(b)(4)(B)(iii), is less than or equal to 100 percent FPL as adjusted annually.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1505. Eligibility for Special Groups**

- A. The following are considered special groups:
  1. A person meeting the requirements in A.R.S. § 36-2903.03 who:
    - a. Is aged, blind, or disabled under 42 CFR 435.520, 42 CFR 435.530, or 42 CFR 435.540 as of October 1, 2012, which are incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
    - b. Received SSI cash or AHCCCS medical coverage under this subsection, or subsections (A)(2), (A)(3), or (A)(4) on or before August 21, 1996;
    - c. Was residing in the United States under color of law on or before August 21, 1996; and
    - d. Meets the requirements under this Article;
  2. A disabled child (DC) under 42 U.S.C. 1396a(a)(10)(A)(i)(II). A disabled child is a child who:
    - a. Was receiving SSI cash benefits as a disabled child on August 22, 1996;
    - b. Lost SSI cash benefits effective July 1, 1997, or later, due to a disability determination under Section 211(d) of Subtitle B of P.L. 104-193;
    - c. Continues to meet the disability requirements for a child that were in effect on August 21, 1996; and
    - d. Meets the requirements under this Article;
  3. A disabled adult child (DAC), under 42 U.S.C. 1383c(c) who:
    - a. Was determined disabled by the Social Security Administration before attaining the age of 22 years,
    - b. Became entitled to or received an increase in child's insurance benefits under Title II of the Act on the basis of blindness or disability,
    - c. Was terminated from SSI cash benefits due to entitlement to or an increase in income under Title II of the Act,
    - d. Meets the requirements under this Article, and
    - e. Is 18 years of age or older;
  4. A disabled widow or widower (DWW) under 42 U.S.C. 1383c(b) and (d) who:
    - a. Is blind or disabled,
    - b. Is ineligible for Medicare Part A benefits,
    - c. Received SSI cash benefits the month before Title II of the Act benefit payments began,
    - d. Meets the requirements under this Article;
    - e. Is at least 50 years of age but under age 65; and
    - f. Is unmarried.
  5. Under 42 CFR 435.135, a person who:
    - a. Is aged, blind, or disabled;

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- b. Receives benefits under Title II of the Act;
  - c. Received SSI cash benefits in the past;
  - d. Received SSI cash benefits and Title II of the Social Security Act benefits concurrently for at least one month anytime after April 1977;
  - e. Became ineligible for SSI cash benefits while receiving SSI and benefits under Title II of the Act concurrently; and
  - f. Meets the requirements under this Article.
- B. Income for special groups.**
1. Except as provided in subsection (B)(2), income eligibility is determined using the income criteria in R9-22-1503.
  2. Exceptions to income for special groups.
    - a. For a person in the DAC coverage group under subsection (A)(3), the applicant's Title II of the Social Security Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(c).
    - b. For a person in the DWW coverage group, under subsection (A)(4), the applicant's Title II of the Social Security Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(b) and (d).
    - c. For an applicant or member in the coverage group under subsection (A)(5), the portion of the applicant's or member's Title II of the Social Security Act benefits attributed to cost-of-living adjustments received by the applicant since the effective date of SSI ineligibility is disregarded in determining income eligibility under 42 CFR 435.135.
- C. 100 percent FBR.** As a condition of eligibility for all special groups, countable income shall be equal to or less than 100 percent of the SSI FBR, as adjusted annually.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1506. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1507. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1508. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**ARTICLE 16. HOSPITAL PRESUMPTIVE ELIGIBILITY****R9-22-1601. General Eligibility Requirements**

- A.** Notwithstanding Article 3, a qualified hospital may determine Hospital Presumptive Eligibility (HPE), on the basis of preliminary information, that an individual is eligible for AHCCCS medical coverage during the presumptive eligibility period described in this section, if the individual is a United States citizen or eligible qualified alien, and the individual is:
1. Pregnant with gross household income that does not exceed 156% of the FPL;
  2. An adult who meets the requirements of R9-22-1427(E);
  3. A caretaker relative as defined in R9-22-1401(B) with gross household income that does not exceed 106% of the FPL;
  4. Under age 19 with gross household income that does not exceed the limit set in R9-22-1427(D) for the child's age;
  5. A woman screened for breast or cervical cancer by an Arizona program of the National Breast and Cervical Cancer Early Detection Program who meets the requirements of R9-22-2003(A); or
  6. A former foster care child who meets the requirements of R9-22-1432.
- B.** Definitions. In addition to definitions contained in R9-22-101 and A.R.S. § 36-2901, the words and phrases in this Article have the following meanings unless the context explicitly requires another meaning: "Qualified hospital" means a hospital that has signed an agreement with the Administration to process HPE applications and has not been disqualified.
- C.** Application Process:
1. Right to apply. A person may apply for presumptive eligibility for AHCCCS medical coverage by submitting an Administration-approved application to the qualified hospital.
  2. Application. To initiate the application process, the qualified hospital will accept an application from the applicant, an adult who is in the applicant's household, as defined in 42 CFR 435.603(f), or family, as defined in section 36B(d)(1) of the Internal Revenue Service (IRS) Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant by submitting a written or online application under 42 CFR 435.907.
- D.** To establish presumptive eligibility, an applicant must complete and submit an AHCCCS-approved presumptive eligibility application signed under penalty of perjury to a qualified hospital. The applicant must attest to the name(s), relationship(s), and income of all persons in the household. In addition, the applicant must provide and attest to the following information regarding each household member on whose behalf AHCCCS medical coverage is sought:
1. The individual's date of birth;
  2. Whether the individual is pregnant;
  3. Whether the individual has been determined eligible for Breast and Cervical Cancer Treatment Program, described under Article 20;
  4. Whether the individual is a former foster child, described under R9-22-1432;
  5. The U.S. citizenship status or eligible qualified alien status under A.R.S. 36-2903.03 of the individual; and
  6. The individual's permanent and mailing addresses;
  7. The individual's Arizona residency status; and
  8. Whether the individual has Medicare coverage.

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**E.** Presumptive eligibility begins on the date the hospital determines an individual's presumptive eligibility and ends with the earlier of:

1. In the case of an individual on whose behalf an application has been submitted to AHCCCS or its designee under Article 3, the day on which AHCCCS or its designee makes a determination on that application; or
2. In the case of an individual on whose behalf an application has not been submitted to AHCCCS or its designee under Article 3, on the last day of the following month in which the determination of presumptive eligibility was made by the qualified hospital.

**F.** An individual may not be determined presumptively eligible more often than once every two years.

**G.** Coverage and reimbursement of services.

1. The Administration shall provide coverage of medically necessary services described under Article 2 to persons determined eligible for HPE on a fee-for-service basis.
2. Providers shall submit claims for services provided to persons determined eligible for HPE to the Administration as described under Article 7.

**H.** A member may withdraw from HPE coverage by notifying the Administration or its designee.

**I.** Upon determining an individual presumptively eligible, the qualified hospital shall:

1. Notify the applicant at the time a determination regarding presumptive eligibility is made, in writing and orally if appropriate, of the determination for each individual on whose behalf presumptive eligibility was requested and the effective date of the presumptive eligibility;
2. Provide the applicant with a regular AHCCCS-approved application form and inform the applicant that the applicant may file an application for Medicaid with the Administration or its designee;
3. Notify AHCCCS of the presumptive eligibility determination;
4. Notify the applicant at the time the determination is made that presumptive eligibility ends with the earlier of:
  - a. In the case of an individual on whose behalf an application has been submitted to AHCCCS or its designee under Article 3, the day on which AHCCCS or its designee makes a determination on that application; or
  - b. In the case of an individual on whose behalf an application has not been submitted to AHCCCS or its designee under Article 3, on the last day of the following month in which the determination of presumptive eligibility was made by the qualified hospital.

**J.** A determination by a qualified hospital that an individual is not presumptively eligible is not appealable under Chapter 34. If a qualified hospital denies an individual presumptive eligibility, the individual may apply for coverage by submitting an application to the Administration or its designee.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011

(Supp. 11-4). New Section made by final rulemaking at 20 A.A.R. 3436, effective January 1, 2015 (Supp. 14-4).

**R9-22-1602. Expired**

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1603. Expired**

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1604. Expired**

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1605. Expired**

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1606. Expired**

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1607. Expired**

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by

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exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1608. Expired****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1609. Expired****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1610. Expired****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1611. Expired****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1612. Expired****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-

1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1613. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1614. Expired****Historical Note**

New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1615. Expired****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1616. Expired****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1617. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1618. Expired****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1619. Expired****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by

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exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1620. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1621. Reserved****R9-22-1622. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1623. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1624. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1625. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1626. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1627. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1628. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1629. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1630. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1631. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1632. Reserved****R9-22-1633. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1634. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1635. Reserved****R9-22-1636. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**ARTICLE 17. ENROLLMENT****R9-22-1701. Enrollment-Related Definitions**

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“Annual enrollment choice” means the annual opportunity for a person to change contractors.

“Auto-assignment algorithm” or “Algorithm” means a formula used by the Administration to assign to a contractor a member who did not make a timely choice under R9-22-1702.

“CMDP” means Comprehensive Medical and Dental Program.

“Disenrollment” means the discontinuance of a person’s entitlement to receive covered services from a contractor of record.

“Enrollment” means the process by which an eligible person becomes a member of a contractor’s plan.

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**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended to correct a typographical error, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

**R9-22-1702. Enrollment of a Member with an AHCCCS Contractor**

- A.** General enrollment requirements. The Administration shall enroll a member with a contractor as described in this Section, unless the member has pre-selected a contractor on the application:
1. Except as provided in subsections (A)(3), (A)(5), and (C), a member who is determined to be eligible under this Chapter and resides in an area served by more than one contractor, may choose an available contractor serving the member's GSA within 30 days from the date of notice of enrollment. A Native American member may select IHS or another available contractor.
  2. If the member does not make a choice under subsection (A)(1), the Administration shall immediately auto-assign the member to:
    - a. IHS if the member is a Native American living on a reservation,
    - b. A contractor based on family continuity, or
    - c. A contractor by using the auto-assignment algorithm.
  3. If the member's period of ineligibility and disenrollment from the contractor of record is for a period of less than 90 days, the Administration shall enroll the member with the member's most recent contractor of record, if available, except if:
    - a. The member no longer resides in the contractor's GSA;
    - b. The contractor's contract is suspended or terminated;
    - c. The member was previously enrolled with CMDP but at the time of re-enrollment the member is not a foster care child;
    - d. The member chooses another contractor or chooses IHS, if available to the member, during the annual enrollment choice period; or
    - e. The member was previously enrolled with a contractor but at the time of re-enrollment the member is a foster care child.
  4. When the member's disenrollment period is more than 90 days, the member may select a contractor as described in subsection (A)(1).
  5. The Administration shall not enroll a member with a contractor if a member:
    - a. Is eligible for the FESP under R9-22-1419;
    - b. Is eligible for less than 30 days from the date the Administration receives notification of a member's eligibility, except for a member who is enrolled with CMDP or IHS;

- c. Is eligible only for a retroactive period of eligibility, except for a member who is enrolled with CMDP or IHS; or
  - d. Resides in an area not served by a contractor.
- B.** Fee-for-service coverage. A member not enrolled with a contractor under subsection (A)(5) shall obtain covered medical services from an AHCCCS-registered provider on a fee-for-service basis under Article 7.
- C.** Foster care child. The Administration shall enroll a member with CMDP if the member is a foster care child under A.R.S. § 8-512.
- D.** Family Planning Services Extension Program. A member eligible for the Family Planning Services Extension Program under R9-22-1431, shall remain enrolled with the member's contractor of record or IHS.
- E.** Contractor or IHS enrollment change for a member.
1. The Administration shall change a member's enrollment if the member requests a change to an available contractor or IHS during an annual enrollment period. A Native American may change from an available contractor to IHS or from IHS to an available contractor at any time.
  2. The Administration shall approve a change in enrollment for any member if the change is a result of the final outcome of a grievance under 9 A.A.C. 34.
  3. A member may choose a different contractor if the member moves into a GSA not served by the current contractor or if the contractor is no longer available. If the member does not select a contractor, the Administration shall auto-assign the member as provided in subsection (A)(2).
  4. The Administration shall provide the member 60-day advance notice of the member's option to change plans by the member's annual enrollment date.
  5. A member may disenroll from a plan if:
    - a. The member moves out of the GSA;
    - b. The plan does not, because of moral or religious objections, cover the service a member seeks; or
    - c. The member needs related services to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.
  6. For exceptions to this Article, the Administration shall approve a change for an enrolled member as determined by the Director.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

**R9-22-1703. Effective Date of Enrollment with a Contractor**

- A.** Effective date of enrollment. A member's date of enrollment is the date enrollment action is taken by the Administration. However, if a plan change occurs for an annual enrollment choice, the effective date is the month of the member's enrollment anniversary date.
- B.** Financial liability of the contractor. The contractor shall be financially liable for an enrolled member's care as specified in contract.

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**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

**R9-22-1704. Newborn Enrollment****A. General.**

1. The Administration shall enroll a newborn child of an eligible mother with an available contractor or IHS, based on the mother's enrollment.
2. The Administration shall auto-assign a newborn child of an eligible mother who is not enrolled with a contractor or IHS or who is enrolled with CMDP. When a mother enrolled in CMDP has a newborn and the newborn is surrendered to Administration on Children, Youth and Families (ACYF), the newborn is then enrolled with CMDP.
3. The Administration shall notify the mother of the right to choose a different contractor for her newborn child. The mother may make her choice within 30 days from the date of notice of enrollment.

- B.** Financial liability for newborns. The contractor shall be financially liable for the medical care of a newborn as specified in contract.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended to correct a typographical error, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

**R9-22-1705. Guaranteed Enrollment Period**

- A.** General. Except for members enrolled with IHS or CMDP, the Administration shall provide a guaranteed enrollment period for a one-time period that begins on the effective date of the member's initial enrollment with a contractor and ends on the last day of the fifth full calendar month after the date of the member's initial enrollment.

- B.** Exceptions to guaranteed period. The Administration shall not grant a guaranteed enrollment period or shall terminate a guaranteed enrollment period as provided in subsection (C), if the member:

1. Did not meet the conditions of eligibility when initially enrolled with the contractor;
2. Except as provided in 9 A.A.C. 22, Article 12, is an inmate of a public institution as defined in 42 CFR 435.1010;
3. Dies;
4. Moves out-of-state;
5. Voluntarily withdraws from the AHCCCS program;
6. Is adopted; or
7. Has whereabouts that are unknown.

- C.** Disenrollment effective date. The Administration shall terminate any guaranteed enrollment period to which the member is not entitled effective on:

1. The date the member is admitted to a public institution under subsection (B);
2. The member's date of death;

3. The last day of the month in which the Administration receives notification that a member moved out-of-state;
4. The date the Administration receives written notification of the member's voluntary withdrawal from the AHCCCS program;
5. The last day of the month in which the Administration receives notification that a member's adoption proceedings are finalized; or
6. The last day of the month in which the Administration receives notification that a member's whereabouts are unknown.

- D.** Retroactive adjustments. The Administration shall adjust the member's eligibility and enrollment retroactively under subsection (C).

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

**ARTICLE 18. RESERVED****ARTICLE 19. FREEDOM TO WORK**

*Article 19, consisting of Sections R9-22-1901 through R9-22-1922, made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).*

**R9-22-1901. General Freedom to Work Requirements**

Under 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and (XVI), the Administration shall determine eligibility for AHCCCS medical services, under Article 2 of this Chapter, using the eligibility criteria and requirements under this Article for an applicant or member who is:

1. At least 16 years of age, but less than 65 years of age,
2. Employed, and
3. Not income eligible under A.R.S. § 36-2901(6)(a).

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1902. General Administration Requirements**

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

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1903. 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 or outstation location approved by the Director as described under R9-22-1406(A).
- C.** The provisions in R9-22-1406(B) and (D) apply to this Section.
- D.** The applicant or representative who files the application may withdraw the application for coverage either orally or in writing. An applicant withdrawing an application shall receive a denial notice under R9-22-1904.
- 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. 95, effective January 1, 2003 (Supp. 02-4). Amended by final

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rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1904. 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, the notice shall contain:
  - 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.
2. If denied, R9-22-1501(G)(3) applies.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1905. Reporting and Verifying Changes**

An applicant or member shall report and verify changes, as described under R9-22-1501(H), to the Administration.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1906. 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 or premium,
2. Discontinuance of eligibility if a condition of eligibility is no longer met,
3. A change in premium amount, or
4. 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. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1907. Notice of Adverse Action Requirements**

- A. The requirements under R9-22-1501(K)(1) apply.
- B. Advance notice of a change in eligibility 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 discontinue eligibility, or increase the premium amount.
- 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 this must be the result of supplying that information, and the member 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 undeliver-

able 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;
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. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1908. 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. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1909. 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 the 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 member shall be disregarded, and
  - c. The deduction for a minor child shall not apply;
6. Comply with the member responsibility provisions under R9-22-1502(D) and (F).

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). Section repealed; new Section made by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1910. Prior Quarter Eligibility**

A person may be made eligible during a prior quarter period when applying for the Freedom to Work program, as described under Article 3.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). New Section made by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

**R9-22-1911. Repealed**

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**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1912. Repealed****Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1913. 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 for more than one month's premium amount.
- 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. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1914. Repealed****Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1915. Institutionalized Person**

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

1. An inmate of a public institution if federal financial participation (FFP) is not available, or
2. Age 21 through age 64 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. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1916. Repealed****Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1917. Repealed****Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1918. Additional Eligibility Criteria for the Basic Coverage Group**

An applicant or member shall meet the following eligibility criteria:

1. Disabled. As a condition of eligibility, an applicant or member shall be disabled. Disabled means a person who has been determined disabled by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E), except employment activity, earnings, and substantial gainful activity shall not be considered in determining whether the individual meets the definition of disability.
2. Employed. 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 or member's work.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1919. Additional Eligibility Criteria for the Medically Improved Group**

As a condition of eligibility for the Medically Improved Group, a member shall:

1. Be employed. Under this Section, employed means an individual who:
  - a. Earns at least the minimum wage and works at least 40 hours per month, or
  - b. Has gross monthly earnings at least equal to those earned by an individual who is earning the minimum wage working 40 hours per month.
2. Cease to be eligible for medical coverage under R9-22-1918 or a similar Basic Coverage Group program administered by another state because the member, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be disabled; and
3. Continues to have a severe medically determinable impairment, as determined under Social Security Act section 1902(a)(10)(A)(ii)(XVI).

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1920. Repealed****Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1921. Enrollment**

The Administration shall enroll members under Article 17 of this Chapter. If a member has not paid a required premium, the Administration shall not grant a guaranteed enrollment period.

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**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1922. 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 R9-22-1918, the Administration shall determine if the member is eligible under other coverage groups including the medically improved group.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**ARTICLE 20. BREAST AND CERVICAL CANCER TREATMENT PROGRAM****R9-22-2001. Breast and Cervical Cancer Treatment Program Related Definitions**

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meaning unless the context explicitly requires another meaning:

“AZ-NBCCEDP” means the Arizona programs of the National Breast and Cervical Cancer Early Detection Program. AZ-NBCCEDP provides breast and cervical cancer screening and diagnosis in Arizona.

“Cryotherapy” means the destruction of abnormal tissue using an extremely cold temperature.

“LEEP” means the loop electrosurgical excision procedure that passes an electric current through a thin wire loop.

“Peer-reviewed study” means that, prior to publication, a medical study has been subjected to the review of medical experts who:

- Have expertise in the subject matter of the study,
- Evaluate the science and methodology of the study,
- Are selected by the editorial staff of the publication, and
- Review the study without knowledge of the identity or qualifications of the author.

“WWHP” means the Well Women Healthcheck Program administered by the Arizona Department of Health Services. The WWHP is one of the programs within AZ-NBCCEDP that provides breast and cervical cancer screening and diagnosis.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

**R9-22-2002. General Requirements**

- A. Confidentiality. The Administration shall maintain the confidentiality of a woman's records and shall not disclose a woman's financial, medical, or other confidential information except as allowed under R9-22-512.
- B. Covered services. A woman who is eligible under this Article receives all medically necessary services under Articles 2 and 12 of this Chapter.

- C. Choice of health plan. A woman who is eligible under this Article shall be enrolled with a contractor under Article 17 of this Chapter.
- D. A Native American woman who receives services through Indian Health Service (IHS) or through a tribal health program qualifies for services provided under this Article if all eligibility requirements are met.
- E. A woman qualified under this Article shall pay co-pays as described in R9-22-711.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

**R9-22-2003. Eligibility Criteria**

- A. General. To be eligible under this Article, a woman shall meet the requirements of this Article and:
  1. Be screened for breast and cervical cancer through AZ-NBCCEDP;
  2. Be less than 65 years of age;
  3. Be ineligible for Title XIX under Articles 14 and 15 in this Chapter;
  4. Receive a positive screen under subsection (A)(1), a confirmed diagnosis through AZ-NBCCEDP, and need treatment for breast cancer or cervical cancer, including a pre-cancerous cervical lesion, as specified in R9-22-2004;
  5. Not be covered under creditable coverage as specified in Section 2701(c) of the Public Health Services Act, 42 U.S.C. 300gg(c). For purposes of this Article, IHS or Tribal health coverage is not considered creditable coverage as specified in 42 U.S.C. 1396a(a)(10)(A)(ii), as amended by the Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2002; and
  6. Meet the requirements under R9-22-1417 and R9-22-1418.
- B. Ineligible woman. A woman is ineligible under this Article if the woman:
  1. Is an inmate of a public institution and federal financial participation (FFP) is not available,
  2. Is at least age 21 but less than age 65 and resides in an Institution for Mental Disease (IMD) as defined in R9-22-112, except if allowed under the Administration's Section 1115 waiver, or
  3. No longer meets an eligibility requirement under this Article.
- C. Metastasized cancer. The AHCCCS Chief Medical Officer may continue a woman's eligibility under this Article if a metastasized cancer is found in another part of the woman's body and that metastasized cancer is a known or a presumed complication of the breast or cervical cancer as determined by the treating physician.
- D. Reoccurrence of cancer. A woman shall have eligibility reestablished after eligibility under this Article ends if the woman is screened under the AZ-NBCCEDP program and additional breast cancer or cervical cancer, including a pre-cancerous cervical lesion, is found.
- E. Ineligible male. A male is precluded from receiving screening and diagnostic services under the AZ-NBCCEDP program and is ineligible under this Article.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Amended by

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final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

**R9-22-2004. Treatment**

- A.** Breast cancer. Coverage for treatment for breast cancer under this Article shall conclude on the last provider visit for the specific treatment of the cancer or at the end of hormonal therapy for the cancer, whichever is later. For purposes of this subsection treatment means:
1. Lumpectomy or surgical removal of breast cancer;
  2. Chemotherapy;
  3. Radiation therapy; and
  4. A treatment for breast cancer that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.
- B.** Pre-cancerous cervical lesion. Coverage for treatment for a pre-cancerous cervical lesion under this Article, including moderate or severe cervical dysplasia or carcinoma in situ, shall conclude on the last provider visit for specific treatment for the pre-cancerous lesion. For purposes of this subsection treatment means:
1. Conization;
  2. LEEP;
  3. Cryotherapy; and
  4. A treatment for pre-cancerous cervical lesion that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.
- C.** Cervical cancer. Coverage for treatment for cervical cancer under this Article shall conclude on the last provider visit for the specific treatment for the cancer. For purposes of this subsection treatment means:
1. Surgery;
  2. Radiation therapy;
  3. Chemotherapy; and
  4. A treatment for cervical cancer that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

**R9-22-2005. Application Process**

- A.** Application. A woman may apply for eligibility under this Article by submitting a complete application as specified in R9-22-1406.
- B.** Submitting the application. The woman may complete and submit an application at the time of the AZ-NBCCEDP screening. The AZ-NBCCEDP staff may mail or fax the application directly to the Administration.
- C.** Date of application. The date of the application is the date of the diagnostic procedure that results in a positive diagnosis for breast cancer or cervical cancer, including a pre-cancerous cervical lesion.
- D.** Responsibility of a woman who is applying or who is a member. A woman who is applying or who is a member shall:
1. Provide medical insurance information, including any changes in medical insurance; and
  2. Inform the Administration about a change in address, residence, and alienage status.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

**R9-22-2006. Approval, Denial, or Discontinuance of Eligibility**

- A.** Eligibility determination. The Administration shall determine eligibility under this Article and send the notice under subsection (B) or (C) within seven days of receiving a complete application.
- B.** Approval. If a woman meets all the eligibility requirements in this Article, the Administration shall provide the woman with an approval notice. The approval notice shall contain:
1. The name of the eligible woman, and
  2. The effective date of eligibility.
- C.** Denial. If the Administration denies eligibility, the Administration shall provide the woman with a denial notice. The denial notice shall contain:
1. The name of the ineligible woman,
  2. The specific reason why the woman is ineligible,
  3. The legal citations supporting the reason for the denial,
  4. The location where the woman can review the legal citations, and
  5. Information regarding the woman's appeal and request for hearing rights.
- D.** Discontinuance.
1. Except as specified in subsection (D)(2), if a woman no longer meets an eligibility requirement under this Article, the Administration shall provide the woman a Notice of Action no later than 10 days before the effective date of the discontinuance.
  2. The Administration may mail the Notice of Action no later than the effective date of the discontinuance if the Administration:
    - a. Receives a written statement from the woman voluntarily withdrawing from AHCCCS,
    - b. Receives information confirming the death of the woman,
    - c. Receives returned mail with no forwarding address from the post office and the woman's whereabouts are unknown, or
    - d. Receives information confirming that the woman has been approved for Title XIX services outside the state of Arizona.
  3. The Notice of Action shall contain the:
    - a. Name of the ineligible woman,
    - b. Effective date of the discontinuance,
    - c. Specific reason why the woman is discontinued,
    - d. Legal citations supporting the reason for the discontinuance,
    - e. Location where the woman can review the legal citations, and
    - f. Information regarding the woman's appeal and request for hearing rights.
- E.** Request for hearing. A woman who is denied, or discontinued for the Breast and Cervical Cancer Treatment Program may request a hearing under Chapter 34.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section

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repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

**R9-22-2007. Effective and End Date of Eligibility**

- A. Eligibility is effective on the first day of the month that all eligibility requirements are met, including the period described under R9-22-303.
- B. The end date of eligibility:
1. For breast cancer, is 12 months after the last provider visit for a treatment specified in R9-22-2004 for the cancer or at the end of hormonal therapy for the cancer, whichever is later.
  2. For pre-cancerous cervical lesion, is four months after the last provider visit for a treatment specified in R9-22-2004 for the pre-cancerous lesion.
  3. For cervical cancer, is 12 months after the last provider visit for a treatment specified in R9-22-2004 for the cancer.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4). Section amended by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

**R9-22-2008. Redetermination of Eligibility**

- A. Redetermination. Except as provided in subsection (B), the Administration shall redetermine eligibility at least once a year. If a woman continues to meet the requirements of eligibility for the Breast and Cervical Cancer Treatment Program under this Article, the Administration shall notify the woman of continued eligibility. A woman is not required to be screened for breast and cervical cancer through AZ-NBC-CEDP at redetermination.
- B. Change in circumstance. The Administration shall complete a redetermination of eligibility if there is a change in the woman's circumstances that may affect eligibility, including a change in treatment.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

**ARTICLE 21. TRAUMA AND EMERGENCY SERVICES FUND**

*Article 21, consisting of Sections R9-22-2101 through R9-22-2103, made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).*

**R9-22-2101. General Provisions**

- A. A.R.S. § 36-2903.07 establishes the Administration as the authority to administer the Trauma and Emergency Services Fund.
- B. The Administration shall distribute 90% of monies from the trauma and emergency services fund to a level I trauma center, as defined in subsection (F) of this Section, for unrecovered trauma center readiness costs as defined in subsection (F) of this Section. Reimbursement is limited to no more than the amount of unrecovered trauma center readiness costs as determined in subsections (D) and (E) of this Section. Unexpended funds may be used to reimburse unrecovered emergency room costs under subsection (C) of this Section.
- C. The Administration shall distribute 10% of monies from the trauma and emergency services fund, for unrecovered emergency services costs, to a hospital having an emergency

department, using criteria under R9-22-2103. Reimbursement is limited to no more than the amount of unrecovered emergency services costs as determined in R9-22-2103. The Administration may distribute more than 10% of the monies for unrecovered emergency room costs when there are unexpended monies under subsection (B) of this Section.

- D. The Administration shall distribute a reporting tool and guidelines to level I trauma centers to determine, on an annual basis, the unrecovered trauma center readiness costs for level I trauma centers as defined in subsection (F) of this Section. The reporting time-frame is July 1 of the prior year through June 30 of the reporting year. A level I trauma center shall submit the requested data and a copy of the most recently completed uniform accounting report under A.R.S. § 36-125.04 to the Administration no later than October 31 of each reporting year.
- E. When a level I trauma center closes in a county where there are one or more level I trauma center(s) remaining in operation, the following shall occur:
1. The closing level I trauma center shall submit the requested data under subsection (D) of this Section for the months of the reporting time-frame in which it met the definition of a level I trauma center, and
  2. The data under subsection (D) of this Section, which is submitted by the closing level I trauma center, shall be added to the remaining level I trauma center(s) in that county for the current reporting time-frame only.
- F. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:
1. "Level I trauma center" means any acute care hospital designated by the Arizona Department of Health Services as a level I trauma center, a provisional level I trauma center, a pediatric level I trauma center or an initial level I trauma center.
  2. "Unrecovered trauma center readiness costs" means losses incurred treating trauma patients:
    - a. Determined in accordance with Generally Accepted Accounting Principles,
    - b. Based on both clinical and professional costs incurred by a level I trauma center necessary for the provision of level I trauma care, and
    - c. Based on administrative and overhead costs directly associated with providing level I trauma care.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

**R9-22-2102. Distribution of Trauma and Emergency Services Fund: Level I Trauma Centers**

- A. On or after November 1, 2003, the Administration shall distribute monies, under R9-22-2101(B), to level I trauma centers using monies available in the trauma and emergency services fund at the time of payment. The Administration shall take into consideration the proportion of those hospitals' trauma case volume. The Administration shall:
1. Recalculate the November 2003 payments in July 2004 using the formula in subsection (B) of this Section;
  2. Recoup November 2003 overpayments by reducing the July 2004 distributions under subsection (C) as appropriate; and

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3. Redistribute recouped funds, with the July 2004 payment, to level I trauma centers underpaid in November 2003.
- B.** On or after January 31 of each year, the Administration shall distribute monies, under R9-22-2101(B), to level I trauma centers using monies available in the trauma and emergency services fund at the time of payment. The Administration shall determine each hospital's unrecovered trauma center readiness costs for the current fiscal year using data from the most recent reporting year as provided under R9-22-2101(D) and (E). The proportion of each hospital's share of the fund for unrecovered trauma center readiness costs is determined after considering:
1. The professional, clinical, administrative, and overhead costs directly associated with providing level I trauma care, and
  2. The volume and acuity of trauma care provided by each hospital.
- C.** On or after July 31 of each year, the Administration shall distribute monies to level I trauma centers using monies, under R9-22-2101(B), available in the trauma and emergency services fund at the time of payment according to the proportions calculated and used for the January payments in the same year, under subsection (B) of this Section.
- Historical Note**
- New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).
- R9-22-2103. Distribution of Trauma and Emergency Services Fund: Emergency Services**
- On or after June 30 of each year, the Administration shall distribute monies available in the trauma and emergency services fund at the time of payment as follows:
1. As allocated under R9-22-2101(C),
  2. To hospitals that had an emergency department from July 1 through June 30 of the prior year, and
  3. On a pro rata share of each hospital's cost of uncompensated emergency care as a percentage of the total statewide cost of uncompensated emergency care provided by hospitals under subsection (2) as reported in the uniform accounting reports to the Arizona Department of Health Services under A.R.S. § 36-125.04.
- Historical Note**
- New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3). Amended by exempt rulemaking at 18 A.A.R. 1748, effective July 1, 2012 (Supp. 12-2).
- R9-22-2104. Additional Trauma and Emergency Services Payments under the Section 1115 Waiver**
- A.** Notwithstanding R9-22-2101(D), for the reporting years ending June 30, 2011 and June 30, 2012, the Administration shall distribute an amount equal to the balance of the Trauma and Emergency Services fund in the following manner:
1. Ninety percent of the amount shall be distributed to Level I trauma centers based upon each center's pro rata share of each center's acuity-adjusted volume as a percentage of the total acuity-adjusted volume for all centers in the state. The acuity-adjusted volume is calculated by multiplying the Injury Severity Score employed by trauma.org by the number of trauma cases at that level treated at the center during the reporting year. Hospitals shall report trauma scores and case volume on a worksheet prescribed by the Administration.
  2. Ten percent of the amount shall be distributed proportionately to hospitals that had an emergency department from July 1 through June 30 of the reporting year based the pro rata share of each hospital's cost of emergency care as a percentage of the total statewide cost of emergency care provided by hospitals as reported on the Worksheet B, column 27, line 61 of the hospital's most current Medicare Cost Report as of January 31 following the end of each reporting year.
- B.** For the reporting years ending June 30, 2011 and June 30, 2012, the Administration shall distribute an amount equal to the federal financial participation made available under the section 1115 waiver for the purpose of making payments for unrecovered trauma and emergency services as follows:
1. Thirty percent of such funds to a Level I trauma center, in amounts calculated in the same manner as described in subsection (A)(1) of this Section, for any unrecovered trauma center readiness costs not reimbursed under subsection (A) of this Section;
  2. Thirty percent of such funds to a hospital having an emergency department from July 1 through June 30 of the reporting year, in amounts calculated in the same manner as described in subsection (A)(2) of this Section, for any unrecovered emergency services costs not reimbursed under subsection (A) of this Section; and
  3. Forty percent of such funds to rural hospitals, as defined in R9-22-718 that are not Level 1 trauma centers as defined in R9-22-2101(F), having an emergency department from July 1 through June 30 of the reporting year, in amounts calculated in the same manner as described in subsection (A)(2) of this Section, for any unrecovered emergency services costs not reimbursed under subsections (A) and (B)(2) of this Section.
- C.** For the reporting years ending June 30, 2011 and June 30, 2012, payments made under this Article shall not be made in an amount that results in aggregate payments to the hospital by the Administration and contractors exceeding of the upper payment limit for the hospital services as calculated in accordance with 42 CFR 447.
- D.** For the reporting years ending June 30, 2011 and June 30, 2012, to ensure compliance with subsection (C), payments under this Article shall be reconciled to the federal fiscal year that is two years subsequent to the payment.
- E.** Any payments that are determined under subsection (D) to exceed the limit in subsection (C) shall be distributed as described in this Article to hospitals that have not received payments in excess of the limit in subsection (C).
- Historical Note**
- New Section made by exempt rulemaking at 18 A.A.R. 1748, effective July 1, 2012 (Supp. 12-2).

36-2903.01. [Additional powers and duties; report; definition](#)

A. The director of the Arizona health care cost containment system administration may adopt rules that provide that the system may withhold or forfeit payments to be made to a noncontracting provider by the system if the noncontracting provider fails to comply with this article, the provider agreement or rules that are adopted pursuant to this article and that relate to the specific services rendered for which a claim for payment is made.

B. The director shall:

1. Prescribe uniform forms to be used by all contractors. The rules shall require a written and signed application by the applicant or an applicant's authorized representative, or, if the person is incompetent or incapacitated, a family member or a person acting responsibly for the applicant may obtain a signature or a reasonable facsimile and file the application as prescribed by the administration.
2. Enter into an interagency agreement with the department to establish a streamlined eligibility process to determine the eligibility of all persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). At the administration's option, the interagency agreement may allow the administration to determine the eligibility of certain persons, including those defined pursuant to section 36-2901, paragraph 6, subdivision (a).
3. Enter into an intergovernmental agreement with the department to:
  - (a) Establish an expedited eligibility and enrollment process for all persons who are hospitalized at the time of application.
  - (b) Establish performance measures and incentives for the department.
  - (c) Establish the process for management evaluation reviews that the administration shall perform to evaluate the eligibility determination functions performed by the department.
  - (d) Establish eligibility quality control reviews by the administration.
  - (e) Require the department to adopt rules, consistent with the rules adopted by the administration for a hearing process, that applicants or members may use for appeals of eligibility determinations or redeterminations.
  - (f) Establish the department's responsibility to place sufficient eligibility workers at federally qualified health centers to screen for eligibility and at hospital sites and level one trauma centers to ensure that persons seeking hospital services are screened on a timely basis for eligibility for the system, including a process to ensure that applications for the system can be accepted on a twenty-four hour basis, seven days a week.
  - (g) Withhold payments based on the allowable sanctions for errors in eligibility determinations or redeterminations or failure to meet performance measures required by the intergovernmental agreement.
  - (h) Recoup from the department all federal fiscal sanctions that result from the department's inaccurate eligibility determinations. The director may offset all or part of a sanction if the department submits a corrective action plan and a strategy to remedy the error.
4. By rule establish a procedure and time frames for the intake of grievances and requests for hearings, for the continuation of benefits and services during the appeal process and for a grievance process at the contractor level. Notwithstanding sections 41-1092.02, 41-1092.03 and 41-1092.05, the administration shall develop rules to establish the procedure and time frame for the informal resolution of grievances and appeals. A grievance that is not related to a claim for payment of system covered services shall be filed in writing with and received by the administration or the prepaid capitated provider or program contractor not later than sixty days after the date of the adverse action, decision or policy implementation being grieved. A grievance that is related to a claim for payment of system covered services must be filed in writing and received by the administration or the prepaid capitated provider or program contractor within twelve months after the date of service, within twelve months after the date that eligibility is posted or within sixty days after the date of the denial of a timely claim submission, whichever is later. A grievance for the denial of a claim for reimbursement of services may contest the validity of any adverse action, decision, policy implementation or rule that related to or resulted in the full or partial denial of the claim. A policy implementation may be subject to a grievance procedure, but it may not be appealed for a hearing. The administration is not required to participate in a mandatory settlement conference if it is not a real party in interest. In any proceeding before the administration, including a grievance or hearing, persons may represent themselves or be represented by a duly authorized agent who is not charging a fee. A legal entity may be represented by an officer, partner or employee who is specifically authorized by the legal entity to represent it in the particular proceeding.
5. Apply for and accept federal funds available under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) in support of the system. The application made by the director pursuant to this paragraph shall be designed to qualify for federal funding primarily on a prepaid capitated basis. Such funds may be used only for the support of persons defined as eligible pursuant to title XIX of the social security act or the approved section 1115 waiver.
6. At least thirty days before the implementation of a policy or a change to an existing policy relating to reimbursement, provide notice to interested parties. Parties interested in receiving notification of policy changes shall submit a written request for notification to the administration.
7. In addition to the cost sharing requirements specified in subsection D, paragraph 4 of this section:
  - (a) Charge monthly premiums up to the maximum amount allowed by federal law to all populations of eligible persons who may be charged.
  - (b) Implement this paragraph to the extent permitted under the federal deficit reduction act of 2005 and other federal laws, subject to the approval of federal waiver authority and to the extent that any changes in the cost sharing requirements under this paragraph would permit this state to

receive any enhanced federal matching rate.

C. The director is authorized to apply for any federal funds available for the support of programs to investigate and prosecute violations arising from the administration and operation of the system. Available state funds appropriated for the administration and operation of the system may be used as matching funds to secure federal funds pursuant to this subsection.

D. The director may adopt rules or procedures to do the following:

1. Authorize advance payments based on estimated liability to a contractor or a noncontracting provider after the contractor or noncontracting provider has submitted a claim for services and before the claim is ultimately resolved. The rules shall specify that any advance payment shall be conditioned on the execution before payment of a contract with the contractor or noncontracting provider that requires the administration to retain a specified percentage, which shall be at least twenty percent, of the claimed amount as security and that requires repayment to the administration if the administration makes any overpayment.

2. Defer liability, in whole or in part, of contractors for care provided to members who are hospitalized on the date of enrollment or under other circumstances. Payment shall be on a capped fee-for-service basis for services other than hospital services and at the rate established pursuant to subsection G of this section for hospital services or at the rate paid by the health plan, whichever is less.

3. Deputize, in writing, any qualified officer or employee in the administration to perform any act that the director by law is empowered to do or charged with the responsibility of doing, including the authority to issue final administrative decisions pursuant to section 41-1092.08.

4. Notwithstanding any other law, require persons eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section 36-2981, paragraph 6 to be financially responsible for any cost sharing requirements established in a state plan or a section 1115 waiver and approved by the centers for medicare and medicaid services. Cost sharing requirements may include copayments, coinsurance, deductibles, enrollment fees and monthly premiums for enrolled members, including households with children enrolled in the Arizona long-term care system.

E. The director shall adopt rules that further specify the medical care and hospital services that are covered by the system pursuant to section 36-2907.

F. In addition to the rules otherwise specified in this article, the director may adopt necessary rules pursuant to title 41, chapter 6 to carry out this article. Rules adopted by the director pursuant to this subsection shall consider the differences between rural and urban conditions on the delivery of hospitalization and medical care.

G. For inpatient hospital admissions and outpatient hospital services on and after March 1, 1993, the administration shall adopt rules for the reimbursement of hospitals according to the following procedures:

1. For inpatient hospital stays from March 1, 1993 through September 30, 2014, the administration shall use a prospective tiered per diem methodology, using hospital peer groups if analysis shows that cost differences can be attributed to independently definable features that hospitals within a peer group share. In peer grouping the administration may consider such factors as length of stay differences and labor market variations. If there are no cost differences, the administration shall implement a stop loss-stop gain or similar mechanism. Any stop loss-stop gain or similar mechanism shall ensure that the tiered per diem rates assigned to a hospital do not represent less than ninety percent of its 1990 base year costs or more than one hundred ten percent of its 1990 base year costs, adjusted by an audit factor, during the period of March 1, 1993 through September 30, 1994. The tiered per diem rates set for hospitals shall represent no less than eighty-seven and one-half percent or more than one hundred twelve and one-half percent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1994 through September 30, 1995 and no less than eighty-five percent or more than one hundred fifteen percent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1995 through September 30, 1996. For the periods after September 30, 1996 no stop loss-stop gain or similar mechanisms shall be in effect. An adjustment in the stop loss-stop gain percentage may be made to ensure that total payments do not increase as a result of this provision. If peer groups are used, the administration shall establish initial peer group designations for each hospital before implementation of the per diem system. The administration may also use a negotiated rate methodology. The tiered per diem methodology may include separate consideration for specialty hospitals that limit their provision of services to specific patient populations, such as rehabilitative patients or children. The initial per diem rates shall be based on hospital claims and encounter data for dates of service November 1, 1990 through October 31, 1991 and processed through May of 1992. The administration may also establish a separate reimbursement methodology for claims with extraordinarily high costs per day that exceed thresholds established by the administration.

2. For rates effective on October 1, 1994, and annually through September 30, 2011, the administration shall adjust tiered per diem payments for inpatient hospital care by the data resources incorporated market basket index for prospective payment system hospitals. For rates effective beginning on October 1, 1999, the administration shall adjust payments to reflect changes in length of stay for the maternity and nursery tiers.

3. Through June 30, 2004, for outpatient hospital services, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to the covered charges. Beginning on July 1, 2004 through June 30, 2005, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to covered charges. If the hospital increases its charges for outpatient services filed with the Arizona department of health services pursuant to chapter 4, article 3 of this title, by more than 4.7 percent for dates of service effective on or after July 1, 2004, the hospital specific cost-to-charge ratio will be reduced by the amount that it exceeds 4.7 percent. If charges exceed 4.7 percent, the effective date of the increased charges will be the effective date of the adjusted Arizona health care cost containment system cost-to-charge ratio. The administration shall develop the methodology for a capped fee-for-service schedule and a statewide cost-to-charge ratio. Any covered outpatient service not included in the capped fee-for-service schedule shall be reimbursed by applying the statewide cost-to-charge ratio that is based on the services not included in the capped fee-for-service schedule. Beginning on July 1, 2005, the administration shall reimburse clean claims with dates of service on or after July 1, 2005, based on the capped fee-for-service schedule or the statewide cost-to-charge ratio established pursuant to this paragraph. The administration may make additional adjustments to the outpatient hospital rates established pursuant to this section based on other factors, including the number of beds in the hospital, specialty services available to patients and the geographic location of the hospital.

4. Except if submitted under an electronic claims submission system, a hospital bill is considered received for purposes of this paragraph on initial receipt of the legible, error-free claim form by the administration if the claim includes the following error-free documentation in legible form:

- (a) An admission face sheet.
- (b) An itemized statement.
- (c) An admission history and physical.
- (d) A discharge summary or an interim summary if the claim is split.
- (e) An emergency record, if admission was through the emergency room.
- (f) Operative reports, if applicable.
- (g) A labor and delivery room report, if applicable.

Payment received by a hospital from the administration pursuant to this subsection or from a contractor either by contract or pursuant to section 36-2904, subsection I is considered payment by the administration or the contractor of the administration's or contractor's liability for the hospital bill. A hospital may collect any unpaid portion of its bill from other third-party payors or in situations covered by title 33, chapter 7, article 3.

5. For services rendered on and after October 1, 1997, the administration shall pay a hospital's rate established according to this section subject to the following:

- (a) If the hospital's bill is paid within thirty days of the date the bill was received, the administration shall pay ninety-nine percent of the rate.
- (b) If the hospital's bill is paid after thirty days but within sixty days of the date the bill was received, the administration shall pay one hundred percent of the rate.
- (c) If the hospital's bill is paid any time after sixty days of the date the bill was received, the administration shall pay one hundred percent of the rate plus a fee of one percent per month for each month or portion of a month following the sixtieth day of receipt of the bill until the date of payment.

6. In developing the reimbursement methodology, if a review of the reports filed by a hospital pursuant to section 36-125.04 indicates that further investigation is considered necessary to verify the accuracy of the information in the reports, the administration may examine the hospital's records and accounts related to the reporting requirements of section 36-125.04. The administration shall bear the cost incurred in connection with this examination unless the administration finds that the records examined are significantly deficient or incorrect, in which case the administration may charge the cost of the investigation to the hospital examined.

7. Except for privileged medical information, the administration shall make available for public inspection the cost and charge data and the calculations used by the administration to determine payments under the tiered per diem system, provided that individual hospitals are not identified by name. The administration shall make the data and calculations available for public inspection during regular business hours and shall provide copies of the data and calculations to individuals requesting such copies within thirty days of receipt of a written request. The administration may charge a reasonable fee for the provision of the data or information.

8. The prospective tiered per diem payment methodology for inpatient hospital services shall include a mechanism for the prospective payment of inpatient hospital capital related costs. The capital payment shall include hospital specific and statewide average amounts. For tiered per diem rates beginning on October 1, 1999, the capital related cost component is frozen at the blended rate of forty percent of the hospital specific capital cost and sixty percent of the statewide average capital cost in effect as of January 1, 1999 and as further adjusted by the calculation of tier rates for maternity and nursery as prescribed by law. Through September 30, 2011, the administration shall adjust the capital related cost component by the data resources incorporated market basket index for prospective payment system hospitals.

9. For graduate medical education programs:

(a) Beginning September 30, 1997, the administration shall establish a separate graduate medical education program to reimburse hospitals that had graduate medical education programs that were approved by the administration as of October 1, 1999. The administration shall separately account for monies for the graduate medical education program based on the total reimbursement for graduate medical education reimbursed to hospitals by the system in federal fiscal year 1995-1996 pursuant to the tiered per diem methodology specified in this section. The graduate medical education program reimbursement shall be adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement. Subject to legislative appropriation, on an annual basis, each qualified hospital shall receive a single payment from the graduate medical education program that is equal to the same percentage of graduate medical education reimbursement that was paid by the system in federal fiscal year 1995-1996. Any reimbursement for graduate medical education made by the administration shall not be subject to future settlements or appeals by the hospitals to the administration. The monies available under this subdivision shall not exceed the fiscal year 2005-2006 appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement, except for monies distributed for expansions pursuant to subdivision (b) of this paragraph.

(b) The monies available for graduate medical education programs pursuant to this subdivision shall not exceed the fiscal year 2006-2007 appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement. Graduate medical education programs eligible for such reimbursement are not precluded from receiving

reimbursement for funding under subdivision (c) of this paragraph. Beginning July 1, 2006, the administration shall distribute any monies appropriated for graduate medical education above the amount prescribed in subdivision (a) of this paragraph in the following order or priority:

(i) For the direct costs to support the expansion of graduate medical education programs established before July 1, 2006 at hospitals that do not receive payments pursuant to subdivision (a) of this paragraph. These programs must be approved by the administration.

(ii) For the direct costs to support the expansion of graduate medical education programs established on or before October 1, 1999. These programs must be approved by the administration.

(c) The administration shall distribute to hospitals any monies appropriated for graduate medical education above the amount prescribed in subdivisions (a) and (b) of this paragraph for the following purposes:

(i) For the direct costs of graduate medical education programs established or expanded on or after July 1, 2006. These programs must be approved by the administration.

(ii) For a portion of additional indirect graduate medical education costs for programs that are located in a county with a population of less than five hundred thousand persons at the time the residency position was created or for a residency position that includes a rotation in a county with a population of less than five hundred thousand persons at the time the residency position was established. These programs must be approved by the administration.

(d) The administration shall develop, by rule, the formula by which the monies are distributed.

(e) Each graduate medical education program that receives funding pursuant to subdivision (b) or (c) of this paragraph shall identify and report to the administration the number of new residency positions created by the funding provided in this paragraph, including positions in rural areas. The program shall also report information related to the number of funded residency positions that resulted in physicians locating their practices in this state. The administration shall report to the joint legislative budget committee by February 1 of each year on the number of new residency positions as reported by the graduate medical education programs.

(f) Local, county and tribal governments and any university under the jurisdiction of the Arizona board of regents may provide monies in addition to any state general fund monies appropriated for graduate medical education in order to qualify for additional matching federal monies for providers, programs or positions in a specific locality and costs incurred pursuant to a specific contract between the administration and providers or other entities to provide graduate medical education services as an administrative activity. Payments by the administration pursuant to this subdivision may be limited to those providers designated by the funding entity and may be based on any methodology deemed appropriate by the administration, including replacing any payments that might otherwise have been paid pursuant to subdivision (a), (b) or (c) of this paragraph had sufficient state general fund monies or other monies been appropriated to fully fund those payments. These programs, positions, payment methodologies and administrative graduate medical education services must be approved by the administration and the centers for medicare and medicaid services. The administration shall report to the president of the senate, the speaker of the house of representatives and the director of the joint legislative budget committee on or before July 1 of each year on the amount of money contributed and number of residency positions funded by local, county and tribal governments, including the amount of federal matching monies used.

(g) Any funds appropriated but not allocated by the administration for subdivision (b) or (c) of this paragraph may be reallocated if funding for either subdivision is insufficient to cover appropriate graduate medical education costs.

10. Notwithstanding section 41-1005, subsection A, paragraph 9, the administration shall adopt rules pursuant to title 41, chapter 6 establishing the methodology for determining the prospective tiered per diem payments that are in effect through September 30, 2014.

11. For inpatient hospital services rendered on or after October 1, 2011, the prospective tiered per diem payment rates are permanently reset to the amounts payable for those services as of October 1, 2011 pursuant to this subsection.

12. The administration shall adopt a diagnosis-related group based hospital reimbursement methodology consistent with title XIX of the social security act for inpatient dates of service on and after October 1, 2014. The administration may make additional adjustments to the inpatient hospital rates established pursuant to this section for hospitals that are publicly operated or based on other factors, including the number of beds in the hospital, the specialty services available to patients, the geographic location and diagnosis-related group codes that are made publicly available by the hospital pursuant to section 36-437. The administration may also provide additional reimbursement for extraordinarily high cost cases that exceed a threshold above the standard payment. The administration may also establish a separate payment methodology for specific services or hospitals serving unique populations.

H. The director may adopt rules that specify enrollment procedures, including notice to contractors of enrollment. The rules may provide for varying time limits for enrollment in different situations. The administration shall specify in contract when a person who has been determined eligible will be enrolled with that contractor and the date on which the contractor will be financially responsible for health and medical services to the person.

I. The administration may make direct payments to hospitals for hospitalization and medical care provided to a member in accordance with this article and rules. The director may adopt rules to establish the procedures by which the administration shall pay hospitals pursuant to this subsection if a contractor fails to make timely payment to a hospital. Such payment shall be at a level determined pursuant to section 36-2904, subsection H or I. The director may withhold payment due to a contractor in the amount of any payment made directly to a hospital by the administration on behalf of a contractor pursuant to this subsection.

J. The director shall establish a special unit within the administration for the purpose of monitoring the third-party payment collections required by contractors and noncontracting providers pursuant to section 36-2903, subsection B, paragraph 10 and subsection F and section 36-2915, subsection E. The director shall determine by rule:

1. The type of third-party payments to be monitored pursuant to this subsection.

2. The percentage of third-party payments that is collected by a contractor or noncontracting provider and that the contractor or noncontracting provider may keep and the percentage of such payments that the contractor or noncontracting provider may be required to pay to the administration. Contractors and noncontracting providers must pay to the administration one hundred percent of all third-party payments that are collected and that duplicate administration fee-for-service payments. A contractor that contracts with the administration pursuant to section 36-2904, subsection A may be entitled to retain a percentage of third-party payments if the payments collected and retained by a contractor are reflected in reduced capitation rates. A contractor may be required to pay the administration a percentage of third-party payments that are collected by a contractor and that are not reflected in reduced capitation rates.

K. The administration shall establish procedures to apply to the following if a provider that has a contract with a contractor or noncontracting provider seeks to collect from an individual or financially responsible relative or representative a claim that exceeds the amount that is reimbursed or should be reimbursed by the system:

1. On written notice from the administration or oral or written notice from a member that a claim for covered services may be in violation of this section, the provider that has a contract with a contractor or noncontracting provider shall investigate the inquiry and verify whether the person was eligible for services at the time that covered services were provided. If the claim was paid or should have been paid by the system, the provider that has a contract with a contractor or noncontracting provider shall not continue billing the member.

2. If the claim was paid or should have been paid by the system and the disputed claim has been referred for collection to a collection agency or referred to a credit reporting bureau, the provider that has a contract with a contractor or noncontracting provider shall:

(a) Notify the collection agency and request that all attempts to collect this specific charge be terminated immediately.

(b) Advise all credit reporting bureaus that the reported delinquency was in error and request that the affected credit report be corrected to remove any notation about this specific delinquency.

(c) Notify the administration and the member that the request for payment was in error and that the collection agency and credit reporting bureaus have been notified.

3. If the administration determines that a provider that has a contract with a contractor or noncontracting provider has billed a member for charges that were paid or should have been paid by the administration, the administration shall send written notification by certified mail or other service with proof of delivery to the provider that has a contract with a contractor or noncontracting provider stating that this billing is in violation of federal and state law. If, twenty-one days or more after receiving the notification, a provider that has a contract with a contractor or noncontracting provider knowingly continues billing a member for charges that were paid or should have been paid by the system, the administration may assess a civil penalty in an amount equal to three times the amount of the billing and reduce payment to the provider that has a contract with a contractor or noncontracting provider accordingly. Receipt of delivery signed by the addressee or the addressee's employee is prima facie evidence of knowledge. Civil penalties collected pursuant to this subsection shall be deposited in the state general fund. Section 36-2918, subsections C, D and F, relating to the imposition, collection and enforcement of civil penalties, apply to civil penalties imposed pursuant to this paragraph.

L. The administration may conduct postpayment review of all claims paid by the administration and may recoup any monies erroneously paid. The director may adopt rules that specify procedures for conducting postpayment review. A contractor may conduct a postpayment review of all claims paid by the contractor and may recoup monies that are erroneously paid.

M. Subject to title 41, chapter 4, article 4, the director or the director's designee may employ and supervise personnel necessary to assist the director in performing the functions of the administration.

N. The administration may contract with contractors for obstetrical care who are eligible to provide services under title XIX of the social security act.

O. Notwithstanding any other law, on federal approval the administration may make disproportionate share payments to private hospitals, county operated hospitals, including hospitals owned or leased by a special health care district, and state operated institutions for mental disease beginning October 1, 1991 in accordance with federal law and subject to legislative appropriation. If at any time the administration receives written notification from federal authorities of any change or difference in the actual or estimated amount of federal funds available for disproportionate share payments from the amount reflected in the legislative appropriation for such purposes, the administration shall provide written notification of such change or difference to the president and the minority leader of the senate, the speaker and the minority leader of the house of representatives, the director of the joint legislative budget committee, the legislative committee of reference and any hospital trade association within this state, within three working days not including weekends after receipt of the notice of the change or difference. In calculating disproportionate share payments as prescribed in this section, the administration may use either a methodology based on claims and encounter data that is submitted to the administration from contractors or a methodology based on data that is reported to the administration by private hospitals and state operated institutions for mental disease. The selected methodology applies to all private hospitals and state operated institutions for mental disease qualifying for disproportionate share payments.

P. Disproportionate share payments made pursuant to subsection O of this section include amounts for disproportionate share hospitals designated by political subdivisions of this state, tribal governments and universities under the jurisdiction of the Arizona board of regents. Subject to the approval of the centers for medicare and medicaid services, any amount of federal funding allotted to this state pursuant to section 1923(f) of the social security act and not otherwise spent under subsection O of this section shall be made available for distribution pursuant to this subsection. Political subdivisions of this state, tribal governments and universities under the jurisdiction of the Arizona board of regents may designate hospitals eligible to receive disproportionate share payments in an amount up to the limit prescribed in section 1923(g) of the social

security act if those political subdivisions, tribal governments or universities provide sufficient monies to qualify for the matching federal monies for the disproportionate share payments.

Q. Notwithstanding any law to the contrary, the administration may receive confidential adoption information to determine whether an adopted child should be terminated from the system.

R. The adoption agency or the adoption attorney shall notify the administration within thirty days after an eligible person receiving services has placed that person's child for adoption.

S. If the administration implements an electronic claims submission system, it may adopt procedures pursuant to subsection G of this section requiring documentation different than prescribed under subsection G, paragraph 4 of this section.

T. In addition to any requirements adopted pursuant to subsection D, paragraph 4 of this section, notwithstanding any other law, subject to approval by the centers for medicare and medicaid services, beginning July 1, 2011, members eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section 36-2981, paragraph 6 shall pay the following:

1. A monthly premium of fifteen dollars, except that the total monthly premium for an entire household shall not exceed sixty dollars.
2. A copayment of five dollars for each physician office visit.
3. A copayment of ten dollars for each urgent care visit.
4. A copayment of thirty dollars for each emergency department visit.

U. Subject to the approval of the centers for medicare and medicaid services, political subdivisions of this state, tribal governments and any university under the jurisdiction of the Arizona board of regents may provide to the Arizona health care cost containment system administration monies in addition to any state general fund monies appropriated for critical access hospitals in order to qualify for additional federal monies. Any amount of federal monies received by this state pursuant to this subsection shall be distributed as supplemental payments to critical access hospitals.

V. For the purposes of this section, "disproportionate share payment" means a payment to a hospital that serves a disproportionate share of low-income patients as described by 42 United States Code section 1396r-4.

**DEPARTMENT OF FINANCIAL INSTITUTIONS AND INSURANCE**

Title 20, Chapter 6

**Amend:** R20-6-307



# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - REGULAR RULEMAKING

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**MEETING DATE:** Mar 7, 2023

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** Feb 16, 2023

**SUBJECT:** DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS  
Title 20, Chapter 6

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### Summary:

This regular rulemaking from the Department of Insurance and Financial Institutions (Department) relates to one rule in Title 20, Chapter 6, rule 307, Life and Disability Reinsurance Agreements. In a prior Five Year Review Report (5YRR), approved by Council in October 2021, the Department indicated they intended to amend the rule to reflect the current name of the Department and update the definition of "Director" at a later date. In doing so, the Department seeks to amend this rule for clarity and to satisfy the prior 5YRR.

1. **Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?**

The Department cites both general and specific statutory authority for these rules.

2. **Do the rules establish a new fee or contain a fee increase?**

The Department indicates that this rulemaking does not establish a new fee or contain a fee increase.

3. **Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

The Department indicates it did not review or rely on any study in conducting this rulemaking.

4. **Summary of the agency's economic impact analysis:**

The Department does not anticipate any costs or benefits in implementing and enforcing the proposed rulemaking. No new full-time employees will be necessary to implement and enforce the proposed rulemaking.

5. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Department believes that the current rulemaking offers the least intrusive and least costly alternative method to notify the regulated community of the current name of the Department and where to find the correct definition of "Director."

6. **What are the economic impacts on stakeholders?**

This regulation applies to insurers and reinsurers seeking to enter into life and disability reinsurance agreements. The impact of the rulemaking on political subdivision of this state, public employment, private persons, and consumers is anticipated to be minimal or nonexistent. The Department anticipates minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to persons who enter into life and disability reinsurance agreements.

7. **Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

The Department indicates that the final rules are not a substantial change, considered as a whole, from the proposed rules and any supplemental proposals.

8. **Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**

The Department indicates that no comments were received during the open comment period or during the oral proceeding.

9. **Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

The Department indicates that the rule does not require a permit as it pertains to Life and Disability Reinsurance Agreements.

**10. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Department states that this section does not apply as there are no federal rules applicable to this rule

**11. Conclusion**

This regular rulemaking from the Department relates to one rule in Title 20, Chapter 6, rule 307, Life and Disability Reinsurance Agreements. The Department seeks to amend the rule to reflect the current name of the Department, to update the definition of “Director,” and to comply with the 5YRR approved by Council in October 2021. The Department is seeking the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032(A). Council staff recommends approval of this rulemaking.



**Director's Office**  
**Arizona Department of Insurance and Financial Institutions**  
100 North 15<sup>th</sup> Avenue, Suite 261, Phoenix, AZ 85007-2624  
Phone: (602) 364-3100 | Web: <https://difi.az.gov>

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**Douglas A. Ducey, Governor**  
**Evan G. Daniels, Director**

December 27, 2022

VIA EMAIL: [grrc@azdoa.gov](mailto:grrc@azdoa.gov)  
Nicole Sornsin, Chairperson  
Governor's Regulatory Review Council  
100 North 15<sup>th</sup> Ave., Suite 305  
Phoenix, AZ 85007

**RE:** Arizona Department of Insurance and Financial Institutions  
Insurance Division  
A.A.C. R20-6-307 – Life and Disability Reinsurance Agreements

Dear Chairperson Sornsin:

Please find enclosed the Final Rulemaking for A.A.C. R20-6-307, the Insurance Division rule governing Life and Disability Reinsurance Agreements, being submitted by the Arizona Department of Insurance and Financial Institutions ("Department").

Pursuant to A.A.C. R1-6-201(A)(1), the Department responds as follows:

- a. The Department closed the record on this rulemaking on December 26, 2022.
- b. This rulemaking does not relate to a Five-Year Review Report. Instead, it is a housekeeping exercise to update the new name of the Department and to point to the correct statutory reference for the definition of "Director."
- c. The rulemaking does not establish a new fee.
- d. The rulemaking does not contain a fee increase.
- e. The rulemaking does not request an immediate effective date under A.R.S. § 41-1032.
- f. The Department certifies that the preamble discloses a reference to any study relevant to the rule that it reviewed and either did or did not rely on in its evaluation of or justification for the rulemaking. The Department did not review or rely on any study relevant to the rulemaking.
- g. No new full-time employees are necessary to implement and enforce the rule.
- h. The following documents are also submitted to the Council with this cover letter:
  - i. The Notice of Final Rulemaking;
  - ii. An economic, small business, and consumer impact statement that contains the information required by A.R.S. § 41-1055;
  - iii. The general and specific statutes authorizing the rulemaking.

By this submission, the Department is requesting approval of this rulemaking from the Council.

For questions about this rulemaking, please contact Mary Kosinski at (602) 364-3476 or [mary.kosinski@difi.az.gov](mailto:mary.kosinski@difi.az.gov).

Sincerely,

A handwritten signature in blue ink that reads "Evan G. Daniels". The signature is written in a cursive style with a large, stylized "S" at the end.

Evan G. Daniels  
Director

NOTICE OF FINAL RULEMAKING  
TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE  
CHAPTER 6. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS  
– INSURANCE DIVISION

PREAMBLE

**1. Articles, Parts, or Sections Affected (as applicable)                      Rulemaking Action**

R20-6-307

Amend

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

Authorizing statute:            A.R.S. § 20-143

Implementing statute:        A.R.S. §§ 20-3602(A)(3) and 20-3604(A)

**3. The effective date of the rule:**

- a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):**

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

- b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):**

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

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

Notice of Rulemaking Docket Opening: 28 A.A.R. 3634, November 25, 2022  
Notice of Proposed Rulemaking: 28 A.A.R. 3613, November 25, 2022

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

Name: Mary E. Kosinski  
Address: Department of Insurance and Financial Institutions  
100 N. 15th Ave., Suite 261  
Phoenix, Arizona 85007-2630  
Telephone: (602)364-3476  
E-mail: mary.kosinski@difi.az.gov  
Web site: <https://difi.az.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:**

Arizona Administrative Code (“A.A.C.”) R20-6-307 is being amended to reflect the current name of the Arizona Department of Insurance and Financial Institutions (“Department”) and update the definition for the “Director” of the Department.

**7. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to 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:**

The Department did not review and does not propose to rely on any study relevant to this rulemaking.

**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:**

The rulemaking updates the definitions for “Department” and “Director” which is of statewide interest to insurers and reinsurers entering into life and disability reinsurance agreements. The rulemaking does not diminish a previous grant of authority granted to the Department.

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

Pursuant to A.R.S. § 41-1055(A)(1):

- The rulemaking is not designed to change any conduct. It merely updates the definitions for “Department” and “Director” to reflect the current name of the Department and point to the correct statutory definition for the Director.

Pursuant to A.R.S. § 41-1055(A)(2):

- The current changes to the rule and table do not impose any additional administrative or other costs required for compliance with the proposed rulemaking. Instead, they are housekeeping provisions required to be made in response to the recent structural changes to the Department.

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

The Department has not made any changes between the proposed rulemaking and the final rulemaking.

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

The Department published the Notice of Proposed Rulemaking for Life and Disability Reinsurance Agreements on November 25, 2022. (28 A.A.R. 3613, November 25, 2022). At that time it also opened a 30-day Comment Period. During the Comment Period, no one submitted a comment to the Department or requested an Oral Proceeding.

**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 prescribed by statute are applicable to the Department or to any specific rule or class of rules.

**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. The rule applies to Life and Disability Reinsurance Agreements.

**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:**

No federal law is applicable to the subject of the rule.

**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:**

No formal analysis has been submitted to the Department that compares the rule's impact of the competitiveness of business in this state to the impact of business in other states.

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

No materials are incorporated by reference.

**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. The rule was not previously made, amended or repealed as an emergency rule.

**15. The full text of the rule follows:**

**Title 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE**  
**CHAPTER 6. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS –**  
**INSURANCE DIVISION**  
**ARTICLE 3. FINANCIAL PROVISIONS AND PROCEDURES**

Section

R20-6-307. Life and Disability Reinsurance Agreements

**ARTICLE 3. FINANCIAL PROVISIONS AND PROCEDURES**

**R20-6-307. Life and Disability Reinsurance Agreements**

**A.** Scope. This rule applies to all domestic life and disability insurers and reinsurers, and to all other licensed life and disability insurers and accredited reinsurers that are not subject to a substantially similar rule in their jurisdictions of domicile. This rule applies to the disability business of licensed property and casualty insurers. This rule does not apply to assumption reinsurance, yearly renewable term reinsurance, or nonproportional stop loss or catastrophe reinsurance, or similar forms of nonproportional reinsurance.

**B.** Definitions

1. "Agreement" means a reinsurance agreement and any amendment to a reinsurance agreement.
2. "Credit Quality" means the risk that invested assets supporting the reinsured business will decrease in value but excludes decreases to changes in interest rate.
3. "Department" means the Arizona Department of Insurance- and Financial Institutions – Insurance Division.
4. "Director" ~~means the Director of the Arizona Department of Insurance.~~ has the same meaning as A.R.S. § 20-102.
5. "Disintermediation" means the risk that interest rates will rise and policy loans and surrenders will increase or maturing contracts will not renew at anticipated rates of renewal.
6. "Lapse" means the risk that a policy will voluntarily terminate before the recoupment of a statutory surplus strain experienced at issuance of the policy.
7. "Reinvestment" means the risk that interest rates will fall and funds reinvested will therefore earn less than expected.

**C.** Accounting Requirements

1. Unless authorized by the ~~director,~~ Director, an insurer shall not, for reinsurance ceded, reduce any liability, or establish any asset in any statutory financial statement filed with the Department if, by the terms of the agreement, or in effect, any of the following conditions exist:
  - a. Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period are not sufficient to cover the ceding insurer's allocable renewal expenses

- anticipated at the time the business is reinsured on the portion of the business reinsured, unless a liability is established for the present value of the shortfall using assumptions equal to the applicable statutory reserve basis on the business reinsured.
- b. The ceding insurer is required to reimburse the reinsurer for negative experience under the agreement. Neither the offset of the ceding insurer's experience refunds against current and prior years' losses, nor payment by the ceding insurer of an amount equal to the reinsurer's current and prior years' losses upon voluntary termination of in-force reinsurance by the ceding insurer, shall be considered a reimbursement to the reinsurer for negative experience.
  - c. The ceding insurer may be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of a specified event, including the insolvency of the ceding insurer. Termination of the agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due shall not be considered a deprivation of surplus or assets within the meaning of this subsection.
  - d. The ceding insurer is required, at scheduled times, to terminate the agreement or recapture automatically all or part of the reinsurance ceded.
  - e. The ceding insurer may be required to pay the reinsurer amounts other than from income reasonably expected from the reinsured policies.
  - f. Significant risks inherent in the business reinsured are not transferred to the reinsurer. Table A identifies the risks deemed significant for representative types of business.
  - g. The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not transfer the underlying assets to the reinsurer, segregate the underlying assets in a trust or escrow account, or otherwise segregate the underlying assets. The assets that support the reserves for classes of business that do not have a significant credit quality, reinvestment, or disintermediation risk, or for long-term care or long-term disability insurance, traditional non-par permanent, traditional par permanent, adjustable premium permanent, indeterminate premium permanent, or universal life fixed premium with no dump-in premiums allowed, may be held by the ceding company without segregation. To determine the reserves for classes of business, the supporting assets of which may be held without being segregated, the reserve interest rate adjustment formula shall reflect the ceding company's investment earnings and incorporate all realized and unrealized gains and losses reported in the ceding insurer's statutory financial statement.
  - h. Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within 90 days of the settlement date.
  - i. The ceding insurer is required to make representations or warranties unrelated to the business reinsured.
  - j. The ceding insurer is required to make representations or warranties related to future performance of the business reinsured.

2. An agreement entered into after the effective date of this rule to reinsure business issued before the effective date of the agreement shall be filed by the ceding insurer with the Director within 30 days after execution of the agreement. Each filing shall be accompanied by a description of the corresponding reduction in liabilities or other credit for reinsurance, and any other financial impact of the agreement, reported in the ceding insurer's statutory financial statements. When an increase in surplus net of federal income tax results from an agreement falling under this subsection, the ceding insurer shall separately identify the increase as a surplus item in the aggregate write-ins for gains and losses in surplus in the Capital and Surplus account of the ceding insurer's statutory financial statement. As earnings emerge from the business reinsured, the ceding insurer shall report in its statutory financial statement recognition of surplus increase as income on a net of tax basis as reinsurance ceded.

**D. Written Agreements**

1. A ceding insurer shall not reduce any liability or establish any asset in any statutory financial statement filed with the Department, unless the ceding insurer and the reinsurer have executed an agreement or a binding letter of intent by the "as of" date of the statutory financial statement.
2. A ceding insurer shall not be allowed a credit for the reinsurance ceded based on a letter of intent unless the ceding insurer and the reinsurer execute an agreement within 90 days from the execution date of the letter of intent.
3. The agreement shall provide that:
  - a. The agreement constitutes the entire contract between the parties with respect to the business reinsured, and there are no understandings between the parties other than as expressed in the agreement; and
  - b. Any change or modification to the agreement shall be void unless made by written amendment signed by all parties.

**A.R.S. § 41-1055(B) Economic, Small Business, And Consumer Impact Statement**

**Title 20. Commerce, Financial Institutions and Insurance**

**Chapter 6. Department of Insurance and Financial Institutions**

**– Insurance Division**

**Article 3. Financial Provisions and Procedures**

**A.R.S. § 41-1055(B)(1): An identification of the proposed rulemaking.**

Arizona Administrative Code (“A.A.C.”) R20-6-307 is being amended to reflect the current name of the Arizona Department of Insurance and Financial Institutions (“Department”) and update the definition for the “Director” of the Department. Questions about this Economic Impact Statement can be directed to: Mary E. Kosinski (mary.kosinski@difi.az.gov).

**A.R.S. § 41-1055(B)(2): An identification of the persons who will be directly affected by, bear the costs of or directly benefit from the proposed rulemaking.**

This regulation applies to insurers and reinsurers seeking to enter into life and disability reinsurance agreements.

**A.R.S. § 41-1055(B)(3): A cost benefit analysis of the following:**

**(a) The probable costs and benefits to the implementing agency and other agencies directly affected by the implementation and enforcement of the proposed rulemaking. The probable costs to the implementing agency shall include the number of new full-time employees necessary to implement and enforce the proposed rule. The preparer of the economic, small business and consumer impact statement shall notify the joint legislative budget committee of the number of new full-time employees necessary to implement and enforce the rule before the rule is approved by the council.**

The Department does not anticipate any costs or benefits in implementing and enforcing the proposed rulemaking. No new full-time employees will be necessary to implement and enforce the proposed rulemaking.

**(b) The probable costs and benefits to a political subdivision of this state directly affected by the implementation and enforcement of the proposed rulemaking.**

No political subdivision of this state is directly affected by the implementation and enforcement of the proposed rulemaking.

**(c) The probable costs and benefits to businesses directly affected by the proposed rulemaking, including any anticipated effect on the revenues or payroll expenditures of employers who are subject to the proposed rulemaking.**

The Department anticipates minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to persons who enter into life and disability reinsurance agreements.

**A.R.S. § 41-1055(B)(4): A general description of the probable impact on private and public employment in businesses, agencies and political subdivisions of this state directly affected by the proposed rulemaking.**

The Department does not anticipate any impact on the private employment of persons entering into life and disability reinsurance agreements. Likewise, the Department does not anticipate any impact on public employment in the Department.

**A.R.S. § 41-1055(B)(5): A statement of the probable impact of the proposed rulemaking on small businesses. The statement shall include:**

**(a) An identification of the small businesses subject to the proposed rulemaking.**

Only insurers and reinsurers are subject to the proposed rulemaking. They do not qualify as small businesses.

**(b) The administrative and other costs required for compliance with the proposed rulemaking.**

The current changes to the rule do not impose any additional administrative or other costs required for compliance with the proposed rulemaking.

**(c) A description of the methods prescribed in section 41-1035 that the agency may use to reduce the impact on small businesses, with reasons for the agency's decision to use or not to use each method.**

Not applicable. The rule does not apply to small businesses.

**(d) The probable cost and benefit to private persons and consumers who are directly affected by the proposed rulemaking.**

Private persons and consumers are not directly affected by the proposed rulemaking.

**A.R.S. § 41-1055(B)(6): A statement of the probable effect on state revenues.**

No impact on state revenues is anticipated.

**A.R.S. § 41-1055(B)(7): A description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed rulemaking, including the monetizing of the costs and benefits for each option and providing the rationale for not using nonselected alternatives.**

The Department believes that the current rulemaking offers the least intrusive and least costly alternative method to notify the regulated community of the current name of the Department and where to find the correct definition of "Director."

**A.R.S. § 41-1055(B)(8): A description of any data on which a rule is based with a detailed explanation of how the data was obtained and why the data is acceptable data. An agency advocating that any data is acceptable data has the burden of proving that the data is acceptable. For the purposes of this paragraph, "acceptable**

**data" means empirical, replicable and testable data as evidenced in supporting documentation, statistics, reports, studies or research.**

The rule is not based on any data.

## TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

## CHAPTER 6. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS - INSURANCE DIVISION

annual statements filed for periods on or after that date (Supp. 78-5). R20-6-305 recodified from R4-14-305 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1).

**R20-6-306. Reserved****R20-6-307. Life and Disability Reinsurance Agreements**

**A.** Scope. This rule applies to all domestic life and disability insurers and reinsurers, and to all other licensed life and disability insurers and accredited reinsurers that are not subject to a substantially similar rule in their jurisdictions of domicile. This rule applies to the disability business of licensed property and casualty insurers. This rule does not apply to assumption reinsurance, yearly renewable term reinsurance, or nonproportional stop loss or catastrophe reinsurance, or similar forms of nonproportional reinsurance.

**B.** Definitions

1. "Agreement" means a reinsurance agreement and any amendment to a reinsurance agreement.
2. "Credit Quality" means the risk that invested assets supporting the reinsured business will decrease in value but excludes decreases to changes in interest rate.
3. "Department" means the Arizona Department of Insurance.
4. "Director" means the Director of the Arizona Department of Insurance.
5. "Disintermediation" means the risk that interest rates will rise and policy loans and surrenders will increase or maturing contracts will not renew at anticipated rates of renewal.
6. "Lapse" means the risk that a policy will voluntarily terminate before the recoupment of a statutory surplus strain experienced at issuance of the policy.
7. "Reinvestment" means the risk that interest rates will fall and funds reinvested will therefore earn less than expected.

**C.** Accounting Requirements

1. Unless authorized by the director, an insurer shall not, for reinsurance ceded, reduce any liability, or establish any asset in any statutory financial statement filed with the Department if, by the terms of the agreement, or in effect, any of the following conditions exist:
  - a. Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period are not sufficient to cover the ceding insurer's allocable renewal expenses anticipated at the time the business is reinsured on the portion of the business reinsured, unless a liability is established for the present value of the shortfall using assumptions equal to the applicable statutory reserve basis on the business reinsured.
  - b. The ceding insurer is required to reimburse the reinsurer for negative experience under the agreement. Neither the offset of the ceding insurer's experience refunds against current and prior years' losses, nor payment by the ceding insurer of an amount equal to the reinsurer's current and prior years' losses upon voluntary termination of in-force reinsurance by the ceding insurer, shall be considered a reimbursement to the reinsurer for negative experience.
  - c. The ceding insurer may be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of a specified event, including the

insolvency of the ceding insurer. Termination of the agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due shall not be considered a deprivation of surplus or assets within the meaning of this subsection.

- d. The ceding insurer is required, at scheduled times, to terminate the agreement or recapture automatically all or part of the reinsurance ceded.
  - e. The ceding insurer may be required to pay the reinsurer amounts other than from income reasonably expected from the reinsured policies.
  - f. Significant risks inherent in the business reinsured are not transferred to the reinsurer. Table A identifies the risks deemed significant for representative types of business.
  - g. The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not transfer the underlying assets to the reinsurer, segregate the underlying assets in a trust or escrow account, or otherwise segregate the underlying assets. The assets that support the reserves for classes of business that do not have a significant credit quality, reinvestment, or disintermediation risk, or for long-term care or long-term disability insurance, traditional non-par permanent, traditional par permanent, adjustable premium permanent, indeterminate premium permanent, or universal life fixed premium with no dump-in premiums allowed, may be held by the ceding company without segregation. To determine the reserves for classes of business, the supporting assets of which may be held without being segregated, the reserve interest rate adjustment formula shall reflect the ceding company's investment earnings and incorporate all realized and unrealized gains and losses reported in the ceding insurer's statutory financial statement.
  - h. Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within 90 days of the settlement date.
  - i. The ceding insurer is required to make representations or warranties unrelated to the business reinsured.
  - j. The ceding insurer is required to make representations or warranties related to future performance of the business reinsured.
2. An agreement entered into after the effective date of this rule to reinsure business issued before the effective date of the agreement shall be filed by the ceding insurer with the Director within 30 days after execution of the agreement. Each filing shall be accompanied by a description of the corresponding reduction in liabilities or other credit for reinsurance, and any other financial impact of the agreement, reported in the ceding insurer's statutory financial statements. When an increase in surplus net of federal income tax results from an agreement falling under this subsection, the ceding insurer shall separately identify the increase as a surplus item in the aggregate write-ins for gains and losses in surplus in the Capital and Surplus account of the ceding insurer's statutory financial statement. As earnings emerge from the business reinsured, the ceding insurer shall report in its statutory financial statement recognition of surplus increase as income on a net of tax basis as reinsurance ceded.



Authorizing Statute: A.R.S. § 20-143

20-143. Rule-making power

A. The director may make reasonable rules necessary for effectuating any provision of this title.

B. The director shall make rules concerning proxies, consents or authorizations in respect of securities issued by domestic stock insurance companies having a class of equity securities held of record by one hundred or more persons to conform with the requirements of section 12(g)(2)(G)(ii) of the securities exchange act of 1934, as amended, and as may be amended. Such rule shall not apply to any such company having a class of equity securities which are registered or are required to be registered pursuant to section 12 of the securities exchange act of 1934, as amended, or as may be amended. Whenever such equity securities of any such company are registered or are required to be registered pursuant to section 12 of the securities exchange act of 1934, as amended, or as may be amended, then, no person shall solicit or permit the use of his name to solicit, in any manner whatsoever, any proxy, consent or authorization in respect of any equity security of such company without having first complied with the rules prescribed by the securities and exchange commission pursuant to section 14 of the securities exchange act of 1934, as amended, or as may be amended.

C. All rules made pursuant to this section shall be subject to title 41, chapter 6.

D. In addition to any other penalty provided, wilful violation of any rule made by the director is a violation of this title.

Implementing Statutes: A.R.S. §§ 20-3602(A) and 20-3604

20-3602. Credit allowed a domestic ceding insurer; definition

A. A domestic ceding insurer shall be allowed a credit for reinsurance as either an asset or a reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of subsection C, D, E, F, G, H or M of this section. The director may adopt rules pursuant to section 20-3604 that specify additional requirements relating to or setting forth any of the following:

1. The valuation of assets or reserve credits.
2. The amount and forms of security supporting reinsurance arrangements described in section 20-3603, subsection B.
3. The circumstances pursuant to which credit will be reduced or eliminated.

B. Credit shall be allowed under subsection C, D or E of this section only for cessions of those kinds or classes of business that the assuming insurer is licensed or otherwise allowed to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance.

Credit shall be allowed under subsection E or F of this section only if the applicable requirements of subsection N have been satisfied.

C. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.

D. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited by the director as a reinsurer in this state. To be eligible for accreditation, a reinsurer shall do all of the following:

1. File with the director evidence of its submission to this state's jurisdiction.
2. Submit to this state's authority to examine its books and records.
3. Be licensed to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an alien assuming insurer, be entered through and licensed to transact insurance or reinsurance in at least one state.
4. File annually with the director a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement.
5. Demonstrate to the satisfaction of the director that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer is deemed to meet this requirement as of the time of its application if it maintains a surplus as regards policyholders of at least \$20,000,000 and its accreditation has not been denied by the director within ninety days after submission of its application.

E. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is domiciled in or, in the case of a United States branch of an alien assuming insurer, is entered through a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this article and the assuming insurer or United States branch of an alien assuming insurer does both of the following:

1. Maintains a surplus as regards policyholders of at least \$20,000,000. This requirement does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.
2. Submits to the authority of this state to examine its books and records.

F. The following apply when credit is allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund for the payment of claims:

1. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution as defined in section 20-3601, subsection B for the payment of the valid claims of its United States ceding insurers, their assigns and successors in interest. To enable the director to determine the sufficiency of the trust

fund, the assuming insurer shall report annually to the director information that is substantially the same as the information licensed insurers are required to report on the national association of insurance commissioners annual statement form. The assuming insurer shall submit to examination of its books and records by the director and bear the expense of examination.

2. Credit for reinsurance may not be granted under this subsection unless the form of the trust and any amendments to the trust have been approved by either:

(a) The insurance commissioner of the state where the trust is domiciled.

(b) The insurance commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

3. The form of the trust and any trust amendments also shall be filed with the insurance commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that contested claims shall be valid and enforceable on the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers, their assigns and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the director.

4. The trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. Not later than February 28 of each year, the trustee of the trust shall report to the director in writing the balance of the trust and listing the trust's investments at the preceding year end and shall certify the date of termination of the trust, if so planned, or certify that the trust will not expire before the following December 31.

5. The following requirements apply to the following categories of assuming insurer:

(a) The trust fund for a single assuming insurer shall consist of monies in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers, and, in addition, the assuming insurer shall maintain a trusteed surplus of at least \$20,000,000, except as provided in subdivision (b) of this paragraph.

(b) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the insurance commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an

amount that is less than thirty percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

(c) In the case of a group, including incorporated and individual unincorporated underwriters, all of the following apply:

(i) For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after January 1, 1993, the trust shall consist of a trusteed account in an amount that is not less than the respective underwriters' several liabilities attributable to business ceded by United States domiciled ceding insurers to any underwriter of the group.

(ii) For reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding any other provision of this article, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States.

(iii) In addition to the trusts described in items (i) and (ii) of this subdivision, the group shall maintain in trust a trusteed surplus of which \$100,000,000 shall be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.

(iv) The incorporated members of the group may not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

(v) Within ninety days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the director an annual certification by the group's domiciliary regulator of the solvency of each underwriter member, or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group.

(d) In the case of a group of incorporated underwriters under common administration, the group shall meet the following requirements:

(i) Have continuously transacted an insurance business outside the United States for at least three years immediately before making application for accreditation.

(ii) Maintain aggregate policyholders' surplus of at least \$10,000,000,000.

(iii) Maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group.

(iv) Maintain a joint trusteed surplus of which \$100,000,000 shall be held jointly for the benefit of United States domiciled ceding insurers of any member of the group as additional security for these liabilities.

(v) Within ninety days after its financial statements are due to be filed with the group's domiciliary regulator, make available to the director an annual certification of each underwriter member's solvency by the member's domiciliary regulator and financial statements of each underwriter member of the group prepared by its independent public accountant.

G. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that has been certified by the director as a reinsurer in this state and that secures its obligations in accordance with the requirements of this subsection, and all of the following apply:

1. To be eligible for certification, the assuming insurer shall meet the following requirements:

(a) The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the director pursuant to paragraph 3 of this subsection.

(b) The assuming insurer must maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the director pursuant to rule.

(c) The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the director pursuant to rule.

(d) The assuming insurer must agree to submit to the jurisdiction of this state, must appoint the director as its agent for service of process in this state and must agree to provide security for one hundred percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment.

(e) The assuming insurer must agree to meet applicable information filing requirements as determined by the director, both with respect to an initial application for certification and on an ongoing basis.

(f) The assuming insurer must satisfy any other requirements for certification deemed relevant by the director.

2. An association that includes incorporated and individual unincorporated underwriters may be a certified reinsurer. To be eligible for certification, in addition to satisfying the requirements prescribed in paragraph 1 of this subsection:

(a) The association shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents, net of liabilities, of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members, in an amount determined by the director to provide adequate protection.

(b) The incorporated members of the association may not be engaged in any business other than underwriting as a member of the association and shall be subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members.

(c) Within ninety days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the director an annual certification by the association's domiciliary regulator of the solvency of each underwriter member or, if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

3. The director shall create and publish a list of qualified jurisdictions under which an assuming insurer that is licensed and domiciled in a qualified jurisdiction is eligible to be considered for certification by the director as a certified reinsurer, and all of the following apply:

(a) To determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the director shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, the benefits and the extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States. A qualified jurisdiction must agree to share information and cooperate with the director with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction may not be recognized as a qualified jurisdiction if the director has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. The director may consider additional factors.

(b) A list of qualified jurisdictions shall be published through the national association of insurance commissioners committee process. The director shall consider this list in determining qualified jurisdictions. If the director approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the director shall provide thoroughly documented justification in accordance with criteria to be developed under rule.

(c) United States jurisdictions that meet the requirement for accreditation under the national association of insurance commissioners financial standards and accreditation program shall be recognized as qualified jurisdictions.

(d) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the director may suspend the reinsurer's certification indefinitely, in lieu of revocation.

4. The director shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable to the director pursuant to rule. The director shall publish a list of all certified reinsurers and their ratings.

5. A certified reinsurer shall secure obligations assumed from United States ceding insurers under this subsection at a level that is consistent with its rating, as specified in rules adopted by the director, and all of the following apply:

(a) For a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form that is acceptable to the director and that is consistent with section 20-3603, or in a multibeneficiary

trust in accordance with subsection F of this section, except as otherwise provided in this subsection.

(b) If a certified reinsurer maintains a trust to fully secure its obligations subject to subsection F of this section and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as allowed by this subsection or comparable laws of other United States jurisdictions and for its obligations subject to subsection F of this section. It shall be a condition to the grant of certification under this subsection that the certified reinsurer shall have bound itself, by the language of the trust and agreement with the insurance commissioner with principal regulatory oversight of each such trust account, to fund, on termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account.

(c) The minimum trustee surplus requirements provided in subsection F of this section are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this subsection, except that such a trust shall maintain a minimum trustee surplus of \$10,000,000.

(d) With respect to obligations incurred by a certified reinsurer under this subsection, if the security is insufficient, the director shall reduce the allowable credit by an amount proportionate to the deficiency, and may impose further reductions in allowable credit on finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(e) A certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure one hundred percent of its obligations. If the director continues to assign a higher rating as allowed by other provisions of this section, this requirement does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended. For the purposes of this subdivision, "terminated" refers to revocation, suspension, voluntary surrender and inactive status.

6. If an applicant for certification has been certified as a reinsurer in a national association of insurance commissioners accredited jurisdiction, the director may defer to that jurisdiction's certification and to the rating assigned by that jurisdiction, and the assuming insurer shall be considered to be a certified reinsurer in this state.

7. To continue to qualify for a reduction in security for its in-force business, a certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status. An inactive certified reinsurer shall continue to comply with all applicable requirements of this subsection, and the director shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

H. Credit shall be allowed when the reinsurance is ceded to an assuming insurer meeting each of the following conditions:

1. The assuming insurer must have its head office or be domiciled in, as applicable, and be licensed in a reciprocal jurisdiction. A reciprocal jurisdiction is a jurisdiction that meets one of the following:

(a) A non-United States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and the European Union, that is a member state of the European Union.

(b) A United States jurisdiction that meets the requirements for accreditation under the national association of insurance commissioners financial standards and accreditation program.

(c) A qualified jurisdiction, as determined by the director pursuant to subsection G, paragraph 3 of this section that is not otherwise described in subdivision (a) or (b) of this paragraph and that meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by the director in rule.

2. The assuming insurer must have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, in an amount to be prescribed in rule. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, minimum capital and surplus equivalents, net of liabilities, calculated according to the methodology applicable in its domiciliary jurisdiction and a central fund containing a balance in amounts to be prescribed in rule.

3. The assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ratio, as applicable, that is prescribed in rule. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its head office or is domiciled, as applicable, and is also licensed.

4. The assuming insurer must agree and provide adequate assurance to the director, in a form specified by the director pursuant to rule, as follows:

(a) The assuming insurer must provide a prompt written notice and explanation to the director if it falls below the minimum requirements prescribed in paragraph 2 or 3 of this subsection or if any regulatory action is taken against it for serious noncompliance with applicable law.

(b) The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the director as agent for service of process. The director may require that consent for service of process be provided to the director and included in each reinsurance agreement. This subdivision does not limit, or in any way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws.

(c) The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained.

(d) Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate.

(e) The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement that involves this state's ceding insurers, and agree to notify the ceding insurer and the director and to provide security in an amount equal to one hundred percent of the assuming insurer's liabilities to the ceding insurer, should the assuming insurer enter into such a solvent scheme of arrangement. The security shall be in a form that is consistent with the requirements prescribed in subsection G of this section and section 20-3603 and as specified by the director in rule.

5. If requested by the director, the assuming insurer or its legal successor must provide on behalf of itself and any legal predecessors certain documentation to the director as specified by the director in rule.

6. The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to criteria prescribed in rule.

7. The assuming insurer's supervisory authority must confirm to the director on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements prescribed in paragraphs 2 and 3 of this subsection.

8. The assuming insurer may provide the director with additional information on a voluntary basis.

I. The director:

1. Shall timely create and publish a list of reciprocal jurisdictions that includes any reciprocal jurisdiction prescribed in subsection H, paragraph 1, subdivisions (a) and (b) of this section and shall consider including any other reciprocal jurisdiction included on the national association of insurance commissioners list of reciprocal jurisdictions published through the national association of insurance commissioners committee process. The director may approve a jurisdiction that does not appear on the national association of insurance commissioners list of reciprocal jurisdictions in accordance with criteria to be developed under rules issued by the director.

2. May remove a jurisdiction from the list of reciprocal jurisdictions on a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, in accordance with a process prescribed in rules issued by the director, except that the director shall not remove from the list a reciprocal jurisdiction prescribed in subsection H, paragraph 1, subdivisions (a) and (b) of this section. On removal of a reciprocal jurisdiction from the list, credit for reinsurance ceded to an assuming insurer that has its home office or is domiciled in that jurisdiction shall be allowed, if otherwise allowed by law.

3. Shall timely create and publish a list of assuming insurers that have satisfied the conditions prescribed in this section and to which cessions shall be granted credit in accordance with this section. The director may add an assuming insurer to the list if a national association of insurance commissioners accredited jurisdiction has added the assuming insurer to a list of such assuming insurers or if, on initial eligibility, the assuming insurer submits the information to the director as required under subsection H, paragraph 4 of this section and complies with any additional requirements that the director may impose by rule, except to the extent that they conflict with an applicable covered agreement.

4. May revoke or suspend the eligibility of an assuming insurer for recognition under this subsection in accordance with procedures prescribed in rule, if the director determines that the assuming insurer no longer meets one or more of the requirements under this section. While the assuming insurer's eligibility is suspended, a reinsurance agreement issued, amended or renewed after the effective date of the suspension does not qualify for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with section 20-3603. If the assuming insurer's eligibility is revoked, credit for reinsurance may not be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into before the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the director and are consistent with the parameters prescribed in section 20-3603.

J. If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

K. Subsection H of this section does not:

1. Limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this article or another applicable law or rule.

2. Authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as allowed by the terms of the agreement.

3. Limit or in any way alter the capacity of parties to any reinsurance agreement to renegotiate the agreement.

L. Credit may be taken under subsection H of this section only for reinsurance agreements entered into, amended or renewed on or after September 29, 2021, and only with respect to losses incurred and reserves reported on or after the later of the date on which the assuming insurer has met all eligibility requirements pursuant to subsection H of this section and the effective date of the new reinsurance agreement, amendment or renewal. This subsection does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this section, as long as the reinsurance qualifies for credit under any other applicable provision of this article.

M. Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of subsection C, D, E, F, G or H of this section, but only as to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

N. If the assuming insurer is not licensed, accredited or certified to transact insurance or reinsurance in this state, the credit allowed by subsections E and F of this section may not be allowed unless the assuming insurer agrees in the reinsurance agreements:

1. That if the assuming insurer fails to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, will submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction and will abide by the final decision of the court or of any appellate court in the event of an appeal. This subsection is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement.

2. To designate the director or a designated attorney as its true and lawful attorney on whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding insurer.

O. If the assuming insurer does not meet the requirements prescribed in subsection C, D, E or H of this section, the credit allowed by subsection F or G of this section may not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

1. Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount that is less than the amount required by subsection F, paragraph 5 of this section, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the insurance commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the insurance commissioner with regulatory oversight all of the assets of the trust fund.

2. The assets shall be distributed by and claims shall be filed with and valued by the insurance commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

3. If the insurance commissioner with regulatory oversight determines that the assets of the trust fund or any part of the assets are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part of the assets shall be returned by the insurance commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement.

4. The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this subsection.

P. If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the director may suspend or revoke the reinsurer's accreditation or certification, and the following apply:

1. The director must give the reinsurer notice and an opportunity for a hearing. The suspension or revocation may not take effect until after the director's order on the hearing, unless either:

(a) The reinsurer waives its right to a hearing.

(b) The director's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under subsection G, paragraph 6 of this section.

(c) The director finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the director's action.

2. While a reinsurer's accreditation or certification is suspended, a reinsurance contract issued or renewed after the effective date of the suspension does not qualify for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with section 20-3603. If a reinsurer's accreditation or certification is revoked, a credit for reinsurance may not be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with subsection G, paragraph 5 of this section or section 20-3603.

Q. A ceding insurer shall take steps to:

1. Manage its reinsurance recoverables proportionate to its own book of business. A domestic ceding insurer shall notify the director within thirty days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, exceed fifty percent of the domestic ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, are likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

2. A ceding insurer shall take steps to diversify its reinsurance program. A domestic ceding insurer shall notify the director within thirty days after ceding to any single assuming insurer, or

group of affiliated assuming insurers, more than twenty percent of the ceding insurer's gross written premium in the prior calendar year, or after it has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

R. For the purposes of this section, "covered agreement" means an agreement that is entered into pursuant to the Dodd-Frank Wall Street reform and consumer protection act (31 United States Code sections 313 and 314), that is currently in effect or in a period of provisional application and that addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance.

#### 20-3604. Rules

A. The director may adopt rules pursuant to title 41, chapter 6 to carry out this article.

B. The rules may include regulation of reinsurance arrangements relating to any of the following:

1. Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits.
2. Universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period.
3. Variable annuities with guaranteed death or living benefits.
4. Long-term care insurance policies.
5. Any other life and health insurance and annuity products for which the national association of insurance commissioners adopts model regulatory requirements with respect to credit for reinsurance.

C. Any rule adopted pursuant to subsection B, paragraph 1 or 2 of this section may apply to any treaty that contains either or both:

1. Policies issued on or after January 1, 2015.
2. Policies issued before January 1, 2015, if risk pertaining to such pre-2015 policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015.

D. Any rule adopted pursuant to subsection B of this section:

1. May require the ceding insurer, in calculating the amounts or forms of security required to be held pursuant to rules adopted by the department, to use the valuation manual adopted by the national association of insurance commissioners under section 11B(1) of the national association

of insurance commissioners standard valuation law, including all amendments adopted by the national association of insurance commissioners and in effect on the date as of which the calculation is made, to the extent applicable.

2. Does not apply to cessions to an assuming insurer that is licensed in at least twenty-six states or that is licensed in at least ten states and licensed or accredited in a total of at least thirty-five states and that either:

(a) Meets the conditions prescribed in section 20-3602, subsection H in this state.

(b) Is certified in this state.

(c) Maintains at least \$250,000,000 in capital and surplus as determined in accordance with the accounting practices and procedures manual and amendments adopted by the national association of insurance commissioners, excluding the impact of any allowed or prescribed practices.

E. The authority to adopt rules pursuant to subsection B of this section does not limit the department's general authority to adopt rules pursuant to subsection A of this section.

**DEPARTMENT OF ENVIRONMENTAL QUALITY**  
Title 18, Chapter 8

**Amend:** R18-8-260, R18-8-270



# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - REGULAR RULEMAKING

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**MEETING DATE:** Mar 7, 2023

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** Feb 16, 2023

**SUBJECT:** ARIZONA DEPARTMENT OF ENVIRONMENTAL QUALITY  
Title 18, Chapter 8

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### **Summary:**

This regular rulemaking from the Arizona Department of Environmental Quality (Department) seeks to amend two (2) rules in Title 18, Chapter 8 related to Hazardous Waste Management. Specifically, the Department seeks to increase two hazardous waste fees as authorized by A.R.S. §§ 49-922(B)(5) and 49-931(A). The fee increases are for two types of hazardous waste entities: (1) hazardous waste generators and (2) permitted facilities that treat, store, or dispose of hazardous waste. This increase addresses the future direct and indirect costs of the Department's relevant hazardous waste duties, including employee salaries and benefits, professional and outside services, equipment, in-state travel, and other necessary operational expenses directly related to issuing hazardous waste permits and enforcing the requirements of the regulatory program. The Hazardous Waste Program does not receive General Fund monies and the goal is to ensure sufficient program funding to maintain primacy; otherwise, United States Environmental Protection Agency Region 9 (EPA) would enforce the hazardous waste laws in Arizona. The program has, however, been operating at a deficit since 2021, meaning that the program has used cash balance to fund expenses that exceeded revenues but were within appropriation.

1. **Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?**

The Department cites both general and specific statutory authority for these rules.

2. **Do the rules establish a new fee or contain a fee increase?**

The Department indicates that this rulemaking does not establish a new fee but does contain a fee increase.

3. **Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

The Department indicates it did not review or rely on any study in conducting this rulemaking.

4. **Summary of the agency's economic impact analysis:**

The rule increases certain hazardous waste fees as authorized by A.R.S. §§ 49-922(B)(5) and 49-931(A). The Department indicates that the rule increases two hazardous waste fees beginning April 1, 2023 to address the future direct and indirect cost of the Arizona Department of Environmental Quality's relevant hazardous waste duties, including employee salaries and benefits, professional and outside services, equipment, in-state travel, and other necessary operational expenses directly related to issuing hazardous waste permits and enforcing the requirements of the regulatory program. The Department's Hazardous Waste Program does not receive General Fund monies and the goal is to ensure sufficient program funding to maintain primacy, otherwise, United States Environmental Protection Agency Region 9 (EPA), located in San Francisco, California, would enforce the hazardous waste laws in Arizona.

The Department indicates that the rules are not designed to change the conduct of any regulated hazardous waste entities. The rules are designed to collect fees from some hazardous waste entities. The per ton and maximum fees for generation and/or disposal of hazardous waste are increased in R18-8-260. The hourly rate is increased for processing hazardous waste permits in R18-8-270.

The Department's Hazardous Waste Program regulates a universe of over 1,500 facilities including metal platers, chemical manufacturers, laboratories, explosive and munitions manufacturers, pesticide manufacturers, hazardous waste treatment storage and disposal (TSD) facilities, and military installations. The Department states that the following entities handle hazardous waste: 14 hazardous waste TSD facilities, 141 large quantity generators, and 1,276 small quantity generators. There are also approximately 99 hazardous waste transporters that either pick up or deliver in Arizona.

5. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Department indicates that the two principal requirements are: (1) the fees should "be fairly assessed and impose the least burden and cost to the parties subject to the fees"; and (2) the permit fees are to be based on "the direct and indirect costs of the department's relevant duties...related to issuing licenses...and enforcing the

requirements of the applicable regulatory program.” Further, the Department interprets “fairly assessed” to mean that the amount of fees collected from any class of hazardous waste entities should not be disproportionate to the “direct and indirect costs” that can be attributed to the class.

**6. What are the economic impacts on stakeholders?**

The Department states that A.R.S. § 49-922 requires that the Department establish and implement a hazardous waste management program “equivalent to and consistent with” the federal hazardous waste program. EPA likewise requires states to adopt a program at least as stringent as the federal program in order to be authorized to implement the federal program in lieu of EPA. As a result of being authorized, the Department receives Resource and Conservation and Recovery Act (RCRA) grant funding from EPA to partially offset the cost of running the program. Through the grant and delegation process, EPA maintains close scrutiny of the Arizona program and requires it to achieve certain benchmarks.

The Department states that based on stakeholder comments, most in the regulated community agree that the Department should implement the federal program rather than EPA, and that the Department should continue to meet the criteria and benchmarks for program authorization in order to implement the program and receive the RCRA grant.

The Department indicates they considered the impact of the fees on the parties subject to the fees as shown by its collection of the least amount necessary to sustain an approvable program, and a fair, proportional assessment of those fees. The Department states that the probable costs for this rule are the \$800,000 in estimated increased fees necessary for the maintenance of the program. They state these costs will be incurred primarily by private and government entities that generate hazardous waste and to a lesser degree by hazardous waste TSD facilities that need a permit or permit action such as a modification.

The Department believes that if the program reverted to the EPA, Arizona businesses could suffer from the inability to engage with the regulators in a timely manor at a convenient location since they would have to engage with EPA Region 9 staff in San Francisco. Further, the Department developed the Compliance and Enforcement Handbook, which is available to the public, with the purpose of promoting appropriate, consistent, and timely enforcement of Arizona’s environmental statutes and rules in a manner that is transparent to all who are affected, including the regulated community. The Department indicates that EPA does not have a similar guidance document that is tailored to the needs of Arizona businesses.

**7. Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

The Department indicates between the Notice of Proposed Rulemaking and the Notice of Final Rulemaking, that the words “and after” were added to the phrase “From and after April 1,

2023 until April 1, 2024,” in R18-8-270(G)(6)(a). No other changes were made. Council staff does not believe this change constitutes a substantially different rule pursuant to A.R.S. § 41-1025.

**8. Does the agency the Department adequately address the comments on the proposed rules and any supplemental proposals?**

The Department requested informal comment on funding for the Hazardous Waste Program and hosted a public meeting on October 12, 2022. The meeting was held virtually and attended by about 50 people in addition to Department staff. The Department presented its plan for equal increases of 29% (cumulative CPI increase from the last time the fees were set in July 2012) to the per ton generation fees, the accompanying maximum fees, and the hourly rate to process permits. A comment was made that the majority of per ton fees being paid into the program comes from Large Quantity Generators (LQGs) whereas a large share of the Department resources goes to costs related to Small Quantity Generators (SQGs), and that SQGs should possibly pay a higher per ton rate than LQGs. The Department believes that SQGs should not pay a higher per ton rate for the following reasons: 1) there should be an incentive to reduce hazardous waste generation, and to go from LQG status to SQG status, not a disincentive; 2) SQGs are more likely to be small businesses and the Department is required to reduce the impact of its rules on small businesses, and higher fees for SQGs would be the opposite.

Participants also commented on the timing of these automatic increases and whether different fees were considered for generators in a county that was itself charging generators similar fees (Pima County). Pima County charges generators registration fees, not per ton generation fees. The Department believes that this is not a duplicate fee. However, the Department will evaluate the fact that it and Pima County are both charging fees to generators, and if necessary, will address it in a future rule-making.

In addition, the department received the following written comments:

Comment 1: There needs to be a limit to the number of hours billed for permitting review to avoid giving the Department a blank check and to minimize uncertainty. A table by permit type would be helpful.

Response: Such a table with maximum amounts for permits already exists in the rule at R18-8-270(G). The Department refers to the unchanged maximum fees in the preamble to the proposed rule at page 3470, under “Fees not increased”. No change to the rule.

Comment 2: Fees for hazardous waste transporters and treatment, storage and disposal (TSD) facilities are not included in the rulemaking although the Department discusses that the generation fees are needed to oversee these activities.

Response: The Department has no authority from the legislature to charge fees to hazardous waste transporters and fees for TSD facilities can be charged only when a permit is issued or modified. However, the Department has to base the fees it is allowed on “the direct and indirect costs” of “enforcing the requirements of the applicable regulatory program.” [A.R.S. §

49-104(B)(17)(a)] The generation fees are charged just once for the generation of the waste, but have to cover routine inspection and outreach activities related to the transportation and treatment, storage and disposal of that waste. No change to the rule.

Comment 3: Small businesses and small quantity generators have to pay a higher cost per ton than large quantity generators to private entities for their hazardous waste transport and disposal. This is an incentive for small businesses to accumulate hazardous waste without the safeguards that might be present at a larger business.

Response: The Department is aware of the challenges that small businesses face accumulating and storing waste so that transport and ultimate disposal is more economical. The federal regulation 40 CFR 262.16(b), recognizes these economies of scale by allowing small quantity generators to accumulate waste on site for 180 days, compared to 90 days for large quantity generators. In general, the Department stands by its statement that small businesses experience a reduced impact from per ton fees because they produce less hazardous waste. No change to the rule.

The Department also received a letter from the owner of a local cabinet manufacturing company requesting that the per ton fee increases be postponed for one year.

Response: The Department recognizes that many in the manufacturing sector are experiencing hardships related to current economic conditions. The Department is required by law to recover its costs related to the hazardous waste program and therefore is not able to postpone this increase for another year. No change to the rule.

**9. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

The Department states that this rulemaking amends an existing rule that requires a regulatory permit. This rulemaking does not require a general permit because:

- 1) A specific alternative permit is authorized by state statute under A.R.S. § 49-922(B)(5) and;
- 2) General permits as defined by A.R.S. § 41-1001 are not recognized under federal hazardous waste regulations.

The Department has however, adopted a federal general permit rule that is similar to Arizona general permits. 40 CFR 270.60, "Permits by Rule", applies to three types of facilities: 1) ocean disposal barges or vessels, 2) hazardous waste injection wells, and 3) publicly owned treatment works. Only the third category exists in Arizona and the federal general permit rule for publicly owned treatment works is incorporated in R18-2-270(A).

**10. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Department indicates that this rule is not applicable as there are no federal laws related to hazardous waste fees.

**11. Conclusion**

This regular rulemaking from the Arizona Department of Environmental Quality (Department) seeks to amend two (2) rules in Title 18, Chapter 8 related to Hazardous Waste Management. Specifically, the Department seeks to increase two hazardous waste fees as authorized by A.R.S. §§ 49-922(B)(5) and 49-931(A). These increases are for two types of hazardous waste entities: (1) hazardous waste generators and (2) permitted facilities that treat, store, or dispose of hazardous waste and are needed to address the future direct and indirect costs of the Department's relevant hazardous waste duties. The Department is requesting an immediate effective date under A.R.S. § 41-1032(A)(1) to preserve public health and safety.

The Department's billing system is online and a quarterly bill is scheduled for posting on April 1, 2023. Some re-programming time is required. If that bill does not contain the increased fees for large quantity generators, smooth continuation of some services, such as outreach, technical assistance, timely complaint response, and inspections of hazardous waste generators, transporters and treatment, storage and disposal facilities would be compromised. Council staff recommends approval of this rulemaking.



Katie Hobbs  
Governor

# ARIZONA DEPARTMENT OF ENVIRONMENTAL QUALITY



January 9, 2023

Nicole Sornsins, Chair  
Governor's Regulatory Review Council  
100 N. 15th Avenue Suite 302  
Phoenix, Arizona 85007

Re: 18 A.A.C. 8, Article 2, Hazardous Wastes

Dear Ms. Sornsins:

Enclosed is the final Arizona Department of Environmental Quality (ADEQ) rule package and I respectfully request that you place it on the Governor's Regulatory Review Council agenda for approval. Pursuant to A.A.C. R1-6-201, I provide the following information:

- The close of record date was December 20, 2022
- This rule does not relate to a five-year review report
- The rule does not establish a new fee
- The rule includes increased fees
- An immediate effective date is requested (see below)

I certify that the preamble contains a reference to any study relevant to the rules that ADEQ reviewed and either did or did not rely on in our evaluation and justification for the rule. No new full-time employees are necessary to implement and enforce the rule, and no competitiveness analysis was submitted.

As required by the Administrative Procedure Act, the Notice of Rulemaking Docket Opening and Notice of Proposed Rulemaking were filed with the Secretary of State, and published in the Arizona Administrative Register on October 21, 2022, and November 11, 2022, respectively.

Immediate effective date. ADEQ is requesting an immediate effective date under A.R.S. § 41-1032(A)(1) to preserve public health and safety. ADEQ's billing system is online and a quarterly bill is scheduled for posting on April 1, 2023. Some re-programming time is required. If that bill does not contain the increased fees for large quantity generators, smooth continuation of some services, such as outreach, technical assistance, timely complaint response, and inspections of hazardous waste generators, transporters and treatment, storage and disposal facilities would be compromised.

**Phoenix Office**

1110 W. Washington St. | Phoenix, AZ 85007  
602-771-2300

**Southern Regional Office**

400 W. Congress St. | Suite 433 | Tucson, AZ 85701  
520-628-6733

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January 9, 2023

Page 2 of 2

ADEQ submitted the proposed rule for these increased fees to the Secretary of State just 35 days after the statutory authority to increase the fees became effective.

Please do not hesitate to call me or Mark Lewandowski, Legal Analyst, at 602-771-2230, if you have any questions.

Sincerely,

**DocuSigned by:**



Misael Cabrera, P.E.  
D75AE75569754AE...  
Director

Electronic Enclosures:

Notice of Final Rulemaking

Economic, small business, and consumer impact statement

Comments

General and specific statutes authorizing the rule, including relevant definitions

Governor's emails granting exemption

**NOTICE OF FINAL RULEMAKING**  
**TITLE 18. ENVIRONMENTAL QUALITY**  
**CHAPTER 8. DEPARTMENT OF ENVIRONMENTAL QUALITY**  
**HAZARDOUS WASTE MANAGEMENT**

**PREAMBLE**

<b><u>1. Sections Affected</u></b>	<b><u>Rulemaking Action</u></b>
R18-8-260	Amend
R18-8-270	Amend

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

Authorizing Statutes: A.R.S. § 49-104(B)(17)

Implementing Statutes: A.R.S. §§ 49-922(B)(5) and 49-931(A)

**3. The effective date of the rules:**

March 7, 2023 (immediate effective date applies)

**4. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the proposed rule:**

Notice of Rulemaking Docket Opening: 28 A.A.R. 3378 (October 21, 2022)

Notice of Proposed Rulemaking: 28 A.A.R. 3468 (November 11, 2022)

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

Name: Mark Lewandowski

Address: Arizona Department of Environmental Quality

Waste Programs Division

1110 W. Washington St.

Phoenix, Arizona 85007

Telephone: (602) 771-2230, or (800) 234-5677, enter 771-2230 (Arizona only)

E-mail: lewandowski.mark@azdeq.gov

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

Summary. This final rule increases certain hazardous waste fees as authorized by A.R.S. §§ 49-922(B)(5) and 49-931(A). The Arizona Department of Environmental Quality (ADEQ) last increased hazardous waste fees in 2012 (18 A.A.R. 1202). This rule increases two hazardous waste fees beginning April 1, 2023 to address the future direct and indirect costs of ADEQ's relevant hazardous waste duties, including employee salaries and benefits, professional and outside services, equipment, in-state travel, and other necessary operational expenses directly related to issuing hazardous waste permits and enforcing the requirements of the regulatory program. ADEQ's Hazardous Waste Program does not receive General Fund monies and the goal is to ensure sufficient program funding to maintain primacy; otherwise, United States Environmental Protection Agency Region 9 (EPA), located in San Francisco, California, would enforce the hazardous waste laws in Arizona.

Background. The Arizona Hazardous Waste Program is required by A.R.S. § 49-922 and consists primarily of a permitting function and an inspection and compliance function. Like other environmental programs, it is based largely on federal law that calls for states to adopt and implement certain federal regulations as stringently as the EPA. As a consequence of Arizona being granted "authorization" to implement the federal hazardous waste regulations in Arizona "in lieu of" EPA, ADEQ also receives annual State and Tribal Assistance Grants (STAG) grants from EPA to implement RCRA (the Resource Conservation and Recovery Act). These grants are conditioned on certain workplan requirements which affect how those funds may be spent. The grant has contributed roughly one third of the annual appropriation for the hazardous waste program but the amount of the grant has been trending downward for the past decade.

The fee increases are for two types of hazardous waste entities: (1) hazardous waste generators and (2) permitted facilities that treat, store, or dispose of hazardous waste. A.R.S. §§ 49-922(B)(5) and 49-931 provide authority for fees based on the costs of evaluating hazardous waste facility permits and based on hazardous waste generated or disposed.

Further authority for these fees is contained in A.R.S. § 49-104(B)(17), which applies to both solid waste and hazardous waste fees. Two principal requirements are: (1) the fees should “be fairly assessed and impose the least burden and cost to the parties subject to the fees”; and (2) the permit fees are to be based on “the direct and indirect costs of the department’s relevant duties” . . . “related to issuing licenses” . . . “and enforcing the requirements of the applicable regulatory program.” Other requirements also apply and are discussed later.

In the context of this rulemaking, ADEQ has interpreted these two main requirements to mean it should collect the amount necessary to maintain an approvable program and to satisfy the detailed requirements to protect the public and the environment from hazardous wastes that are set out in A.R.S. § 49-922. ADEQ interprets “fairly assessed” to mean that the amount of fees collected from any class of hazardous waste entities should be not be disproportionate to the “direct and indirect costs” that can be attributed to that class.

ADEQ’s Hazardous Waste Program. The following Arizona entities handle hazardous waste: 14 hazardous waste treatment, storage, and disposal facilities, 141 large quantity generators, and 1,276 small quantity generators. There are also approximately 99 hazardous waste transporters that either pick up or deliver in Arizona. Generators exist in most industrial categories, such as construction, demolition, and renovation; dry cleaning; educational & vocational shops; equipment repair; furniture manufacturing and refinishing; laboratories; metal plating shops; leather manufacturing; motor freight and railroad transportation; pesticide end users and application services; photo processing; printing; textile manufacturing; auto body shops; pharmacies and mining.

To oversee and enforce the federal hazardous waste program in Arizona, ADEQ currently operates with 15 total full-time equivalent employees (FTEs). The increases in this rule will not increase the number of FTEs, but the program has been operating at a deficit since 2021, meaning that the program has used cash balance to fund expenses that exceeded revenues but were within appropriation.

Informal Comment. ADEQ requested informal comment on funding for the Hazardous Waste Program and hosted a public meeting on October 12, 2022. The meeting was announced to over 4,000 unique email addresses after combining the “Waste Programs Division Rulemaking” email list and Arizona facilities with EPA ID numbers matching either small quantity generator (SQG) or large quantity generator (LQG) status. The meeting was held virtually and attended by about 50 people in addition to ADEQ staff. ADEQ presented its plan for equal increases of 29% to the per ton generation fees, the accompanying maximum fees, and the hourly rate to process permits. Twenty-nine percent is the cumulative Consumer Price Index (CPI) increase from the last time the fees were set, July 2012, measured through August 2022.

At this public meeting, ADEQ explained how the increased fees would be automatically adjusted annually based on the CPI increase or decrease for the previous year. Participant comments and questions on ADEQ’s planned rulemaking related to the timing of these automatic increases, the proportion of fees paid by large quantity generators vs. small quantity generators, and whether different fees were considered for generators in a county that was itself charging generators similar fees. ADEQ posted its presentation slides to its website after the meeting to further explain how the fees would increase annually.

A comment was made that the majority of per ton fees being paid into the program comes from LQGs whereas a large share of ADEQ resources goes to costs related to SQGs, and that SQGs should possibly pay a higher per ton rate than LQGs. ADEQ believes that SQGs should not pay a higher per ton rate for the following reasons: 1) there should be an incentive to reduce hazardous waste generation, and to go from LQG status to SQG status, not a disincentive; 2) SQGs are more likely to be small businesses and ADEQ is required to reduce the impact of its rules on small businesses, and higher fees for SQGs would be the opposite.

With regard to fees charged to generators in Pima County, the County charges generators registration fees, not per ton generation fees. ADEQ believes that this is not a duplicate fee. However, ADEQ will evaluate the fact that ADEQ and Pima County are both charging fees to generators, and if necessary, will address it in a future rule-making.

Explanation of Increased Fees. The Hazardous Waste Management Fund (HWMF), was established in A.R.S. § 49-927 and is used to implement ADEQ's Hazardous Waste Program. In fiscal year (FY) 22, the HWMF's income from its two listed sources was approximately \$1.3 million. In FY 22, and in previous years, the revenue to the HWMF had to be supplemented by money from the Recycling Fund (A.R.S. § 49-837) to cover the increased costs to implement the Hazardous Waste Program (\$1.7 million in FY 22). Factoring in cost increases since 2012 and future predicted cost increases, ADEQ needs to increase revenue to the HWMF to \$2.1 million to continue to implement the Hazardous Waste Program in FY 24. The additional revenues needed to address increased costs since 2012 and future projected costs to cover the program beyond FY 24 require the fee increases in this rulemaking. The majority of the funds in the HWMF come from the per ton generation fee authorized by A.R.S. § 49-931(A)(1) for hazardous waste which is generated and shipped offsite. This fee, implemented in R18-8-260(M)(1), will be increased by the cumulative CPI increase of 29% to \$87 per ton, along with a proportionate increased maximum fee of \$258,000. This rule increases the per ton rate in R18-8-260(M)(2) and (M)(3) as well, but the waste quantities in those categories are so small that ADEQ focused on the fee in R18-8-260(M)(1). The hourly rate for permit processing listed in R18-270(G) is also increased by the cumulative CPI increase of 29%.

Fees not increased. ADEQ did not increase the application or maximum fees in R18-8-270(G) in this rulemaking. Since these maximum fees were created in 2012, no permit processing invoice has reached any specified maximum. Any increase for these fees would not have been justified and, in addition, would produce no anticipated increase in revenue.

Consumer Price Index (CPI) limit on fee increases. A.R.S. § 41-1008(A) limits fee increases for most state agencies to the amount the CPI increased from the time the fee was last set to the effective date of the new fee, with two exceptions. In order to facilitate stakeholder input and due to budget needs, ADEQ limited the increases in the proposed rule to the cumulative CPI increase between July, 2012 and August, 2022, or 29% based on the Bureau of Labor Statistics CPI Calculator at [https://www.bls.gov/data/inflation\\_calculator.htm](https://www.bls.gov/data/inflation_calculator.htm).

Annual CPI related adjustments. This rule also contains language for automatic annual adjustments to the increased fees in this rule equal to the annual increase or decrease in the CPI using the United States Bureau of Labor Statistics' CPI Inflation Calculator. The rule language is designed so that generators can easily track and forecast any increase ahead of time. The first adjustment will occur on April 1, 2024. ADEQ's Air Quality Division has used automatic increases in its fees since 1994. See R18-2-326(H).

In analyzing its budgetary needs, ADEQ initially considered two scenarios. In the first, the \$67.50 per ton fee was increased by the cumulative CPI increase of 29% to \$87, but the maximum fee for this category remained at \$200,000. In the second scenario, the per ton fee was increased to \$87 but the maximum fee was also increased by the cumulative CPI increase of 29% to \$258,000. With the first option, ADEQ would not have been able to support all Hazardous Waste Program functions without transfers from the Recycling Fund established in A.R.S. § 49-837. With the second option, implemented by this rulemaking and due to large generators of hazardous waste that reach the maximum, ADEQ will be able to eliminate these transfers. ADEQ therefore decided to increase the maximum generation fees by 29% as well.

Hourly rate. Some hours of Hazardous Waste Program employees can be more directly attributed to specific hazardous waste entities because those hours are spent processing permits or permit actions for individual facilities. A.R.S. § 49-104(B)(17), requiring that fees be "fairly assessed" and "related to issuing licenses," required ADEQ to increase this separate fee even though only a small percentage of HWMF funds come from permit processing fees.

ADEQ also increased by 29% the hourly rate for processing hazardous waste permits at R18-8-270(G). This percentage increase is the cumulative CPI increase from July 2012 through August 2022. An internal salary inquiry of hazardous waste permit processing employees showed that a current senior engineer's salary increased 26% between July 2012 and 2022. However, the salary to hire a new engineer level 3, as provided by Arizona Dept.

of Administration market rate hiring guidelines has risen from \$50,000 per year to \$85,000 per year in that same time, a 41% increase. For consistency, ADEQ used the cumulative CPI increase of 29% for the hourly rate. As mentioned previously, the tables in that subsection also contain application fees and maximum fees, but in this rulemaking, ADEQ only increased the hourly rate it uses for permit review, from \$136/hour to \$175/hour.

The rate of \$175 per hour is comparable to private sector rates and with the rates charged by other ADEQ divisions and state agencies that are engaged in similar levels of technical review and project management. The Hazardous Waste program requires specialty technical review and the program is required to recover full processing costs through fees.

Alternatives. In its 2012 hazardous waste fee rulemaking, ADEQ analyzed different combinations of per ton fees and generator site maximums using various factors including proportionality and impacts on small businesses. Since federal regulations have definitions for LQG and SQG, these categories allowed assessment of both the proportionality and the small business impact of various hazardous waste generation fee and cap combinations. However, in this rulemaking ADEQ decided to increase both the maximum fee and the per ton rate by the cumulative CPI increase or 29% to avoid increasing either fee by more than the CPI increase, which would have required additional approval pursuant to A.R.S. § 41-1008(A)(3). If ADEQ increased the maximum fees less than 29%, an increase in the per ton rate would have been necessary to make up the difference, leading to an increase in the per ton generation rate greater than the CPI increase for the period. Conversely, ADEQ could have increased the per ton rate less than 29%, but the difference would have had to be made up by an increase in the maximum fee of greater than 29%.

Additional requirements. Under A.R.S. § 49-104(B)(17)(b), (c), and (d), ADEQ must also consider the availability of other funds, the impact of the fees on the parties subject to the fees, and the fees charged for similar duties performed by the department, other agencies, and the private sector.

ADEQ has already discussed the availability of the federal grant for RCRA, and ADEQ is using the grant to the maximum extent. It should be noted that since 1996, civil and criminal penalties that result from hazardous waste enforcement go to the General Fund and not the Hazardous Waste Management Fund, so that these funds are not available to mitigate these fee increases. Finally, under A.R.S. § 49-929, all hazardous waste transporters, generators, and treatment, storage, and disposal (TSD) facilities pay varying registration fees into the Water Quality Assurance Revolving Fund (WQARF) established under A.R.S. § 49-282, for the purpose of assisting the WQARF program to remediate contamination from hazardous waste sites.

ADEQ has considered the impact of the increased fees on the parties subject to the fees through its collection of the least amount of fees necessary to sustain an approvable program, and a fair, proportional assessment of those fees. ADEQ notes that it is required to conduct a Pollution Prevention program under A.R.S. §§ 49-961 *et seq.* to aid generators in reducing generation of hazardous waste, which has the effect of reducing revenue from generation of hazardous waste. The table below summarizes the impact of a 29% increase on various categories of generators assuming, for comparison purposes, the number of generators and the distribution in generator size remains the same.

Under previous fees

ADEQ Hazardous Waste (HW) average annual generator fees; Actual Calendar Year (CY) 21 data

Generation amount in tons	# of generators sites in this category	Average amount paid by each facility annually
>1,000 tons (LQGs)	3	\$183,441
12-1000 (LQGs)	138	\$5242
5-12 (SQGs)	58	\$508
2-5 (SQGs)	116	\$196
1-2 (SQGs)	147	\$91
<1 (SQGs)	955	\$11

With the new fees

ADEQ Hazardous Waste (HW) average annual generator fees; Estimated Calendar Year (CY) 23 data

Generator size in tons	# of generators sites in this category	Average amount paid by each facility annually
>1,000 tons (LQGs)	3	\$236,583
12-1000 (LQGs)	138	\$6762

5-12 (SQGs)	58	\$655
2-5 (SQGs)	116	\$253
1-2 (SQGs)	147	\$117
<1 (SQGs)	955	\$14

Immediate effective date. As mentioned in the proposed rule, ADEQ requested an immediate effective date under A.R.S. § 41-1032(A)(1) when it submitted this rule to the Governor’s Regulatory Review Council (GRRC), in order to preserve public health and safety by ensuring necessary funding for the hazardous waste program. An immediate effective date was approved at the March 7, 2023 GRRC meeting. Software changes formally began on March 7. The actual rates charged change effective April 1, 2023.

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

Not applicable

**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:**

Identification of the rulemaking: 18 A.A.C. 8, Article 2, amending R18-8-260 and R18-8-270. (For further information, see Part 6 of the preamble.) These rules are not designed to change the conduct of any regulated hazardous waste entities. The rules are designed to collect fees from some hazardous waste entities. The per ton and maximum fees for generation and/or disposal of hazardous waste are increased in R18-8-260. The hourly rate is increased for processing hazardous waste permits in R18-8-270.

Program Description. Under A.R.S. § 49-922 and federal law, Arizona's Hazardous Waste Program is responsible for ensuring that all regulated hazardous waste in Arizona is treated, stored, transported, and disposed of properly, and is largely a preventative program to keep hazardous waste from entering the environment. The program maintains an inventory of hazardous waste generators, transporters, and treatment, storage and disposal (TSD) facilities in Arizona. Permits are issued, managed, and maintained for TSD facilities and this activity includes permit modifications, renewals, closure plans, and financial assurance reviews. Generators, transporters and TSD facilities are periodically inspected. Hazardous waste complaints are investigated. Compliance data is collected and stored. Hazardous waste is tracked from generation to disposal. Compliance assistance is provided, enforcement actions are pursued against significant violators, and oversight is provided for the remediation of contaminated sites.

Regulatory Universe. ADEQ's Hazardous Waste Program regulates a universe of over 1,500 facilities, including metal platers, chemical manufacturers, laboratories, explosive and munition manufacturers, pesticide manufacturers, hazardous waste TSD facilities, and military installations. There are currently approximately 14 permitted TSD facilities, 141 large quantity generators, 1,276 small quantity generators, and 99 transporters.

Current Hazardous Waste Staff and FY24 costs. With a continued shortage of funds, the Hazardous Waste Program would have experienced a reduction in staffing levels from the current 15 FTEs. ADEQ believes this staffing level represents the minimum necessary to process the existing and future workload efficiently and within applicable licensing time-frames. Factoring in cost increases since 2012 and future predicted cost increases, the budget necessary to operate the Hazardous Waste Program in FY24 is approximately \$2.1 million. Without a fee increase, the hazardous waste permitting and generation fees generated would be, at best, the FY22 level, or approximately \$1.3 million. This rule was designed to address the FY24 deficit, projected to be \$800,000. Hazardous Waste Programs staffing levels will not expand as a result of this rulemaking, other than filling any vacancies

Recent Implemented Efficiencies. In the past decade, the Hazardous Waste Program has employed two significant tools to accomplish more required work with fewer resources: lean principles from the Arizona Management System and the myDEQ platform for online processing of many items formerly handled by paper. Permitting program efficiencies in this timeframe include permits being processed 567% faster at one fourth of their former cost. Compliance and inspection improvements include increased outreach, facility inspections increased 169%, and facilities returning to compliance 246% faster since 2016. The program also administers the Pollution Prevention program, processing 175-200 reports annually on facility progress. The ADEQ Hazardous Waste Program launched registration and data reporting under the myDEQ platform, and removed the requirement for a facility annual report in favor of a biennial report consistent with EPA's rules. Finally, two recent rulemakings have allowed the Program to be up to date with respect to federal rule adoption and authorized by EPA.

Discussion and Demonstration: The Regulatory Objective. A.R.S. § 49-922 requires that ADEQ establish and implement a hazardous waste management program “equivalent to and consistent with” the federal hazardous waste program. EPA likewise requires states to adopt a program at least as stringent as the federal program in order to be authorized to implement the federal program in lieu of EPA. As a result of being authorized, ADEQ receives RCRA grant funding from EPA to partially offset the cost of running the program. Through the grant and delegation process, EPA maintains close scrutiny of the Arizona program and requires it to achieve certain benchmarks.

Based on stakeholder comments, most in the regulated community agree that ADEQ should implement the federal program rather than EPA, and that ADEQ should continue to meet the criteria and benchmarks for program authorization in order to implement the program and receive the federal RCRA (Resource Conservation and Recovery Act) grant. The FY22 EPA grant provided approximately \$1 million to ADEQ and must be spent according to grant provisions. There is usually some money earmarked specifically for program activities at the Mexico border. In addition, Arizona must match the RCRA grant with 25% additional state funds.

Resource Reduction Impacts. Failure to adequately staff and fund the program could cause the loss of the EPA authorized program and approximately \$1 million in federal dollars. If the program reverts back to EPA, Arizona would lose control over enforcement and permitting decisions. If the program continues to receive federal dollars, but is not adequately funded by the state, efforts would be focused on the EPA grant required performance measures. Continuation of some services, such as outreach, technical assistance, timely complaint response, and inspections of small and very small quantity generators, and transporters could cease, with a resulting impact on public health and safety.

Least burden and cost; description of alternatives. A.R.S. § 41-1052(D)(3) requires ADEQ to demonstrate it has selected the alternative with the least burden and cost necessary to achieve the underlying regulatory objective. A nearly identical issue was discussed in part 6 of the Preamble with regard to A.R.S. § 49-104(B)(17), which requires that the fees should “be fairly assessed and impose the least burden and cost to the parties subject to the fees”; and that the fees are to be based on “the direct and indirect costs of the department’s relevant duties” . . . “related to issuing licenses” . . . “and enforcing the requirements of the applicable regulatory program.”

In the context of this hazardous waste rule, ADEQ has interpreted these two main requirements to mean collecting an amount necessary to maintain an approvable program and satisfy the detailed requirements to protect human health and the environment from hazardous wastes that are specified in A.R.S. § 49-922. ADEQ considers “fairly assessed” to mean that the amount of fees collected from any class of hazardous waste entities should not be disproportionate to the “direct and indirect costs” that can be attributed to that class.

Alternatives. In 2012, several members of the regulated community requested that ADEQ consider additional fee scenarios that would keep the generator site maximums lower than the amounts being considered by ADEQ. At that time, ADEQ determined that the adopted balance of maximum and per ton rates was the best possible for small business. For this rule, ADEQ has determined that other combinations of per ton fees and generator site maximums

necessary to erase the \$800,000 structural deficit would increase either the per ton fees or the generator site maximums more than the CPI increase for the same period.

ADEQ considered the impact of the fees on the parties subject to the fees as shown by its collection of the least amount of fees necessary to sustain an approvable program, and a fair, proportional assessment of those fees.

Cost/Benefit. The probable costs for this rule are the \$800,000 in estimated increased fees necessary for the maintenance of the program described above. These costs will be incurred primarily by private and government entities that generate hazardous waste and to a lesser degree by hazardous waste TSD facilities that need a permit or permit action such as a modification.

The probable benefits are:

- *Ability of Arizona to implement the federal hazardous waste program.* EPA currently does not have the staff to perform hazardous waste inspections and permitting activities in Arizona; therefore, if the program reverted to EPA, there could be a significant period of time during which there would be no hazardous waste oversight in Arizona, including responding to citizens' complaints regarding hazardous waste issues. In terms of permitting activities, ADEQ is held to specific licensing time frames to issue hazardous waste permits in a timely manner; EPA would not be bound by Arizona's rules on licensing time frames. EPA administration of the hazardous waste program would most certainly result in a delay of statutorily mandated permit processing, causing Arizona businesses to delay start-up, expansion or modification.
  
- *Local control over enforcement and permitting decisions:* Hazardous waste enforcement and permitting are inexact processes. ADEQ engages heavily with the regulated community during these processes. Arizona businesses could suffer from the inability to engage with the regulators in a timely manner at a convenient location since they would have to engage with EPA Region 9 staff in San Francisco. Furthermore, the regulated community could no

longer take advantage of ADEQ's efforts to educate regulated entities about enforcement policies. ADEQ developed the Compliance and Enforcement Handbook, which is available to the public, with the purpose of promoting appropriate, consistent, and timely enforcement of Arizona's environmental statutes and rules in a manner that is transparent to all who are affected, including the regulated community. EPA does not have a similar guidance document that is tailored to the needs of Arizona businesses.

- *Control over other hazardous waste activities:* RCRA has numerous reporting requirements for generators of hazardous waste. Because Arizona has the authority to implement the hazardous waste program, the business community in Arizona submits documentation to and requests required information (e.g., EPA identification numbers) from ADEQ. Absent an Arizona-specific hazardous waste program, Arizona businesses will be forced to submit reports to and request needed information from EPA in San Francisco. ADEQ receives dozens of calls each month from Arizona businesses handling hazardous waste, requesting compliance assistance. In addition, a significant amount of compliance assistance takes place during inspections. This service to Arizona businesses would no longer be available.
  
- *Arizona businesses will be subject to Arizona's Penalty Authority rather than EPA's Administrative Penalty Authority:* ADEQ has authority to seek a penalty of up to \$1,000 per day for the violation of a Compliance Order [A.R.S. § 49-923] or to seek penalties of up to \$25,000 per day for violations of the Arizona Hazardous Waste Management Act [A.R.S. § 49-924]. In contrast, EPA can assess a penalty of up to \$37,500 per day for violations under RCRA and this amount is periodically adjusted for inflation. EPA's penalty authority places the burden on the responsible party to contest EPA's alleged violations whereas ADEQ's places the burden on the state.
  
- *Rulemaking oversight:* A.R.S. § 49-922 requires the Director to adopt rules to establish a hazardous waste program. Hazardous waste rules adopted by ADEQ currently go through the Governor's Regulatory Review Council and stakeholder review processes. When EPA

adopts a new regulation, Arizona currently has the authority to review the regulation and decide whether to propose it for adoption. If the Hazardous Waste Program reverted to EPA, Arizona would lose the ability to decide whether to adopt federal regulations; future EPA regulations would become effective in Arizona at the same time they became effective nationwide.

- *Compliance assistance outreach to regulated community:* Throughout the year, ADEQ staff participates in numerous conferences and training seminars with the goal of educating the regulated community about ADEQ hazardous waste requirements and policies. It is unlikely that EPA would schedule trips to Arizona for staff to participate in short-term outreach events.
- *Increased Staffing Flexibility.* With sufficient funds, ADEQ can more quickly fill any vacancies and maintain sufficient funding for those positions.

In addition to these benefits, there is a general benefit to the state budget when the Hazardous Waste Program can maintain a fee-based revenue system without the need for General Fund support. At the same time, this rule is fair and equitable, in that more of the costs of the Hazardous Waste Program will be borne by those who need the ability to legally generate and dispose of hazardous waste.

For these reasons, ADEQ believes that the benefits exceed the cost.

Rules More Stringent than Corresponding Federal Law [A.R.S. § 41-1052(D)(9)] There is no corresponding federal law related to hazardous waste fees.

Probable Impact on Political Subdivisions of this State Directly Affected by this Rulemaking [A.R.S. § 49-1055 (B)(3)(b)]

Political subdivisions that will be directly impacted by this fee rule are generators of hazardous waste, or ones that hold or apply for a hazardous waste permit. Several municipal

water treatment plants are hazardous waste generators. One municipal wastewater treatment plant is a large quantity generator (LQG) which generated approximately 73 tons of hazardous waste in 2021. Assuming hazardous waste generation there remains the same, it is impacted by this fee rule with approximately a \$1,424 increase: \$6,351 versus \$4,927.50 previously. Other municipal treatment plants are small quantity generators. In 2021, the three state universities together generated a total of 97 tons of hazardous waste. The average impact to each university of the generation fee being increased from \$67.50 is 97 tons X \$19.50 or \$1,891, divided by 3, or \$630. This is less than the cost of one student's yearly in-state tuition. ADEQ has classified these impacts as minimal.

Reduction of Impact on Small Businesses [A.R.S. § 41-1035] requires state agencies to reduce the impact of a rulemaking on small businesses, if any of the following methods are legal and feasible in meeting the statutory objectives which are the basis of the rule making:

1. Establish less stringent compliance or reporting requirements in the rule for small businesses.
2. Establish less stringent schedules or deadlines in the rule for compliance or reporting requirements for small businesses.
3. Consolidate or simplify the rule's compliance or reporting requirements for small businesses.
4. Establish performance standards for small businesses to replace design or operational standards in the rule.
5. Exempt small businesses from any or all requirements of the rule.

The listed methods are not generally relevant to a rule establishing fees, (fees must be fairly assessed and based on direct and indirect costs). ADEQ believes that small businesses experience a reduced impact because they generate less hazardous waste.

Probable Impact on Small Businesses. [A.R.S. § 41-1055(B)(5)] ADEQ has looked at its database of hazardous waste generators and permittees and tried to determine which ones are likely to be small businesses. One example is dry cleaners. Dry cleaners are often independently owned and operated and not likely to exceed the revenue and employee limits

in the statutory definition of small business. Most dry cleaners are also SQGs, so that the impact of the increased generation fees will be based on an annual generation of approximately 12 tons or less. It is likely that most small businesses that generate hazardous waste will be small quantity generators and that these increased generation fees will have only a limited to moderate impact on them.

**10. The agency’s contact person who can answer questions about the economic, small business, and consumer impact statement:**

Name: Mark Lewandowski  
Address: Arizona Department of Environmental Quality  
Waste Programs Division  
1110 W. Washington St.  
Phoenix, Arizona 85007  
Telephone: (602) 771-2230, or (800) 234-5677, enter 771-2230 (Arizona only)  
E-mail: lewandowski.mark@azdeq.gov

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

The words “and after” were added to the phrase “From and after April 1, 2023 until April 1, 2024,” in R18-8-270(G)(6)(a). No other changes were made.

**12. An agency’s summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:**

The proposed rule was posted on ADEQ’s website and published in the Arizona Register on November 11, 2022. A virtual oral proceeding regarding these proposed rules was held on December 20, 2022. Close of comment was December 20, 2022. ADEQ received no comments at the oral proceeding, but received written comments from two commenters.

ADEQ received an email with the following three comments on the proposed rule and preamble from the chairman of a rural county board of supervisors.

Comment 1: There needs to be a limit to the number of hours billed for permitting review to avoid giving ADEQ a blank check and to minimize uncertainty. A table by permit type would be helpful.

Response: Such a table with maximum amounts for permits already exists in the rule at R18-8-270(G), but it was not shown since no change was made to that table. ADEQ refers to the unchanged maximum fees in the preamble to the proposed rule at page 3470, under “Fees not increased”. No change to the rule.

Comment 2: Fees for hazardous waste transporters and treatment, storage and disposal (TSD) facilities are not included in the rulemaking although ADEQ discusses that the generation fees are needed to oversee these activities.

Response: ADEQ has no authority from the legislature to charge fees to hazardous waste transporters and fees for TSD facilities can be charged only when a permit is issued or modified. However, ADEQ has to base the fees it is allowed on “the direct and indirect costs” of “enforcing the requirements of the applicable regulatory program.” [A.R.S. § 49-104(B)(17)(a)] The generation fees are charged just once for the generation of the waste, but have to cover routine inspection and outreach activities related to the transportation and treatment, storage and disposal of that waste. No change to the rule.

Comment 3: Small businesses and small quantity generators have to pay a higher cost per ton than large quantity generators to private entities for their hazardous waste transport and disposal. This is an incentive for small businesses to accumulate hazardous waste without the safeguards that might be present at a larger business.

Response: ADEQ is aware of the challenges that small businesses face accumulating and storing waste so that transport and ultimate disposal is more economical. The federal regulation 40 CFR 262.16(b), which ADEQ incorporates by reference, recognizes these economies of scale by allowing small quantity generators to accumulate waste on site for 180 days, compared to 90 days for large quantity generators. Some small quantity generators,

such as Wal-Mart, are not small businesses but ADEQ's inspections pay particular attention to the storage practices of all small quantity generators. In general, ADEQ stands by its statement that small businesses experience a reduced impact from ADEQ's per ton fees because they produce less hazardous waste. ADEQ inserted the phrase "compared to large quantity generators" in the summary of the economic impact of the rules. No change to the rule.

ADEQ also received a letter from the owner of a local cabinet manufacturing company requesting that the per ton fee increases be postponed for one year.

Response: ADEQ recognizes that many in the manufacturing sector are experiencing hardships related to current economic conditions. ADEQ is required by law to recover its costs related to the hazardous waste program and therefore is not able to postpone this increase for another year. No change to the rule.

**13. 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:**

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

See A.R.S. § 41-1037(A)(1) and (2). This rulemaking amends an existing rule that requires a regulatory permit. This rulemaking does not require a general permit because:

- 1) A specific alternative permit is authorized by state statute under A.R.S. § 49-922(B)(5) and;
- 2) General permits as defined by A.R.S. § 41-1001 are not recognized under federal hazardous waste regulations with which ADEQ is required to be consistent.

However, it should be noted that ADEQ has already adopted a federal general permit rule that is similar to Arizona general permits. 40 CFR 270.60, "Permits by Rule", applies to three types of facilities: 1) ocean disposal barges or vessels, 2) hazardous

waste injection wells, and 3) publicly owned treatment works. Under the federal rule, these three types of facilities are “deemed to have a RCRA permit if the conditions listed are met”. Only the third category exists in Arizona and DEQ has incorporated the federal general permit rule for publicly owned treatment works in R18-2-270(A). It should also be noted that the hazardous waste standardized permit, which is not incorporated in Arizona rules, is not a general permit as defined by A.R.S. § 41-1001 since each standardized permit applies to just one facility.

**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:**

Not applicable. There is no federal law related to hazardous waste fees. There are only federal laws that regulate the generation, transport and storage of hazardous waste.

**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:**

No analysis was submitted

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

None

**15. The full text of the rules follows:**

**TITLE 18. ENVIRONMENTAL QUALITY**  
**CHAPTER 8. DEPARTMENT OF ENVIRONMENTAL QUALITY**  
**HAZARDOUS WASTE MANAGEMENT**  
**ARTICLE 2. HAZARDOUS WASTES**

Section

R18-8-260. Hazardous Waste Management System: General

R18-8-270. Hazardous Waste Permit Program

## ARTICLE 2. HAZARDOUS WASTES

### **R18-8-260. Hazardous Waste Management System: General**

**A.** No change

**B.** No change

**C.** No change

1. No change

2. No change

**D.** No change

1. No change

2. No change

a. No change

i. No change

ii. No change

b. No change

i. No change

ii. No change

iii. No change

iv. No change

c. No change

i. No change

ii. No change

iii. No change

d. No change

i. No change

ii. No change

iii. No change

e. No change

i. No change

(1) No change

(2) No change

- ii. No change
  - (1) No change
  - (2) No change
- iii. No change
  - (1) No change
  - (2) No change
  - (3) No change
  - (4) No change
- f. No change
  - i. No change
  - ii. No change
  - iii. No change
  - iv. No change
  - v. No change

**E. No change**

- 1. No change
- 2. No change
- 3. No change
- 4. No change
- 5. No change
- 6. No change
- 7. No change
- 8. No change
- 9. No change
- 10. No change
- 11. No change
  - a. No change
  - b. No change
  - c. No change
  - d. No change
  - e. No change

- f. No change
- g. No change
- h. No change
- i. No change

12. No change

13. No change

14. No change

15. No change

16. No change

17. No change

18. No change

19. No change

20. No change

21. No change

- a. No change

- b. No change

22. No change

23. No change

24. No change

25. No change

26. No change

27. No change

28. No change

29. No change

30. No change

31. No change

32. No change

33. No change

**F.** No change

- 1. No change

- 2. No change

- 3. No change
  - a. No change
  - b. No change
  - c. No change
- 4. No change
- 5. No change
- 6. No change
- 7. No change
  - a. No change
  - b. No change
  - c. No change
  - d. No change
  - e. No change
  - f. No change
  - g. No change
  - h. No change

**G.** No change

**H.** No change

**I.** No change

**J.** No change

**K.** No change

**L.** No change

- 1. No change
- 2. No change
- 3. No change

**M.** A person shall pay hazardous waste generation and disposal fees as required under A.R.S. § 49-931 after the rates are updated for the billing period. The ~~DEQ shall send an invoice to~~ billing period for large-quantity generators shall be quarterly and for small-quantity generators, including very small quantity generators who become a small quantity generator due to an episodic event, annually. The person shall pay ~~an invoice~~ the fee within 30 days of

the ~~postmark on the invoice~~ close of the billing period. The following hazardous waste fees shall apply:

1. A person who generates hazardous waste in calendar year 2023 that is shipped off site shall pay ~~\$67.50~~ \$87.00 per ton but not more than ~~\$200,000~~ \$258,000 per generator site per year of hazardous waste generated; For each succeeding calendar year, these rates shall be adjusted according to paragraph (4) below.
2. An owner or operator of a facility that disposes of hazardous waste in calendar year 2023 shall pay ~~\$270~~ \$348 per ton but not more than ~~\$5,000,000~~ \$6,245,000 per disposal site per year of hazardous waste disposed; and, For each succeeding calendar year, these rates shall be adjusted according to paragraph (4) below.
3. A person who generates hazardous waste in calendar year 2023 that is retained on site for disposal or that is shipped off site for disposal to a facility that is owned and operated by that generator shall pay ~~\$27~~ \$34.83 per ton but not more than ~~\$160,000~~ \$206,000 per generator site per year of hazardous waste disposed. For each succeeding calendar year, these rates shall be adjusted according to paragraph (4) below.
4. From and after January 1, 2024, the amounts in paragraphs 1, 2 and 3, above, and R18-8-270(G)(6) shall be updated annually before each April 1 by the following method:
  - a. On or about January 15 after the calendar year to be updated, ADEQ shall use the United States Bureau of Labor Statistics CPI Inflation Calculator at [bls.gov/data/inflation\\_calculator.htm](https://bls.gov/data/inflation_calculator.htm), as follows unless updated:
    - i. Insert the current maximum fee, per ton rate, or hourly rate in the first box.
    - ii. Insert December of the calendar year 13 months previous in the before-inflation box. Insert the previous December in the after-inflation box.
    - iii. Select "Calculate". The new maximum, per ton rate, or hourly rate for the billing period beginning January 1 will be shown.
  - b. ADEQ shall post the new rates on its webpage and install them in the billing software as soon as practicable.

#### **R18-8-270. Hazardous Waste Permit Program**

**A.** No change

1. No change
2. No change
- B.** No change
  1. No change
    - a. No change
    - b. No change
    - c. No change
  2. No change
    - a. No change
    - b. No change
- C.** No change
- D.** No change
- E.** No change
- F.** No change
- G.** No change
  1. No change
  2. No change
    - a. No change
    - b. No change
    - c. No change
  3. No change
  4. No change
  5. The DEQ shall provide the applicant itemized bills at least semiannually for the expenses associated with evaluating the application and approving or denying the permit or permit modification. The following information shall be included in each bill:
    - a. The dates of the billing period;
    - b. ~~After January 1, 2013, the~~ The date and number of review hours performed during the billing period itemized by employee name, position type and specifically describing;
      - i. Each review task performed;
      - ii. The facility and operational unit involved;
      - iii. The hourly rate;

- c. No change
- d. No change
- 6. Fees shall consist of processing charges and review-related costs as follows:
  - a. Processing charges. From and after April 1, 2023 until April 1, 2024, the ~~The~~ DEQ shall calculate the processing charges using a rate of ~~\$136~~ \$175 per hour, multiplied by the number of review hours used to evaluate and approve or deny the permit or permit modification. From and after April 1, 2024, the hourly rate shall be adjusted annually each April 1 according to R18-8-260(M)(4).
  - b. No change
    - i. No change
    - ii. No change
    - iii. No change
    - iv. No change
    - v. No change
    - vi. No change
    - vii. No change
    - viii. No change
    - ix. No change
  - c. No change
- 7. No change
  - a. No change
  - b. No change
- 8. No change
- 9. No change
- H.** No change
- I.** No change
- J.** No change
- K.** No change
- L.** No change
- M.** No change
- N.** No change

- O.** No change
- P.** No change
- Q.** No change
- R.** No change
- S.** No change
- T.** No change
- U.** No change

**OakCraft Inc.**

7733 West Olive Avenue

Peoria, AZ 85345

Tel 623-412-1901 Fax 623-412-9319

[www.oakcraft.com](http://www.oakcraft.com)



December 19, 2022

ADEQ

Ms. Dena Kalamchi

1110 W. Washington Street

Phoenix, AZ 85007

**RECEIVED**

**JAN 10 2023**

**Re: Proposed Hazardous Waste Fee Increase**

Dear Ms. Kalamchi,

Thank you for the opportunity to comment on the proposed increase in the hazardous waste generation fee effective January 1, 2023. As I understand, the fee will increase from \$67.50 to \$87.00 per ton of hazardous waste generated. OakCraft, Inc. (OakCraft) is a kitchen cabinet manufacturing facility and is classified as a large quantity generator. The fee increase will affect us greatly.

It is understandable that regulatory agencies must from time to time assess their own costs while operating in an efficient manner. It is acknowledged your service has improved over the last several years as the ADEQ has advanced itself in the use of the portal and in other areas of management. The problem with the fee increase at this time is the ever increasing difficulties being confronted by the manufacturing sector. OakCraft is confronting these obstacles for quite some time. Covid 19 was the start of these obstacles in early 2020. Price increases and supply chain issues followed, which continue through today. Labor issues, including wage increases to find qualified employees, and in many cases not finding employees at all with the skill set to build the quality products for which we are well known. These are not small issues and we know all local manufacturers are encountering these problems.

Considering these concerns, we would like to respectfully request that ADEQ delay the implementation of the proposed hazardous waste fee increase fee for one year, until January 1, 2024. Your consideration of this request will be greatly appreciated by all our organization and employees at OakCraft.

Sincerely,

A handwritten signature in blue ink that reads "Charles Waiser".

Charles Waiser

Owner, CFO

**GENERAL AND SPECIFIC STATUTES AUTHORIZING ADEQ'S HAZARDOUS WASTE FEE RULE**

A.R.S. §§ 49-104(B)(17), 49-922(B)(5) and 49-931(A)

**WITH RELEVANT DEFINITIONS**

A.R.S. § 49-921

**49-104. Powers and duties of the department and director**

A. The department shall:

1. Formulate policies, plans and programs to implement this title to protect the environment.
2. Stimulate and encourage all local, state, regional and federal governmental agencies and all private persons and enterprises that have similar and related objectives and purposes, cooperate with those agencies, persons and enterprises and correlate department plans, programs and operations with those of the agencies, persons and enterprises.
3. Conduct research on its own initiative or at the request of the governor, the legislature or state or local agencies pertaining to any department objectives.
4. Provide information and advice on request of any local, state or federal agencies and private persons and business enterprises on matters within the scope of the department.
5. Consult with and make recommendations to the governor and the legislature on all matters concerning department objectives.
6. Promote and coordinate the management of air resources to ensure their protection, enhancement and balanced utilization consistent with the environmental policy of this state.
7. Promote and coordinate the protection and enhancement of the quality of water resources consistent with the environmental policy of this state.
8. Encourage industrial, commercial, residential and community development that maximizes environmental benefits and minimizes the effects of less desirable environmental conditions.
9. Ensure the preservation and enhancement of natural beauty and man-made scenic qualities.
10. Provide for the prevention and abatement of all water and air pollution including that related to particulates, gases, dust, vapors, noise, radiation, odor, nutrients and heated liquids in accordance with article 3 of this chapter and chapters 2 and 3 of this title.

11. Promote and recommend methods for the recovery, recycling and reuse or, if recycling is not possible, the disposal of solid wastes consistent with sound health, scenic and environmental quality policies. The department shall report annually on its revenues and expenditures relating to the solid and hazardous waste programs overseen or administered by the department.

12. Prevent pollution through the regulation of the storage, handling and transportation of solids, liquids and gases that may cause or contribute to pollution.

13. Promote the restoration and reclamation of degraded or despoiled areas and natural resources.

14. Participate in the state civil defense program and develop the necessary organization and facilities to meet wartime or other disasters.

15. Cooperate with the Arizona-Mexico commission in the governor's office and with researchers at universities in this state to collect data and conduct projects in the United States and Mexico on issues that are within the scope of the department's duties and that relate to quality of life, trade and economic development in this state in a manner that will help the Arizona-Mexico commission to assess and enhance the economic competitiveness of this state and of the Arizona-Mexico region.

16. Unless specifically authorized by the legislature, ensure that state laws, rules, standards, permits, variances and orders are adopted and construed to be consistent with and no more stringent than the corresponding federal law that addresses the same subject matter. This paragraph does not adversely affect standards adopted by an Indian tribe under federal law.

17. Provide administrative and staff support for the oil and gas conservation commission.

**B. The department, through the director, shall:**

1. Contract for the services of outside advisers, consultants and aides reasonably necessary or desirable to enable the department to adequately perform its duties.

2. Contract and incur obligations reasonably necessary or desirable within the general scope of department activities and operations to enable the department to adequately perform its duties.

3. Utilize any medium of communication, publication and exhibition when disseminating information, advertising and publicity in any field of its purposes, objectives or duties.

4. Adopt procedural rules that are necessary to implement the authority granted under this title, but that are not inconsistent with other provisions of this title.

5. Contract with other agencies, including laboratories, in furthering any department program.
6. Use monies, facilities or services to provide matching contributions under federal or other programs that further the objectives and programs of the department.
7. Accept gifts, grants, matching monies or direct payments from public or private agencies or private persons and enterprises for department services and publications and to conduct programs that are consistent with the general purposes and objectives of this chapter. Monies received pursuant to this paragraph shall be deposited in the department fund corresponding to the service, publication or program provided.
8. Provide for the examination of any premises if the director has reasonable cause to believe that a violation of any environmental law or rule exists or is being committed on the premises. The director shall give the owner or operator the opportunity for its representative to accompany the director on an examination of those premises. Within forty-five days after the date of the examination, the department shall provide to the owner or operator a copy of any report produced as a result of any examination of the premises.
9. Supervise sanitary engineering facilities and projects in this state, authority for which is vested in the department, and own or lease land on which sanitary engineering facilities are located, and operate the facilities, if the director determines that owning, leasing or operating is necessary for the public health, safety or welfare.
10. Adopt and enforce rules relating to approving design documents for constructing, improving and operating sanitary engineering and other facilities for disposing of solid, liquid or gaseous deleterious matter.
11. Define and prescribe reasonably necessary rules regarding the water supply, sewage disposal and garbage collection and disposal for subdivisions. The rules shall:
  - (a) Provide for minimum sanitary facilities to be installed in the subdivision and may require that water systems plan for future needs and be of adequate size and capacity to deliver specified minimum quantities of drinking water and to treat all sewage.
  - (b) Provide that the design documents showing or describing the water supply, sewage disposal and garbage collection facilities be submitted with a fee to the department for review and that no lots in any subdivision be offered for sale before compliance with the standards and rules has been demonstrated by approval of the design documents by the department.
12. Prescribe reasonably necessary measures to prevent pollution of water used in public or semipublic swimming pools and bathing places and to prevent deleterious conditions at those places. The rules shall prescribe minimum standards for the design of and for sanitary conditions at any public or semipublic swimming pool or bathing

place and provide for abatement as public nuisances of premises and facilities that do not comply with the minimum standards. The rules shall be developed in cooperation with the director of the department of health services and shall be consistent with the rules adopted by the director of the department of health services pursuant to section 36-136, subsection I, paragraph 10.

13. Prescribe reasonable rules regarding sewage collection, treatment, disposal and reclamation systems to prevent the transmission of sewage borne or insect borne diseases. The rules shall:

- (a) Prescribe minimum standards for the design of sewage collection systems and treatment, disposal and reclamation systems and for operating the systems.
- (b) Provide for inspecting the premises, systems and installations and for abating as a public nuisance any collection system, process, treatment plant, disposal system or reclamation system that does not comply with the minimum standards.
- (c) Require that design documents for all sewage collection systems, sewage collection system extensions, treatment plants, processes, devices, equipment, disposal systems, on-site wastewater treatment facilities and reclamation systems be submitted with a fee for review to the department and may require that the design documents anticipate and provide for future sewage treatment needs.
- (d) Require that construction, reconstruction, installation or initiation of any sewage collection system, sewage collection system extension, treatment plant, process, device, equipment, disposal system, on-site wastewater treatment facility or reclamation system conform with applicable requirements.

14. Prescribe reasonably necessary rules regarding excreta storage, handling, treatment, transportation and disposal. The rules may:

- (a) Prescribe minimum standards for human excreta storage, handling, treatment, transportation and disposal and shall provide for inspection of premises, processes and vehicles and for abating as public nuisances any premises, processes or vehicles that do not comply with the minimum standards.
- (b) Provide that vehicles transporting human excreta from privies, septic tanks, cesspools and other treatment processes shall be licensed by the department subject to compliance with the rules. The department may require payment of a fee as a condition of licensure. The department may establish by rule a fee as a condition of licensure, including a maximum fee. As part of the rulemaking process, there must be public notice and comment and a review of the rule by the joint legislative budget committee. The department shall not increase that fee by rule without specific statutory authority for the increase. The fees shall be deposited, pursuant to sections 35-146 and 35-147, in the solid waste fee fund established by section 49-881.

15. Perform the responsibilities of implementing and maintaining a data automation management system to support the reporting requirements of title III of the superfund amendments and reauthorization act of 1986 (P.L. 99-499) and article 2 of this chapter.

16. Approve remediation levels pursuant to article 4 of this chapter.

17. Establish or revise fees by rule pursuant to the authority granted under title 44, chapter 9, article 8 and chapters 4 and 5 of this title for the department to adequately perform its duties. All fees shall be fairly assessed and impose the least burden and cost to the parties subject to the fees. In establishing or revising fees, the department shall base the fees on:

(a) The direct and indirect costs of the department's relevant duties, including employee salaries and benefits, professional and outside services, equipment, in-state travel and other necessary operational expenses directly related to issuing licenses as defined in title 41, chapter 6 and enforcing the requirements of the applicable regulatory program.

(b) The availability of other funds for the duties performed.

(c) The impact of the fees on the parties subject to the fees.

(d) The fees charged for similar duties performed by the department, other agencies and the private sector.

18. Appoint a person with a background in oil and gas conservation to act on behalf of the oil and gas conservation commission and administer and enforce the applicable provisions of title 27, chapter 4 relating to the oil and gas conservation commission.

C. The department may:

1. Charge fees to cover the costs of all permits and inspections it performs to ensure compliance with rules adopted under section 49-203, except that state agencies are exempt from paying those fees that are not associated with the dredge and fill permit program established pursuant to chapter 2, article 3.2 of this title. For services provided under the dredge and fill permit program, a state agency shall pay either:

(a) The fees established by the department under the dredge and fill permit program.

(b) The reasonable cost of services provided by the department pursuant to an interagency service agreement.

2. Monies collected pursuant to this subsection shall be deposited, pursuant to sections 35-146 and 35-147, in the water quality fee fund established by section 49-210.

3. Contract with private consultants for the purposes of assisting the department in reviewing applications for licenses, permits or other authorizations to determine

whether an applicant meets the criteria for issuance of the license, permit or other authorization. If the department contracts with a consultant under this paragraph, an applicant may request that the department expedite the application review by requesting that the department use the services of the consultant and by agreeing to pay the department the costs of the consultant's services. Notwithstanding any other law, monies paid by applicants for expedited reviews pursuant to this paragraph are appropriated to the department for use in paying consultants for services.

D. The director may:

1. If the director has reasonable cause to believe that a violation of any environmental law or rule exists or is being committed, inspect any person or property in transit through this state and any vehicle in which the person or property is being transported and detain or disinfect the person, property or vehicle as reasonably necessary to protect the environment if a violation exists.
2. Authorize in writing any qualified officer or employee in the department to perform any act that the director is authorized or required to do by law.

49-922. Department rules and standards; prohibited permittees

A. The director shall adopt rules to establish a hazardous waste management program equivalent to and consistent with the federal hazardous waste regulations promulgated pursuant to subtitle C of the federal act. Federal hazardous waste regulations may be adopted by reference. The director shall not adopt a nonprocedural standard that is more stringent than or conflicts with those found in 40 Code of Federal Regulations parts 260 through 268, 270 through 272, 279 and 124. The director shall not identify a waste as hazardous if not so identified in the federal hazardous waste regulations unless the director finds, based on all the factors in 40 Code of Federal Regulations section 261.11(a)(1), (2), or (3), that the waste may cause or significantly contribute to an increase in serious irreversible or incapacitating reversible illness or pose a substantial present or potential hazard to human health or the environment when it is improperly treated, stored, transported, disposed or otherwise managed.

B. These rules shall establish criteria and standards for the characteristics, identification, listing, generation, transportation, treatment, storage and disposal of hazardous waste within this state. In establishing the standards the director shall, where appropriate, distinguish between new and existing facilities. The criteria and standards shall include requirements respecting:

1. Maintaining records of hazardous waste identified under this article and the manner in which the waste is generated, transported, treated, stored or disposed.
2. Submitting reports, data, manifests and other information necessary to ensure compliance with such standards.

3. Transporting hazardous waste, including appropriate packaging, labeling and marking requirements and requirements respecting the use of a manifest system, which are consistent with the regulations of the state and United States departments of transportation governing transporting hazardous materials.

4. The operation, maintenance, location, design and construction of hazardous waste treatment, storage or disposal facilities, including such additional qualifications as to ownership, continuity of operation, contingency plans, corrective actions and abatement of continuing releases, monitoring and inspection programs, personnel training, closure and postclosure requirements and financial responsibility as may be necessary and appropriate.

5. Requiring a permit for a hazardous waste treatment, storage or disposal facility including the modification and termination of permits, the authority to continue activities and permits existing on July 27, 1983 consistent with the federal hazardous waste regulations and the payment of reasonable fees. The director shall establish and collect reasonable fees from the applicant to cover the cost of administrative services and other expenses associated with evaluating the application and issuing or denying the permit. The director shall establish by rule an application fee to cover the cost of administrative services and other expenses associated with evaluating the application and issuing or denying the permit, including a maximum fee. The fees shall be deposited, pursuant to sections 35-146 and 35-147, in the hazardous waste management fund established by section 49-927.

6. Providing the right of entry for inspection and sampling to ensure compliance with the standards.

7. Providing for appropriate public participation in developing, revising, implementing, amending and enforcing any rule, guideline, information or program under this article consistent with the federal hazardous waste program.

C. The director may refuse to issue a permit for a facility for storage, treatment or disposal of hazardous waste to a person if any of the following applies:

1. The person fails to demonstrate sufficient reliability, expertise, integrity and competence to operate a hazardous waste facility.

2. The person has been convicted of, or pled guilty or no contest to, a felony in any state or federal court during the five years before the date of the permit application.

3. In the case of a corporation or business entity, if any of its officers, directors, partners, key employees or persons or business entities holding ten percent or more of its equity or debt liability has been convicted of, or pled guilty or no contest to, a felony in any state or federal court during the five years before the date of the permit application.

D. This article does not affect the validity of any existing rules adopted by the director that are equivalent to and consistent with the federal hazardous waste regulations until new rules for hazardous waste are adopted.

E. This article does not authorize the regulation of small quantity generators as defined by 40 Code Of Federal Regulations part 262 in a manner inconsistent with the federal hazardous waste regulations. However, the director may require reports of any small quantity generator or group of small quantity generators regarding the treatment, storage, transportation, disposal or management of hazardous waste if the hazardous waste of such generator or generators may pose a substantial present or potential hazard to human health or the environment when it is improperly treated, stored, transported, disposed or otherwise managed.

49-931. Hazardous waste fees; definitions

A. The following fees apply:

1. A person that generates hazardous waste that is shipped off site shall pay a fee for each ton of waste generated. The department shall establish by rule a fee for the generation of hazardous waste that is shipped off site, including a maximum fee. Hazardous waste that is shipped off site to a facility that is in this state and that is owned or operated by the same person that generates the waste is exempt from the fees in this paragraph.

2. An owner or operator of a facility that disposes of hazardous waste shall pay a fee for each ton of waste disposed. The department shall establish by rule a fee for an owner or operator of a facility that disposes of hazardous waste, including a maximum fee. Hazardous waste that is disposed at a facility that is owned or operated by the same person that generates the waste is exempt from the fee in this paragraph.

3. A person that generates hazardous waste that is retained on site for disposal or that is shipped off site for disposal to a facility that is owned or operated by that generator shall pay a fee for each ton of hazardous waste delivered to the disposal facility. The department shall establish by rule a fee for each ton of hazardous waste delivered to the disposal facility, including a maximum fee.

B. Each operator or person that is required to pay a fee as prescribed by this section shall make the fee payment as determined by the department.

C. The department shall collect all fees due under this section and shall deposit, pursuant to sections 35-146 and 35-147, those fees in the hazardous waste management fund established by section 49-927. Each fee payment shall be accompanied by a form furnished by the department and completed by the operator or person. The form shall state the total volume or weight of hazardous waste generated or disposed at that facility during the payment period and shall provide any other

information deemed necessary by the department. The operator or person shall sign the form.

D. If an operator or person fails to pay the fee prescribed by this section, the operator or person is additionally liable for interest on the unpaid amount at the rate prescribed by section 44-1201.

E. State agencies, including state universities, are not exempt from the fees prescribed by this section.

F. For the purposes of this section:

1. "Generates" means the act or process of producing hazardous waste and includes importing hazardous waste into this state for disposal.

2. "Off site" means any transportation that is not on site as defined in section 49-851.

3. "Person" means an individual, trust, firm, joint stock company, corporation, including a government corporation, partnership, association, state, municipality, commission, political subdivision of this state, interstate body or federal facility.

#### RELEVANT DEFINITIONS

#### 9-921. Definitions

In this article, unless the context otherwise requires:

1. "Disposal" means discharging, depositing, injecting, dumping, spilling, leaking or placing hazardous waste into or on land or water so that hazardous waste or any constituent of hazardous waste may enter the environment, be emitted into the air or discharged into any waters, including groundwater.

2. "Facility" includes all contiguous land and structures, other appurtenances and improvements on the land used for treating, storing or disposing of hazardous waste. A facility may consist of several treatment, storage or disposal units.

3. "Federal act" means the solid waste disposal act, as amended by the resource conservation and recovery act of 1976 and the hazardous and solid waste amendments of 1984 (P.L. 94-580; 90 Stat. 2795).

4. "Generation" means the act or process of producing hazardous waste.

5. "Hazardous waste" means garbage, refuse, sludge from a waste treatment plant, water supply treatment plant or air pollution control facility, or other discarded materials, including solid, liquid, semisolid or contained gaseous material, resulting from industrial, commercial, mining and agricultural operations or from community activities which because of its quantity, concentration or physical, chemical or

infectious characteristics may cause or significantly contribute to an increase in mortality or an increase in serious irreversible or incapacitating reversible illness or pose a substantial present or potential hazard to human health or the environment if improperly treated, stored, transported, disposed of or otherwise managed or any waste identified as hazardous pursuant to section 49-922. Hazardous waste does not include solid or dissolved material in domestic sewage, solid or dissolved materials in irrigation return flows or industrial discharges which are point sources subject to permits under section 402 of the federal water pollution control act (P.L. 92-500; 86 Stat. 816), as amended, or source, special nuclear or by-product material as defined by the atomic energy act of 1954 (68 Stat. 919), as amended.

6. "Key employee" means any person employed by an applicant or permittee in a supervisory capacity or empowered to make discretionary decisions with respect to the solid waste or hazardous waste operations of the business concern. Key employee does not include an employee exclusively engaged in the physical or mechanical collection, transportation, treatment, storage or disposal of solid or hazardous waste.

7. "Manifest" means the form used for identifying the quantity, composition, origin, routing and destination of hazardous waste during its transportation from the point of generation to the point of disposal, treatment or storage.

8. "Person" means an individual, trust, firm, joint stock company, corporation, including a government corporation, partnership, association, state, municipality, commission, political subdivision of the state, interstate body or federal facility.

9. "Storage" means the holding of hazardous waste for a temporary period at the end of which the hazardous waste is treated, disposed of or stored elsewhere.

10. "Transportation" means the movement of hazardous waste by air, rail, highway or water.

11. "Treatment" means a method, technique or process designed to change the physical, chemical or biological character or composition of hazardous waste so as to neutralize such waste or to render such waste nonhazardous, safer for transport, amenable for recovery, amenable for storage or reduced in volume.

**ECONOMIC IMPACT STATEMENT  
TITLE 18. ENVIRONMENTAL QUALITY  
CHAPTER 8. DEPARTMENT OF ENVIRONMENTAL QUALITY  
HAZARDOUS WASTE MANAGEMENT**

Identification of the rulemaking: 18 A.A.C. 8, Article 2, amending R18-8-260 and R18-8-270. (For further information, see Part 6 of the preamble.) These rules are not designed to change the conduct of any regulated hazardous waste entities. The rules are designed to collect fees from some hazardous waste entities. The per ton and maximum fees for generation and/or disposal of hazardous waste are increased in R18-8-260. The hourly rate is increased for processing hazardous waste permits in R18-8-270.

Program Description. Under A.R.S. § 49-922 and federal law, Arizona's Hazardous Waste Program is responsible for ensuring that all regulated hazardous waste in Arizona is treated, stored, transported, and disposed of properly, and is largely a preventative program to keep hazardous waste from entering the environment. The program maintains an inventory of hazardous waste generators, transporters, and treatment, storage and disposal (TSD) facilities in Arizona. Permits are issued, managed, and maintained for TSD facilities and this activity includes permit modifications, renewals, closure plans, and financial assurance reviews. Generators, transporters and TSD facilities are periodically inspected. Hazardous waste complaints are investigated. Compliance data is collected and stored. Hazardous waste is tracked from generation to disposal. Compliance assistance is provided, enforcement actions are pursued against significant violators, and oversight is provided for the remediation of contaminated sites.

Regulatory Universe. ADEQ's Hazardous Waste Program regulates a universe of over 1,500 facilities, including metal platers, chemical manufacturers, laboratories, explosive and munition manufacturers, pesticide manufacturers, hazardous waste TSD facilities, and military installations. There are currently approximately 14 permitted TSD facilities, 141 large quantity generators, 1,276 small quantity generators, and 99 transporters.

Current Hazardous Waste Staff and FY24 costs. With a continued shortage of funds, the Hazardous Waste Program would have experienced a reduction in staffing levels from the current 15 FTEs. ADEQ believes this staffing level represents the minimum necessary to process the existing and future workload efficiently and within applicable licensing time-frames. Factoring in cost increases since 2012 and future predicted cost increases, the budget necessary to operate the Hazardous Waste Program in FY24 is approximately \$2.1 million. Without a fee increase, the hazardous waste permitting and generation fees generated would be, at best, the FY22 level, or approximately \$1.3 million. This rule was designed to address the FY24 deficit, projected to be \$800,000. Hazardous Waste Programs staffing levels will not expand as a result of this rulemaking, other than filling any vacancies

Recent Implemented Efficiencies. In the past decade, the Hazardous Waste Program has employed two significant tools to accomplish more required work with fewer resources: lean principles from the Arizona Management System and the myDEQ platform for online processing of many items formerly handled by paper. Permitting program efficiencies in this timeframe include permits being processed 567% faster at one fourth of their former cost. Compliance and inspection improvements include increased outreach, facility inspections increased 169%, and facilities returning to compliance 246% faster since 2016. The program also administers the Pollution Prevention program, processing 175-200 reports annually on facility progress. The ADEQ Hazardous Waste Program launched registration and data reporting under the myDEQ platform, and removed the requirement for a facility annual report in favor of a biennial report consistent with EPA's rules. Finally, two recent rulemakings have allowed the Program to be up to date with respect to federal rule adoption and authorized by EPA.

Discussion and Demonstration: The Regulatory Objective. A.R.S. § 49-922 requires that ADEQ establish and implement a hazardous waste management program “equivalent to and consistent with” the federal hazardous waste program. EPA likewise requires states to adopt a program at least as stringent as the federal program in order to be authorized to implement the federal program in lieu of EPA. As a result of being authorized, ADEQ receives RCRA

grant funding from EPA to partially offset the cost of running the program. Through the grant and delegation process, EPA maintains close scrutiny of the Arizona program and requires it to achieve certain benchmarks.

Based on stakeholder comments, most in the regulated community agree that ADEQ should implement the federal program rather than EPA, and that ADEQ should continue to meet the criteria and benchmarks for program authorization in order to implement the program and receive the federal RCRA (Resource Conservation and Recovery Act) grant. The FY22 EPA grant provided approximately \$1 million to ADEQ and must be spent according to grant provisions. There is usually some money earmarked specifically for program activities at the Mexico border. In addition, Arizona must match the RCRA grant with 25% additional state funds.

Resource Reduction Impacts. Failure to adequately staff and fund the program could cause the loss of the EPA authorized program and approximately \$1 million in federal dollars. If the program reverts back to EPA, Arizona would lose control over enforcement and permitting decisions. If the program continues to receive federal dollars, but is not adequately funded by the state, efforts would be focused on the EPA grant required performance measures. Continuation of some services, such as outreach, technical assistance, timely complaint response, and inspections of small and very small quantity generators, and transporters could cease, with a resulting impact on public health and safety.

Least burden and cost; description of alternatives. A.R.S. § 41-1052(D)(3) requires ADEQ to demonstrate it has selected the alternative with the least burden and cost necessary to achieve the underlying regulatory objective. A nearly identical issue was discussed in part 6 of the Preamble with regard to A.R.S. § 49-104(B)(17), which requires that the fees should “be fairly assessed and impose the least burden and cost to the parties subject to the fees”; and that the fees are to be based on “the direct and indirect costs of the department’s relevant duties” . . . “related to issuing licenses” . . . “and enforcing the requirements of the applicable regulatory program.”

In the context of this hazardous waste rule, ADEQ has interpreted these two main requirements to mean collecting an amount necessary to maintain an approvable program and satisfy the detailed requirements to protect human health and the environment from hazardous wastes that are specified in A.R.S. § 49-922. ADEQ considers “fairly assessed” to mean that the amount of fees collected from any class of hazardous waste entities should not be disproportionate to the “direct and indirect costs” that can be attributed to that class.

Alternatives. In 2012, several members of the regulated community requested that ADEQ consider additional fee scenarios that would keep the generator site maximums lower than the amounts being considered by ADEQ. At that time, ADEQ determined that the adopted balance of maximum and per ton rates was the best possible for small business. For this rule, ADEQ has determined that other combinations of per ton fees and generator site maximums necessary to erase the \$800,000 structural deficit would increase either the per ton fees or the generator site maximums more than the CPI increase for the same period.

ADEQ considered the impact of the fees on the parties subject to the fees as shown by its collection of the least amount of fees necessary to sustain an approvable program, and a fair, proportional assessment of those fees.

Cost/Benefit. The probable costs for this rule are the \$800,000 in estimated increased fees necessary for the maintenance of the program described above. These costs will be incurred primarily by private and government entities that generate hazardous waste and to a lesser degree by hazardous waste TSD facilities that need a permit or permit action such as a modification.

The probable benefits are:

- *Ability of Arizona to implement the federal hazardous waste program.* EPA currently does not have the staff to perform hazardous waste inspections and permitting activities in Arizona; therefore, if the program reverted to EPA, there could be a significant period of

time during which there would be no hazardous waste oversight in Arizona, including responding to citizens' complaints regarding hazardous waste issues. In terms of permitting activities, ADEQ is held to specific licensing time frames to issue hazardous waste permits in a timely manner; EPA would not be bound by Arizona's rules on licensing time frames. EPA administration of the hazardous waste program would most certainly result in a delay of statutorily mandated permit processing, causing Arizona businesses to delay start-up, expansion or modification.

- *Local control over enforcement and permitting decisions:* Hazardous waste enforcement and permitting are inexact processes. ADEQ engages heavily with the regulated community during these processes. Arizona businesses could suffer from the inability to engage with the regulators in a timely manner at a convenient location since they would have to engage with EPA Region 9 staff in San Francisco. Furthermore, the regulated community could no longer take advantage of ADEQ's efforts to educate regulated entities about enforcement policies. ADEQ developed the Compliance and Enforcement Handbook, which is available to the public, with the purpose of promoting appropriate, consistent, and timely enforcement of Arizona's environmental statutes and rules in a manner that is transparent to all who are affected, including the regulated community. EPA does not have a similar guidance document that is tailored to the needs of Arizona businesses.
- *Control over other hazardous waste activities:* RCRA has numerous reporting requirements for generators of hazardous waste. Because Arizona has the authority to implement the hazardous waste program, the business community in Arizona submits documentation to and requests required information (e.g., EPA identification numbers) from ADEQ. Absent an Arizona-specific hazardous waste program, Arizona businesses will be forced to submit reports to and request needed information from EPA in San Francisco. ADEQ receives dozens of calls each month from Arizona businesses handling hazardous waste, requesting compliance assistance. In addition, a significant amount of compliance assistance takes place during inspections. This service to Arizona businesses would no longer be available.

- *Arizona businesses will be subject to Arizona's Penalty Authority rather than EPA's Administrative Penalty Authority:* ADEQ has authority to seek a penalty of up to \$1,000 per day for the violation of a Compliance Order [A.R.S. § 49-923] or to seek penalties of up to \$25,000 per day for violations of the Arizona Hazardous Waste Management Act [A.R.S. § 49-924]. In contrast, EPA can assess a penalty of up to \$37,500 per day for violations under RCRA and this amount is periodically adjusted for inflation. EPA's penalty authority places the burden on the responsible party to contest EPA's alleged violations whereas ADEQ's places the burden on the state.
  
- *Rulemaking oversight:* A.R.S. § 49-922 requires the Director to adopt rules to establish a hazardous waste program. Hazardous waste rules adopted by ADEQ currently go through the Governor's Regulatory Review Council and stakeholder review processes. When EPA adopts a new regulation, Arizona currently has the authority to review the regulation and decide whether to propose it for adoption. If the Hazardous Waste Program reverted to EPA, Arizona would lose the ability to decide whether to adopt federal regulations; future EPA regulations would become effective in Arizona at the same time they became effective nationwide.
  
- *Compliance assistance outreach to regulated community:* Throughout the year, ADEQ staff participates in numerous conferences and training seminars with the goal of educating the regulated community about ADEQ hazardous waste requirements and policies. It is unlikely that EPA would schedule trips to Arizona for staff to participate in short-term outreach events.
  
- *Increased Staffing Flexibility.* With sufficient funds, ADEQ can more quickly fill any vacancies and maintain sufficient funding for those positions.

In addition to these benefits, there is a general benefit to the state budget when the Hazardous Waste Program can maintain a fee-based revenue system without the need for General Fund support. At the same time, this rule is fair and equitable, in that more of the costs of the Hazardous Waste Program will be borne by those who need the ability to legally generate and dispose of hazardous waste.

For these reasons, ADEQ believes that the benefits exceed the cost.

Rules More Stringent than Corresponding Federal Law [A.R.S. § 41-1052(D)(9)] There is no corresponding federal law related to hazardous waste fees.

Probable Impact on Political Subdivisions of this State Directly Affected by this Rulemaking [A.R.S. § 49-1055 (B)(3)(b)]

Political subdivisions that will be directly impacted by this fee rule are generators of hazardous waste, or ones that hold or apply for a hazardous waste permit. Several municipal water treatment plants are hazardous waste generators. One municipal wastewater treatment plant is a large quantity generator (LQG) which generated approximately 73 tons of hazardous waste in 2021. Assuming hazardous waste generation there remains the same, it is impacted by this fee rule with approximately a \$1,424 increase: \$6,351 versus \$4,927.50 previously. Other municipal treatment plants are small quantity generators. In 2021, the three state universities together generated a total of 97 tons of hazardous waste. The average impact to each university of the generation fee being increased from \$67.50 is 97 tons X \$19.50 or \$1,891, divided by 3, or \$630. This is less than the cost of one student's yearly in-state tuition. ADEQ has classified these impacts as minimal.

Reduction of Impact on Small Businesses [A.R.S. § 41-1035] requires state agencies to reduce the impact of a rulemaking on small businesses, if any of the following methods are legal and feasible in meeting the statutory objectives which are the basis of the rule making:

1. Establish less stringent compliance or reporting requirements in the rule for small businesses.

2. Establish less stringent schedules or deadlines in the rule for compliance or reporting requirements for small businesses.
3. Consolidate or simplify the rule's compliance or reporting requirements for small businesses.
4. Establish performance standards for small businesses to replace design or operational standards in the rule.
5. Exempt small businesses from any or all requirements of the rule.

The listed methods are not generally relevant to a rule establishing fees, (fees must be fairly assessed and based on direct and indirect costs). ADEQ believes that small businesses experience a reduced impact because they generate less hazardous waste.

Probable Impact on Small Businesses. [A.R.S. § 41-1055(B)(5)] ADEQ has looked at its database of hazardous waste generators and permittees and tried to determine which ones are likely to be small businesses. One example is dry cleaners. Dry cleaners are often independently owned and operated and not likely to exceed the revenue and employee limits in the statutory definition of small business. Most dry cleaners are also SQGs, so that the impact of the increased generation fees will be based on an annual generation of approximately 12 tons or less. It is likely that most small businesses that generate hazardous waste will be small quantity generators and that these increased generation fees will have only a limited to moderate impact on them.

**CITIZENS CLEAN ELECTION COMMISSION**

Title 2, Chapter 20

Amend: R2-20-211, R2-20-220, R2-20-223



# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - REGULAR RULEMAKING

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**MEETING DATE:** March 7, 2023

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** February 13, 2023

**SUBJECT:** **CITIZENS CLEAN ELECTION COMMISSION**  
Title 2, Chapter 20

Amend: R2-20-211, R2-20-220, R2-20-223

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### **Summary:**

This regular rulemaking from the Citizens Clean Election Commission (Commission) seeks to amend three (3) rules in Title 2, Chapter 20, Article 2 regarding Compliance and Enforcement Procedures. Specifically, the Commission is amending its rules to clarify how the Commission may issue subpoenas, take depositions, prevent ex parte communications, and draft notices of appealable agency actions. For example, the Commission is clarifying that the Executive Director may delegate the authority to issue subpoenas and take depositions to any person authorized to provide legal services for the Commission and such person may also draft and serve notice of an appealable agency action.

**1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?**

The Commission has both general and specific statutory authority for these rules. A.R.S. § 16-956(C) states, "[t]he commission may adopt rules to carry out the purposes of this article and to govern procedures of the commission." A.R.S. § 16-956(A)(6) states, the Commission shall "[a]dopt rules to implement the reporting requirements of section 16-958, subsections D

and E.” Furthermore, A.R.S. § 16-956(A)(7) states the Commission shall, “[e]nforce this article, ensure that money from the fund is placed in candidate campaign accounts or otherwise spent as specified in this article and not otherwise, monitor reports filed pursuant to this chapter and financial records of candidates as needed and ensure that money required by this article to be paid to the fund is deposited in the fund.”

A.R.S. § 16-956(B) also states, “[t]he commission may subpoena witnesses, compel their attendance and testimony, administer oaths and affirmations, take evidence and require by subpoena the production of any books, papers, records or other items material to the performance of the commission's duties or the exercise of its powers.” Additionally, A.R.S. § 16-974(A) states the Commission may “[a]dopt and enforce rules,” “[i]ssue and enforce civil subpoenas, including third-party subpoenas,” “[i]nitiate enforcement actions,” “[c]onduct fact-finding hearings and investigations,” and “[p]erform any other act that may assist in implementing this chapter.” *See* A.R.S. § 16-974(A)(1)-(4) & (8).

**2. Do the rules establish a new fee or contain a fee increase?**

This rulemaking does not establish a new fee or contain a fee increase.

**3. Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

The Commission indicates it did not review or rely on any study relevant to the proposed amended rules.

**4. Summary of the agency’s economic impact analysis:**

The Commission states that the rule revisions are intended to simplify and clarify responsibility for procedures relating to compliance and enforcement. There is little to no economic, small business, or consumer impact, other than the cost to the Commission to prepare the rule package, because the rulemaking simply clarifies statutory requirements and processes that already exist. Thus, the economic impact is minimized.

**5. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Commission believes this is the least intrusive or less costly method for completing its objectives with the rulemaking.

**6. What are the economic impacts on stakeholders?**

The Commission states that the primary group impacted by these rules would be candidates for state and legislative office, political parties and committees, nonprofits, and other groups that make candidate related expenditures. The Commission believes that the amendments should help with ease of implementing the compliance and enforcement of rules and should not

increase costs for impacted parties. The amendments are intended to lower or eliminate transaction costs associated with ensuring compliance and enforcement procedures.

7. **Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

The Commission indicates there were not changes between the Notice of Proposed Rulemaking published in the Administrative Register and the Notice of Final Rulemaking now before the Council

8. **Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**

The Commission indicates it did not receive any public comments related to this rulemaking.

9. **Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

Not applicable. The rules do not require a permit, license, or agency authorization.

10. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Commission indicates there are no corresponding federal laws applicable to the subject of this rulemaking.

11. **Conclusion**

This regular rulemaking from the Citizens Clean Election Commission (Commission) seeks to amend three (3) rules in Title 2, Chapter 20, Article 2 regarding Compliance and Enforcement Procedures. Specifically, the Commission is amending its rules to clarify how the Commission may issue subpoenas, take depositions, prevent ex parte communications, and draft notices of appealable agency actions.

The Commission is seeking the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032(A). Council staff recommends approval of this rulemaking.

December 28, 2022

Ms. Nicole Sornsin, Chair  
The Governor's Regulatory Review Council  
100 North 15th Avenue, Ste. 402  
Phoenix, AZ 85007

**Re: A.A.C. Title 2. Administration  
Chapter 20. Citizens Clean Elections Commission**

Dear Ms. Sornsin:

The attached final rule package is submitted for review and approval by the Council. The following information is provided for Council's use in reviewing the rule package:

1. Close of record date: The rulemaking record was closed on December 15, 2022 following a period for public comment and an oral proceeding.
2. Relation of the rulemaking to a five-year-review report: This rulemaking does not relate to a Five-year Review Report.
3. New fee or fee increase: This rulemaking does not establish a new fee or increase an existing fee.
4. Immediate effective date: An immediate effective date is not requested.
5. Certification regarding studies: I certify that the Commission did not rely on any studies for this rulemaking.
8. Certification that the preparer of the EIS notified the JLBC of the number of new full-time employees necessary to implement and enforce the rule: I certify that the rules in this rulemaking will not require a state agency to employ a new full-time employee. No notification was provided to JLBC.
9. List of documents enclosed:
  - a. Cover letter signed by the Commission's Executive Director;
  - b. Notice of Final Rulemaking including the preamble, table of contents for the rulemaking, and rule text; and
  - c. Economic, Small Business, and Consumer Impact Statement.

Sincerely,



Tom Collins  
Executive Director

NOTICE OF FINAL RULEMAKING

TITLE 2. ADMINISTRATION

CHAPTER 20. CITIZENS CLEAN ELECTIONS COMMISSION

PREAMBLE

**1. Articles, Parts, and Sections Affected**

**Rulemaking Action**

R2-20-211

Amend

R2-20-220

Amend

R2-20-223

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. §§ 16-956(A)(6) and (A)(7)

Implementing statutes: A.R.S. § 16-948(C)

**3. The effective date for the rules:**

As specified under A.R.S. § 41-1032(A), the rule will be effective 60 days after the rule package is filed with the Office of the Secretary of State.

**a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):**

Not applicable.

**b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):**

Not applicable.

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

Notice of Rulemaking Docket Opening: 28 A.A.R. 3489, October 28, 2022

Notice of Proposed Rulemaking: 28 A.A.R. 3409, October 28, 2022

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

Name: Tom Collins, Executive Director

Address: Citizens Clean Elections Commission  
1802 W. Jackson St.  
Phoenix, AZ 85007  
Telephone: (602) 364-3477  
E-Mail: [ccec@azcleaselections.gov](mailto:ccec@azcleaselections.gov)  
Web site: [www.azcleaselections.gov](http://www.azcleaselections.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 Commission needs to amend its rules to clarify how the Commission may issue subpoenas, take depositions, prevent ex parte communications, and draft notices of appealable agency actions. Such clarification will ensure the rules are clear, concise, and consistent and the public is aware of how the Commission ensures compliance with clean elections rules and statutes.

**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:**

No study was reviewed.

**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:**

There is little to no economic, small business, or consumer impact, other than the cost to the Commission to prepare the rule package, because the rulemaking simply clarifies statutory requirements and processes that already exist. Thus, the economic impact is minimized.

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

There were no changes between the proposed rulemaking and the final rulemaking.

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

The Commission held an Oral Proceeding on December 15, 2022 and no comments were received.

**12. All agencies shall list any 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:**

None.

**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:**

Not applicable.

**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:**

No analysis was submitted.

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

No materials are incorporated by reference.

**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 2. ADMINISTRATION**  
**CHAPTER 20. CITIZENS CLEAN ELECTIONS COMMISSION**  
**ARTICLE 2. COMPLIANCE AND ENFORCEMENT PROCEDURES**

Section

R2-20-211. Subpoenas and Subpoenas Duces Tecum; Depositions

R2-20-220. Ex Parte Communications

R2-20-223. Notice of Appealable Agency Action

## ARTICLE 2. COMPLIANCE AND ENFORCEMENT PROCEDURES

### R2-20-211. Subpoenas and Subpoenas Duces Tecum; Depositions

- A. The Commission may authorize its Executive Director ~~or Assistant Attorney General~~ to issue subpoenas requiring the attendance and testimony of any person by deposition and to issue subpoenas duces tecum for the production of documentary or other tangible evidence in connection with a deposition or otherwise. The Executive Director may delegate the authority to issue subpoenas to any person authorized to provide legal services. The Executive Director's delegee may delegate this authority to any person authorized to provide legal services as the Executive Director's delegee deems necessary.
- B. If the Commission orders oral testimony to be taken by deposition or for documents to be produced, the subpoena shall so state and shall advise the deponent or person subpoenaed that all testimony will be under oath. The Commission may authorize its Executive Director to take a deposition and have the power to administer oaths. The Executive Director may delegate the authority to take depositions to any person authorized to provide legal services. The Executive Director's delegee may delegate this authority to any person authorized to provide legal services as the Executive Director's delegee deems necessary.
- C. The deponent shall have the opportunity to review and sign depositions taken pursuant to this rule.

### R2-20-220. Ex Parte Communications

- A. In order to avoid the possibility of prejudice, real or apparent, to the public interest in enforcement actions pending before the Commission pursuant to its compliance procedures, except to the extent required for the disposition of ex parte matters as

required by law (for example, during the normal course of an investigation or a conciliation effort), no interested person outside the agency shall make or cause to be made to any Commissioner or any member of any Commission staff any ex parte communication relative to the factual or legal merits of any enforcement action, nor shall any Commissioner or member of the Commission's staff make or entertain any such ex parte communications.

- B. This rule shall apply from the time a complaint is filed with the Commission or from the time that the Commission determines on the basis of information ascertained in the normal course of its statutory responsibilities that it has reason to believe that a violation of a statute or rule over which the Commission has jurisdiction has occurred or may occur, and remains in force until the Commission has finally concluded all action with respect to the matter in question.
- C. Nothing in this Section shall be construed to prohibit contact between a respondent or respondent's attorney and any staff member or other authorized representative of the Commission or the Commission staff ~~attorney or the Administrative Counsel or the Assistant Attorney General~~ in the course of representing the Commission or the respondent with respect to an enforcement proceeding or civil action. No statement made by a Commission representative ~~attorney~~ or staff member shall bind or estop the Commission.

**R2-20-223. Notice of Appealable Agency Action**

If the Commission makes a probable cause finding pursuant to R2- 20-215 or decides to initiate an enforcement proceeding pursuant to R2-20-217, ~~the~~ any person authorized to provide legal services on behalf of the Commission ~~Assistant Attorney General (AAG)~~ shall draft and serve

notice of an appealable agency action pursuant to A.R.S. § 41-1092.03 and § 41-1092.04 on the respondent. The notice shall identify the following:

1. The statute or rule violated and specific facts constituting the violation;
2. A description of the respondent's right to request a hearing and to request an informal settlement conference; and
3. A description of what the respondent may do if the respondent wishes to remedy the situation without appealing the Commission's decision.

**ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT<sup>1</sup>**

**TITLE 2. ADMINISTRATION**

**CHAPTER 20. CITIZENS CLEAN ELECTIONS COMMISSION**

1. Identification of the rulemaking:

The Commission needs to amend its rules related to Compliance and Enforcement Procedures.

- a. The conduct and its frequency of occurrence that the rule is designed to change:
  - b. The harm resulting from the conduct the rule is designed to change and the likelihood it will continue to occur if the rule is not changed:
  - c. The estimated change in frequency of the targeted conduct expected from the rule change:
2. A brief summary of the information included in the economic, small business, and consumer impact statement:
3. The person to contact to submit or request additional data on the information included in the economic, small business, and consumer impact statement:
4. Persons who will be directly affected by, bear the costs of, or directly benefit from the rulemaking:

Candidates for state and legislative office, Political Parties, and Political Committees are directly affected. Additionally, organizations that have tax status under Section 501(a) of the internal revenue code and are either (a) authorized to make candidate related expenditures or, (b) make such expenditures are directly affected. Finally, persons who are agents of any of the above are directly affected.

5. Cost-benefit analysis:

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<sup>1</sup> If adequate data are not reasonably available, the agency shall explain the limitations of the data, the methods used in an attempt to obtain the data, and characterize the probable impacts in qualitative terms. (A.R.S. § 41-1055(C)).

- a. Costs and benefits to state agencies directly affected by the rulemaking including the number of new full-time employees at the implementing agency required to implement and enforce the proposed rule:

No state agencies are directly affected by the rulemaking and no new FTEs are required.

- b. Costs and benefits to political subdivisions directly affected by the rulemaking:

No political subdivision of this state is directly affected by the implementation and enforcement of this amended rule.

- c. Costs and benefits to businesses directly affected by the rulemaking:

No businesses are directly affected by this rulemaking.

6. Impact on private and public employment:

There is not impact of private and public employment.

7. Impact on small businesses<sup>2</sup>:

- a. Identification of the small business subject to the rulemaking:

Small businesses subject to this rulemaking may include political committees and nonprofits that make expenditures and those serve as agents of those entities or other subject to enforcement of substantive law.

- b. Administrative and other costs required for compliance with the rulemaking:

The Commission does not anticipate administrative or other costs for compliance with these procedural amendments. The amendments are intended

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<sup>2</sup> Small business has the meaning specified in A.R.S. § 41-1001(20).

to simplify and clarify responsibility for certain procedures in the context of compliance and enforcement.

d. Description of methods that may be used to reduce the impact on small businesses:

The agency is open to any of the methods prescribed in section 41-1035.

None of them apply to these amendments.

8. Cost and benefit to private persons and consumers who are directly affected by the rulemaking:

The amendments do not impact private or public employment among any person directly affected by the amendments.

9. Probable effects on state revenues:

The amendments have no probable impact on state revenues.

10. Less intrusive or less costly alternative methods considered:

The Commission believes this is the less intrusive or less costly method. The amendments are intended to lower or eliminate transaction costs associated with ensuring compliance and enforcement procedures are clearer and simpler.

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TITLE 2. ADMINISTRATION

CHAPTER 20. CITIZENS CLEAN ELECTIONS COMMISSION

Authority: A.R.S. § 16-956(A)(7)

Supp. 22-1

Editor’s Note: The Office of the Secretary of State, Administrative Rules Division, complied with its legal obligation to publish the Notice of Rule Expiration filed for Sections R2-20-109 and R2-20-111 under A.R.S. § 41-1011(C) and 41-1056(G) and (J)(2) in Supp. 17-2, version 2. As a courtesy to the Commission, the Office also published R2-20-109 and R2-20-111 as adopted and made by the Commission because it stated the Governor’s Regulatory Review Council did not have the authority to file such a notice. On December 14, 2017, the Commission “re-adopted” rules in the disputed Sections of R2-20-109 and R2-20-111; therefore, our Division has removed the expired rule Sections as published in Supp. 17-2, version 2. The Office will not interpret the legality of any actions made by the Commission or the Council as to whether the rules in R2-20-109 and R2-20-111 were effective at 23 A.A.R. 1761 or expired at 23 A.A.R. 1757 between the dates of June 7, and December 14, 2017. Those interested in that issue should consult counsel.

Editor’s Note: The Citizen’s Clean Elections Commission has filed a Notice of Public Information with the Office of the Secretary of State (Office) stating the Governor’s Regulatory Review Council (G.R.R.C.) “cannot effectively repeal the rules” in this Chapter. The Notice also states, “persons subject to the Act and Rules are advised that it is the Commission’s position [sic] that an action of G.R.R.C.... cannot relieve them of their obligations under the Act and Rules.” [published at 23 A.A.R. 1761]

The Office has received a Notice of Rule Expiration from the G.R.R.C. stating R2-20-109 and R2-20-111 have automatically expired [published at 23 A.A.R. 1757]. Under A.R.S. § 41-1056(G), our Office publishes filed G.R.R.C. notices and has included the rule expiration in this Chapter. Since the Office is merely the publisher, it has not, nor will it interpret the legality of the G.R.R.C. authority to “effectively repeal rules.”

Editor’s Note: The Office of the Secretary of State publishes all Code Chapters on white paper (Supp. 02-1).

Editor’s Note: This Chapter contains rules that were adopted under an exemption from the rulemaking provisions of the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 16-956(D). Exemption from A.R.S. Title 41, Chapter 6 means that these rules were not certified by the Attorney General or the Governor’s Regulatory Review Council. Because this Chapter contains rules that are exempt from the regular rulemaking process, the Chapter is printed on blue paper. The rules affected by this exemption appear throughout this Chapter.

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## ARTICLE 1. GENERAL PROVISIONS

### R2-20-101. Definitions

In addition to the definitions provided in A.R.S. § 16-961, the following shall apply to the Chapter, unless the context otherwise requires:

1. "Act" means the Citizens Clean Elections Act set forth in the Arizona Revised Statutes, Title 16, Chapter 6, Article 2.
2. "Audit" means a written report pertaining to an examination of a candidate's campaign finances that is reviewed by the Commission in accordance with A.A.C. Title 2, Chapter 20, Article 4.
3. "Campaign account" means an account at a financial institution designated by a political committee that is used solely for political campaign purposes.
4. "Candidate" means a natural person who receives or gives consent for receipt of a contribution for the person's nomination for or election to any office in this state, and includes the person's campaign committee, the political committee designated and authorized by the person, or any agents or personnel of the person. When not otherwise specified by statute or these rules, "Candidate" includes a Candidate for Statewide Office or a Legislative Candidate.
5. "Candidate for Statewide Office" means:  
A natural person seeking the office of governor, attorney general, secretary of state, treasurer, superintendent of public instruction, or mine inspector
6. "Current campaign account" means a campaign account used solely for election campaign purposes in the present election cycle.
7. "Direct campaign purpose" includes, but is not limited to, materials, communications, transportation, supplies and expenses used toward the election of a candidate. This does not include the candidate's personal appearance, support, or support of a candidate's family member.
8. "Early contributions" means private contributions that are permitted pursuant to A.R.S. § 16-945.
9. "Examination" means an inspection by the Commission or agent of the Commission of a candidate's books, records, accounts, receipts, disbursements, debts and obligations, bank account records, and campaign finance reports related to the candidate's campaign, which may include fieldwork, or a visit to the campaign headquarters, to ensure compliance with campaign finance laws and rules.
10. "Executive Director" means the highest ranking Commission staff member, who is appointed pursuant to A.R.S. § 16-955(J) and is responsible for directing the day-to-day operations of the Commission.
11. "Expressly advocates" means:
  - a. Conveying a communication containing a phrase such as "vote for," "elect," "re-elect," "support," "endorse," "cast your ballot for," "(name of candidate) in (year)," "(name of candidate) for (office)," "vote against," "defeat," "reject," or a campaign slogan or words that in context can have no reasonable meaning other than to advocate the election or defeat of one or more clearly identified candidates.
  - b. Making a general public communication, such as in broadcast medium, newspaper, magazine, billboard, or direct mailer referring to one or more clearly identified candidates and targeted to the electorate of that candidate(s) that in context can have no reasonable meaning other than to advocate the election or defeat of the candidate(s), as evidenced by factors such as the presentation of the candidate(s) in a favorable or unfavorable light, the targeting, placement, or timing of the communication, or the inclusion of statements of the candidate(s) or opponents.
  - c. A communication within the scope of subsection (10)(b) shall not be considered as one that "expressly advocates" merely because it presents information about the voting record or position on a campaign issue of three or more candidates, so long as it is not made in coordination with a candidate, political party, agent of the candidate or party, or a person who is coordinating with a candidate or candidate's agent.
12. "Extension of credit" means the delivery of goods or services or the promise to deliver goods or services to a candidate in exchange for a promise from the candidate to pay for such goods or services at a later date.
13. "Family member" means parent, grandparent, aunt, uncle, child or sibling of the candidate or the candidate's spouse, including the spouse of any of the listed family members, regardless of whether the relation is established by marriage or adoption.
14. "Fair market value" means the amount at which property would change hands between a willing buyer and a willing seller, neither being under any compulsion to buy or sell and both having reasonable knowledge of the relevant facts.
15. "Fixed Asset" means tangible property usable in a capacity that will benefit the candidate for a period of more than one year from the date of acquisition.
16. "Fund" means the Citizens Clean Elections Fund established pursuant to A.R.S. § 16-949(D).
17. "Future campaign account" means a campaign account that is used solely for campaign election purposes in an election that does not include the present or prior primary or general elections.
18. "Independent candidate" means a candidate who is registered as an independent or with no party preference or who is registered with a political party that is not eligible for recognition on the ballot.
19. "Legislative Candidate" means:  
A natural person seeking the office of state senator or state representative.
20. "Officeholder" means a person who has been elected to a statewide office or the legislature in the most recent election, as certified by the Secretary of State, or who is appointed to or otherwise fills a vacancy in such office.
21. "Person," unless stated otherwise, or having context requiring otherwise, means:  
A corporation, company, partnership, firm, association or society, as well as a natural person.
22. "Prior campaign account" means a campaign account used solely for campaign election purposes in a prior election.
23. "Public funds" includes all funds deposited into the Citizens Clean Elections Fund and all funds disbursed by the Commission to a participating candidate.

24. "Solicitor" means a person who is eligible to be registered to vote in this state and seeks qualifying contributions from qualified electors of this state.
25. "Unopposed" means in reference to state senate candidates and statewide candidates other than Corporation Commission, that the candidate is opposed by no candidates who will appear on the ballot. In reference to candidates for the House of Representatives and Corporation Commission, "unopposed" means that no more candidates will appear on the ballot than the number of seats available for the office sought.

**Historical Note**

New Section adopted by exempt rulemaking at 6 A.A.R. 1567, effective June 21, 2000 (Supp. 00-2). Section repealed; new Section made by exempt rulemaking at 8 A.A.R. 588, effective October 17, 2001 (Supp. 02-1). Amended by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4). Amended by exempt rulemaking at 13 A.A.R. 2434, effective August 27, 2007 (Supp. 07-2). Amended by exempt rulemaking at 15 A.A.R. 1156, effective August 31, 2009 (Supp. 09-2). Amended by exempt rulemaking at 19 A.A.R. 3515, effective September 27, 2013 (Supp. 13-4). Amended by final exempt rulemaking at 23 A.A.R. 113, effective December 15, 2016 (Supp. 16-4). Amended by final rulemaking at 28 A.A.R. 491 (March 4, 2022), with an immediate effective date of February 7, 2022 (Supp. 22-1).

**R2-20-102. Repealed**

**Historical Note**

New Section adopted by exempt rulemaking at 6 A.A.R. 1567, effective June 21, 2000 (Supp. 00-2). Section repealed; new Section made by exempt rulemaking at 8 A.A.R. 588, effective October 17, 2001 (Supp. 02-1). Repealed by exempt rulemaking at 19 A.A.R. 3518, effective September 27, 2013 (Supp. 13-4).

**R2-20-103. Communications: Time and Method**

- A. General rule: in computing any period of time prescribed or allowed by the Act or these rules, unless otherwise specified, days are calculated by calendar days, and the day of the act, event, or default from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday. The term "legal holiday" includes New Year's Day, Martin Luther King Jr. Day, President's Day, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day, and any other day appointed as a holiday for employees of the state.
- B. Special rule for periods less than seven days: when the period of time prescribed or allowed is less than seven days, intermediate Saturdays, Sundays, and legal holidays shall be excluded in the computation.
- C. Whenever the Commission or any person has the right or is required to do some act within a prescribed period after the service of any paper by or upon the Commission by regular mail, three calendar days shall be added to the prescribed period.
- D. Whenever the Commission or any person is required to do some act within a prescribed period after the service of paper by or upon the Commission by overnight delivery, the time period shall begin on the date the recipient signs for the overnight delivery.
- E. The Commission shall use the address of the candidate that is provided on the application for certification filed pursuant to A.R.S. § 16-947. A candidate may designate in writing for the Commission to send written correspondence to a person other than the candidate.
- F. If possible, the Commission shall furnish a copy of all communications electronically.
- G. Delivery of subpoenas, orders and notifications to a natural person may be made by handing a copy to the person, or leaving a copy at his or her office with the person in charge thereof, by leaving a copy at his or her dwelling place or usual place of abode with a person of suitable age and discretion residing therein, by mailing a copy by overnight delivery to his or her last known address, or by any other method whereby actual notice is given.
- H. When the person to be served is not an individual, delivery of subpoenas, orders and notifications may be made by mailing a copy by overnight delivery to the person at its place of business or by handing a copy to a registered agent for service, or to any officer, director, or agent in charge of any office of such person, or by mailing a copy by overnight delivery to such representative at his or her last known address, or by any other method whereby actual notice is given.

**Historical Note**

New Section adopted by exempt rulemaking at 6 A.A.R. 1567, effective June 21, 2000 (Supp. 00-2). Section repealed; new Section made by exempt rulemaking at 8 A.A.R. 588, effective October 17, 2001 (Supp. 02-1). Amended by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4). Amended by exempt rulemaking at 12 A.A.R. 758, effective February 15, 2006 (Supp. 06-1). Amended by exempt rulemaking at 13 A.A.R. 2434, effective August 27, 2007 (Supp. 07-2).

**R2-20-104. Certification as a Participating Candidate**

- A. A nonparticipating candidate who accepts contributions up to the limits authorized by A.R.S. § 16-941(B), but later chooses to run as a participating candidate, shall:
  1. Make the change to participating candidate status during the exploratory and qualifying periods only;
  2. Return the amount of each contribution in excess of the individual contribution limit for participating candidates;
  3. Return all Political Action Committee (PAC) monies received;
  4. Not have made expenditures exceeding the early contribution limit, or have spent any part of a contribution exceeding the early contribution limit;
  5. Comply with all provisions of A.R.S. § 16-941 and Commission rules.
  6. Return all contributions received from another candidate's candidate committee.
- B. Money from prior election. If a nonparticipating candidate has a cash balance remaining in the campaign account from the prior election cycle, the candidate may seek certification as a participating candidate in the current election after:
  1. Transferring money from the prior campaign account to the candidate's current election campaign account. The amount transferred shall not exceed the permitted personal monies, early contributions, and debt-retirement contributions, as defined in A.R.S. § 16-945(C), and shall contain contributions received from individuals only;
  2. Spending the money lawfully prior to April 30 of an election year in a way that does not constitute a direct campaign purpose and does not meet the definition of "expenditure" under A.R.S. § 16-901(24); and the event or item purchased is completed or otherwise used and depleted prior to April 30 of an election year;
  3. Remitting the money to the Fund;

or

  4. Holding the money in the prior election campaign account, not to be used during the current election, except as provided pursuant to this Section.

- C. Application for certification as a participating candidate. Pursuant to A.R.S. § 16-947, a candidate seeking certification shall file with the Secretary of State a Commission-approved application and a campaign finance report reflecting all campaign activity to date. In the application, a candidate shall certify under oath that the candidate:
1. Agrees to use all Clean Elections funding for direct campaign purposes only;
  2. Has filed a campaign finance report, showing all campaign activity to date in the current election cycle;
  3. Will comply with all requirements of the Act and Commission rules;
  4. Is subject to all enforcement actions by the Commission as authorized by the Act and Commission rules;
  5. Has the burden of proving that expenditures made by or on behalf of the candidate are for direct campaign purposes;
  6. Will keep and furnish to the Commission all documentation relating to expenditures, receipts, funding, books, records (including bank records for all accounts), and supporting documentation and other information that the Commission may request;
  7. Will permit an audit or examination by the Commission of all receipts and expenditures including those made by the candidate. The candidate shall also provide any material required in connection with an audit, investigation, or examination conducted by the Commission. The candidate shall facilitate the audit by making available in one central location, such as the Commission's office space, records and such personnel as are necessary to conduct the audit or examination, and shall pay any amounts required to be repaid;
  8. Will submit the name and mailing address of the person who is entitled to receive primary and general election funding on behalf of the candidate and the name and address of the campaign depository designated by the candidate. Changes in the information required by this subsection shall not be effective until submitted to the Commission in a letter signed or submitted electronically, by the candidate or the committee treasurer;
  9. Will pay any civil penalties included in a conciliation agreement or otherwise imposed against the candidate;
  10. Will timely file all campaign finance reports with the Secretary of State in an electronic format; and
  11. Will file an amended application for certification reporting any change in the information prescribed in the application for certification within five days after the change.
- D. If certified as a participating candidate, the candidate shall:
1. Only accept early contributions from individuals during the exploratory and qualifying periods in accordance with A.R.S. § 16-945. No contributions may be accepted from political action committees, political parties or corporations;
  2. Not accept any private contributions, other than early contributions and a limited number of \$5 qualifying contributions;
  3. Make expenditures of personal monies of no more than the amounts prescribed in A.R.S. § 16-941(A)(2) for legislative candidates and for statewide office candidates;
  4. Conduct all campaign activity through a single campaign account. A participating candidate shall only deposit early contributions, qualifying contributions and Clean Elections funds into the candidate's current campaign account. The campaign account shall not be used for any non-direct campaign purpose as provided in Article 7 of these rules;
  5. Attend a Commission sponsored candidate training class within 60 days of being certified or within 60 days of the beginning of the qualifying period if the candidate is certified before the beginning of the qualifying period. If the candidate is unable to attend a training class, the candidate shall:
    - a. Notify the Commission that the candidate is unable to attend a training class. The Commission then will send that person the Commission training materials; and
    - b. The candidate shall sign and send to the Commission a statement certifying that he or she has received and reviewed the Commission training materials; and
  6. Limit campaign expenditures. Prior to qualifying for Clean Elections funding, a candidate shall not incur debt, or make an expenditure in excess of the amount of cash on hand. Upon approval for funding by the Secretary of State, a candidate may incur debt, or make expenditures, not to exceed the sum of the cash on hand and the applicable spending limit.
- E. Loans. A participating candidate may accept an individual contribution as a loan or may loan his or her campaign committee personal monies during the exploratory and qualifying periods only. The total sum of the contribution received or personal funds and loans shall not exceed the expenditure limits set forth in A.R.S. § 16-941(A)(1) and (2). If the loan is to be repaid, the loans shall be repaid promptly upon receipt of Clean Elections funds if the participating candidate qualifies for Clean Elections funding. Loans from a financial institution or bank, to a candidate used for the purpose of influencing that candidate's election shall be considered personal monies and shall not exceed the personal monies expenditure limits set forth in A.R.S. § 16-941(A)(2).
- F. A participating candidate may raise early contributions for election to one office and choose to run for election to another office.
- G. Contributions to officeholder expense accounts are subject to the restrictions of A.R.S. § 41-1234.01, contributions prohibited during session; exceptions.

#### Historical Note

New Section adopted by exempt rulemaking at 6 A.A.R. 1567, effective June 21, 2000 (Supp. 00-2). Section repealed; new Section made by exempt rulemaking at 8 A.A.R. 588, effective October 17, 2001 (Supp. 02-1). Amended by exempt rulemaking at 9 A.A.R. 3506, effective April 2, 2002 (Supp. 03-3). Amended by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4). Amended by exempt rulemaking at 12 A.A.R. 758, effective February 15, 2006 (Supp. 06-1). Amended by exempt rulemaking at 13 A.A.R. 3597, effective January 1, 2008 (Supp. 07-4). Amended by exempt rulemaking at 15 A.A.R. 1156, effective August 31, 2009 (Supp. 09-2). Amended by exempt rulemaking at 15 A.A.R. 1420, effective April 30, 2010 (Supp. 09-3). Subsection R2-20-104(C)(8) amended by exempt rulemaking at 19 A.A.R. 1685, effective October 6, 2011; Subsection R2-20-104(D)(5) amended by exempt rulemaking at 19 A.A.R. 1685, effective May 23, 2013 (Supp. 13-2). Amended by final exempt rulemaking at 23 A.A.R. 115, effective December 15, 2016 (Supp. 16-4).

#### **R2-20-105. Certification for Funding**

- A. After a candidate is certified as a participating candidate, pursuant to A.R.S. § 16-947, in accordance with the procedure set forth in R2-20-104, that candidate may collect qualifying contributions only during the qualifying period.
- B. A participating candidate must submit to the Secretary of State, a list of names of persons who made qualifying contributions, an application for funding prescribed by the Secretary of State, the minimum number of original reporting slips, and an amount equal to the sum of the qualifying contributions collected pursuant to A.R.S. § 16-950 no later than one week after the end of the qualifying period. Any and all expenses associated with obtaining the qualifying contributions, including credit card processing fees must be paid for from the candidate's early contributions or personal monies. A candidate may develop his or her own three-part reporting slip for qualifying contributions, or one that is photocopied or computer reproduced, if the form substantially complies with the form prescribed by the Commission. The candidate must comply with the Act and ensure that the original qualifying slip is tendered to the Secretary of State, a copy remains with the candidate, and that a copy is given to the contributor.

- C. A candidate may accept electronic \$5 qualifying contributions for the elected office sought by the candidate. The Secretary of State's secured internet portal must be used to collect electronic \$5 qualifying. A \$5 contribution must accompany every \$5 qualifying contribution form and must be submitted via the Secretary of State's portal using a private electronic payment service, specified by the Secretary of State's Office, bank account, credit or debit card. A non-refundable transaction fee may be assessed on electronic \$5 qualifying contribution transactions. The transaction fee is not a contribution to the candidate's campaign and is paid by the contributor. If excess funds are accumulated by the candidate's campaign based on the transaction fee then all excess funds must be given to the Commission and must be entered into the candidate's campaign finance report in a manner that indicates the transaction fees have been accumulated and transferred.
- D. A solicitor who seeks signatures and qualifying contributions on behalf of a participating candidate shall provide his or her residential address, typed or printed name and signature on each reporting slip. The solicitor shall also sign a sworn statement on the contribution slip avowing that the contributor signed the slip, that the contributor contributed the \$5, that based on information and belief, the contributor's name and address are correctly stated and that each contributor is a qualified elector of this state. If a contribution is received unsolicited, the candidate or contributor may sign the qualifying contribution form as the solicitor and is accountable for all of the responsibilities of a solicitor. Nothing in this rule shall prohibit the use of direct mail or the internet to obtain qualifying contributions as long as an original signature is provided on the qualifying contribution form. The candidate may sign the qualifying contribution form as the solicitor and is accountable for all of the responsibilities of a solicitor. For qualifying contributions received in accordance with subsection (C) of this Section, the residential address and signature of the solicitor is not required.
- E. The Secretary of State has the authority to approve or deny a candidate for Clean Elections funding, pursuant to A.R.S. § 16-950(C) based upon the verification of the qualifying contribution forms by the appropriate county recorder. The county recorder shall disqualify any qualifying contribution forms that are:
  1. Unsigned by the contributor;
  2. Undated; or
  3. That the recorder is unable to verify as matching signature of a person who is registered to vote, on the date specified inside the electoral district the candidate is seeking.
- F. The Secretary of State will notify the candidate and the Commission regarding the approval or denial of Clean Elections funds. A candidate who is denied Clean Elections funding after all of the slips are verified is eligible to submit supplemental qualifying contribution forms for one additional opportunity to be approved for funding pursuant to subsection (G) of this rule.
- G. The amount equal to the sum of the qualifying contributions collected and tendered to the Secretary of State pursuant to A.R.S. § 16-950(B) will be deposited into the fund, and the amount tendered will not be returned to a candidate if a candidate is denied Clean Elections funding.
- H. In accordance with the procedure set forth at A.R.S. § 16-950(C), if the Secretary of State determines that the result of the five percent random sample is less than 110 percent of the slips needed to qualify for funding, then the Secretary of State shall send all of the slips for verification. If the county recorder has verified all of the candidate's signature slips and there is an insufficient number of valid qualifying contribution slips to qualify the candidate for funding, the candidate may make only one supplemental filing of additional qualifying contribution slips and qualifying contributions to the Secretary of State if all of the following apply:
  1. The candidate files at least the minimum number of additional slips needed to qualify for funding;
  2. The slips are not receipts for duplicate contributions from individuals who have previously contributed to that candidate; and
  3. The period for filing qualifying contributions slips has not expired.
- I. The Secretary of State shall forward facsimiles of all of the supplemental qualifying contribution slips to the appropriate county recorders for the county of the contributors' addresses as shown on the contribution slips. The county recorder shall verify all of the supplemental slips within 10 business days after receipt of the facsimiles and shall provide a report to the Secretary of State identifying as disqualified any slips that are unsigned by the contributor or undated or that the recorder is unable to verify as matching the signature of a person who is registered to vote, on the date specified on the slip, inside the electoral district of the office the candidate is seeking. On receipt of the report of the county recorder on all supplemental slips, the Secretary of State shall calculate the candidate's total number of valid qualifying contribution slips and shall approve or deny the candidate for funds.

#### **Historical Note**

New Section adopted by exempt rulemaking at 6 A.A.R. 1567, effective June 21, 2000 (Supp. 00-2). Section repealed; new Section made by exempt rulemaking at 8 A.A.R. 588, effective October 17, 2001 (Supp. 02-1). Amended by exempt rulemaking at 9 A.A.R. 3506, effective April 30, 2002 (Supp. 03-3). Amended by exempt rulemaking at 13 A.A.R. 2434, effective August 27, 2007 (Supp. 07-2). Amended by exempt rulemaking at 16 A.A.R. 1200, effective February 28, 2008 (Supp. 10-2). Subsection R2-20-105(C) amended by exempt rulemaking at 19 A.A.R. 1688, effective October 6, 2011; Subsection R2-20-105(J) amended by exempt rulemaking at 19 A.A.R. 1688, effective May 23, 2013 (Supp. 13-2). Amended by final exempt rulemaking at 23 A.A.R. 117, effective January 1, 2017 (Supp. 16-4).

#### **R2-20-106. Distribution of Funds to Certified Candidates**

- A. Before the initial disbursement of funds, the Commission shall review the candidate's funding application and all relevant facts and circumstances and:
  1. Verify that the number of signatures on the candidate's nominating petitions equals or exceeds the number required pursuant to A.R.S. § 16-322 as follows:
    - a. If the application is submitted before the March 1 voter registration list is determined, the Commission shall verify that the number of signatures on the candidate's nominating petitions equals or exceeds 115 percent of the number required pursuant to A.R.S. § 16-322 based on the prior election voter registration list as determined by the Secretary of State; or
    - b. If the application is submitted after the current year March 1 voter registration list is determined, the Commission shall verify that the number of signatures on the candidate's nominating petitions is equal to or greater than the number required pursuant to A.R.S. § 16-322.
  2. Determine that the required number of qualifying contributions have been received and paid to the Secretary of State for deposit in the Fund; and
  3. Determine whether the candidate is opposed in the election.
- B. In making the determinations described in subsection (A)(3), the Commission shall consider all relevant facts and circumstances, and it shall not be bound by election formalities such as the filing of nominating petitions by others in determining whether an applicant is opposed. Among other evidence the Commission may consider is the existence of exploratory committees or filings made to organize campaign committees of opponents and other like indicia.
- C. The Commission may review and affirm or change its determination that the candidate is or is not opposed until the ballot for the election is established.

- D. Within seven days after a primary election and before the Secretary of State completes the canvass, the Commission shall disburse funds for general election campaigns to the participating candidates who received the greatest number of votes at each primary election, provided that the candidate with the highest number of votes out of the total number of votes, has at least two percentage points greater than the candidate with the next highest votes based on the unofficial results as of that date. In a legislative race for the Arizona House of Representatives, the Commission shall disburse funds for general election campaigns to participating candidates with the highest or second highest number of votes cast, provided such candidate received votes totaling at least two percentage points, of the total ballots cast, larger than the vote total cast for the candidate with the third highest vote total.
- E. Promptly after the Secretary of State completes the canvass, the Commission shall disburse funds for general election campaigns to all eligible participating candidates to whom payment has not been made. If a participating candidate has received funds from the Commission pursuant to subsection (D) and the canvass or recount determines that the candidate is not eligible to appear on the general election ballot, the participating candidate shall return all unused funds to the Fund within 10 days after such determination is made. That candidate shall make no expenditures from general election funds from the date of the canvass.
- F. The Commission may refuse to distribute funds to participating candidates in cases in which the Commission finds evidence of fraud or illegal activity committed by the participating candidate.
- G. Pursuant to A.R.S. § 16-953, a participating candidate shall return to the Fund:
  1. All primary election funds not committed to expenditures (1) during the primary election period; and (2) for goods or services directed to the primary election. A candidate shall not be deemed to have violated A.R.S. § 16-953(A) or this subsection on account of failure to use all materials purchased with primary election funds prior to the primary election, provided such candidate exercises good faith and diligent efforts to comply with the requirement that goods and services purchased with primary election funds be directed to the primary election. Subject to A.R.S. § 16-953(A) and this subsection, a candidate may continue to use goods purchased with primary election funds during the general election period.
  2. All general funds not committed to expenditures (1) during the general election period; and (2) for goods or services directed to the general election.
- H. All funds returned to the Commission pursuant to subsection (G) of this rule, shall be returned to the Fund by a cashier's check drawn on the candidate's campaign bank account. Any fee associated with the issuance of a cashier's check shall be deemed a direct campaign expenditure and reported on the candidate's campaign finance report.
- I. If a participating candidate does not account for any outstanding expenditures in the amount of the funds returned to the Commission, the participating candidate must reconcile the outstanding expenditures with personal monies. Once funds have been returned to the Commission, no further reimbursements from the Clean Elections Fund shall be permitted. Participating candidates may not exceed the primary or general election spending limits.
- J. Commission staff may waive the return of funds if:
  1. The Commission staff determines the amount to be returned is de minimus;
  2. The Commission staff determines the cost of recovery exceeds the amount of the return;
  3. The funds to be returned shall not exceed \$25; and
  4. The Commission is notified of any waiver of the return of funds.

#### **Historical Note**

New Section adopted by exempt rulemaking at 6 A.A.R. 1567, effective June 21, 2000 (Supp. 00-2). Section repealed; new Section made by exempt rulemaking at 8 A.A.R. 588, effective October 17, 2001 (Supp. 02-1). Amended by exempt rulemaking at 13 A.A.R. 2434, effective August 27, 2007 (Supp. 07-2). Amended by final exempt rulemaking at 24 A.A.R. 107, effective December 14, 2017 (Supp. 17-4).

#### **R2-20-107. Candidate Debates**

- A. The Commission shall sponsor debates among statewide and legislative office candidates prior to the primary and general elections. Except as set forth in the subsection below, the Commission shall not be required to sponsor a debate if there is no participating candidate in the election for a particular office.
- B. In the primary election period, the Commission shall sponsor political party primary election debates for every office in which:
  1. There are more candidates appearing on the ballot than there are seats available for the political party's nomination for general election candidates, and
  2. At least one of the candidates is a participating candidate.
- C. The following candidates will not be invited to participate in debates as follows:
  1. In the primary election, write-in candidates for the primary election, independent candidates, no party affiliation or unrecognized party candidates.
  2. In the general election, write-in candidates.
- D. In the event that there is no participating candidate in a primary or general election but there is an election involving candidates who are not unopposed, a candidate may request that the Commission sponsor a debate pursuant to this rule. If the requesting candidate is the sole participant in the debate the format shall be as prescribed in R2-20-107(K).
  1. A nonparticipating candidate who requests a debate pursuant to this rule shall complete and return the invitation form sent to the candidate by the Commission by the deadline identified on the form. Forms received by the Commission past the deadline may still be considered at the discretion of the Commission. Commission staff shall notify all invited candidates if a debate will be sponsored by the Commission and which candidates will participate.
  2. If a candidate requests that the Commission sponsor a debate and fails or refuses to attend the debate, or a candidate agrees to participate in a debate and subsequently fails or refuses to attend the debate sponsored by the Commission, each candidate who fails or refuses to attend the debate shall reimburse the Commission for the cost of debate preparations not to exceed \$10,000 for a non-participating candidate for the legislature and \$25,000 for a non-participating candidate for statewide office. In the event that a candidate requests a general election debate or agrees to participate in a general election debate but does not advance to the general election, the candidate shall not be liable for the reimbursement.
- E. Pursuant to A.R.S. § 16-956(A)(2), all participating candidates certified pursuant to A.R.S. § 16-947 shall attend and participate in the debates sponsored by the Commission. No proxies or representatives are permitted to participate for any candidate and no statements may be read on behalf of an absent candidate.
- F. Unless exempted, if a participating candidate fails to participate in any Commission-sponsored debate, the participating candidate shall be fined \$500.00. For purposes of this Section, each primary or general election shall be considered a separate election.
- G. A participating candidate may request to be exempt from participating in a required debate by doing the following:
  1. Submit a written request to the Commission at least one week prior to the scheduled debate, and

2. State the reasons and circumstances justifying the request for exemption.
- H.** After examining the request to be exempt, the Commission will exempt a candidate from participating in a debate if at least three Commissioners determine that the circumstances are:
1. Beyond the control of the candidate;  
or
  2. Of such nature that a reasonable person would find the failure to attend justifiable or excusable.
- I.** A participating candidate who fails to participate in a required debate may submit a request for excused absence to the Commission.
1. The candidate's request for excused absence shall:
    - a. State the reason the candidate failed to participate in the debate, and
    - b. State the reason the candidate failed to request an exemption in advance, and
    - c. Be submitted to the Commission no later than five business days after the date of the debate the candidate failed to attend.
  2. After examining the request for excused absence, the Commission may excuse a candidate from the penalties imposed if at least three Commissioners determine that the circumstances were:
    - a. Beyond the control of the candidate;  
or
    - b. Of such nature that a reasonable person would find the failure to attend justifiable or excusable.
- J.** When a participating candidate is not opposed in the general election, the candidate shall be exempt from participating in a Commission-sponsored debate for the general election.
- K.** In the event that a participating candidate is opposed in the primary election or general election but is the only candidate taking part in a primary election period or general election period debate, as applicable, the debate will be held and will consist of a 30-minute question and answer session for the single participating candidate. If more than one candidate takes part in the debate, regardless of participation status, the debate will be held in accordance with the procedures established by the Commission staff.

#### **Historical Note**

New Section adopted by exempt rulemaking at 6 A.A.R. 1567, effective June 21, 2000 (Supp. 00-2). Section repealed; new Section made by exempt rulemaking at 8 A.A.R. 588, effective October 17, 2001 (Supp. 02-1). Section repealed by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4). New Section made by exempt rulemaking at 12 A.A.R. 758, effective February 15, 2006 (Supp. 06-1). Amended by exempt rulemaking at 13 A.A.R. 2434, effective August 27, 2007 (Supp. 07-2). Amended by exempt rulemaking at 15 A.A.R. 1156, effective August 31, 2009 (Supp. 09-2). Amended by exempt rulemaking at 19 A.A.R. 1690, effective October 6, 2011 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 4213, effective November 21, 2013 (Supp. 13-4). Amended by final exempt rulemaking at 21 A.A.R. 1627, effective July 23, 2015 (Supp. 15-3). Amended by final exempt rulemaking at 23 A.A.R. 119, effective December 15, 2016 (Supp. 16-4).

#### **R2-20-108. Termination of Participating Candidate Status**

- A.** A candidate may voluntarily request termination of his or her participating candidate status at any time prior to notification by the Commission that such candidate has qualified for Clean Elections funding. To withdraw from participating candidate status, a candidate shall send a letter to the Commission stating the candidate's intent to withdraw and the reason for the withdrawal. The candidate shall not accept any private monies until the withdrawal is approved by the Commission. The Commission shall act on the withdrawal request within seven days. If the Commission takes no action within the seven-day time period, the withdrawal is automatic.
- B.** A candidate's participating candidate status shall automatically terminate if:
1. The candidate fails to make such submissions to the Secretary of State as prescribed in R2-20-105(B) within seven days after the end of the qualifying period, or
  2. The candidate is denied Clean Elections funding by the Secretary of State and the candidate is ineligible to make a supplemental filing with the Secretary of State in accordance with R2-20-105(G).
- C.** A candidate whose participating candidate status has been terminated in accordance with this Section shall be ineligible to receive Clean Elections funding for that election cycle unless he/she reapplies for certification and is in compliance with R2-20-104(A) and (C).
- D.** In the event that a candidate who has collected qualifying contributions decides not to seek certification as a participating candidate, the candidate shall return all qualifying contributions received from contributors who have not given written permission to use their qualify contributions as campaign contributions. Written permission may include a check box on the original \$5 form that authorizes a candidate to treat the qualifying contribution as a general campaign contribution if he or she decides not to participate in the Clean Elections system. If a good faith attempt to return the funds to the contributor is unsuccessful, the contributions shall be submitted to the Fund.

#### **Historical Note**

New Section adopted by exempt rulemaking at 6 A.A.R. 1567, effective June 21, 2000 (Supp. 00-2). Section repealed; new Section made by exempt rulemaking at 8 A.A.R. 588, effective October 17, 2001 (Supp. 02-1). Amended by exempt rulemaking at 13 A.A.R. 2434, effective August 27, 2007 (Supp. 07-2). Amended by exempt rulemaking at 17 A.A.R. 1950, effective August 25, 2011 (Supp. 11-3).

**Revised Editor's Note: The Office will not interpret the legality of any actions made by the Commission or the Governor's Regulatory Review Council as to whether the rules in R2-20-109 and R2-20-111 were effective at 23 A.A.R. 1761 or expired at 23 A.A.R. 1757 between the dates of June 7, and December 14, 2017. Those interested in that issue should consult counsel.**

#### **R2-20-109. Independent Expenditure Reporting Requirements**

- A.** In accordance with A.R.S. § 16-958(E), all persons obligated to file any campaign finance report under any provisions of Chapter 6, Article 2 of the Arizona Revised Statutes shall file such reports using the Secretary of State's Internet-based finance-reporting system, except if:
1. Expressly provided otherwise by another Commission rule; or
  2. That system, or the necessary function on the system, is unavailable, in which case the executive director shall implement a suitable process.
- B.** Independent Expenditure Reporting Requirements.
1. Any person making independent expenditures cumulatively exceeding the amount prescribed in A.R.S. § 16-941(D) in an election cycle shall file campaign finance reports in accordance with A.R.S. § 16-958 and Commission rules.
  2. Any person who fails to file a timely campaign finance report pursuant to A.R.S. § 16-941(D), A.R.S. § 16-958, shall be subject to a civil penalty as prescribed in A.R.S. § 16-942(B). Subsection R2-20-109(B)(4) does not apply to reports pursuant to A.R.S. §§ 16-

941(D) and 16-958 or this subsection. Any expenditure advocating against one or more candidates shall be considered an expenditure on behalf of any opposing candidate or candidates. Penalties shall be assessed as follows:

- a. For an election involving a candidate for statewide office, the civil penalty shall be \$300 per day.
  - b. For an election involving a legislative candidate, the civil penalty shall be \$100 per day.
  - c. The penalties in (a) and (b) shall be doubled if the amount not reported for a particular election cycle exceeds ten (10%) percent of the applicable adjusted primary election spending limit or adjusted general election spending limit.
  - d. The dollar amounts in items (a) and (b), and the spending limits in item (c) are subject to adjustment of A.R.S. § 16-959.
  - e. Penalties imposed pursuant to this subsection shall not exceed twice the amount of expenditures not reported.
3. A.R.S. § 16-942(B) applies to any entity including political committees that accepts contributions or makes expenditures on behalf of any candidate regardless of any other contributions taken or expenditures made and fails to timely file a campaign finance report under Chapter 6 of Title 16, Arizona Revised Statutes. Any expenditure advocating against one or more candidates shall be considered an expenditure on behalf of any opposing candidate or candidates. Penalties shall be assessed as follows:
- a. For an election involving a candidate for statewide office, the civil penalty shall be \$300 per day.
  - b. For an election involving a legislative candidate, the civil penalty shall be \$100 per day.
  - c. The penalties in (a) and (b) shall be doubled if the amount not reported for a particular election cycle exceeds ten (10%) percent of the applicable adjusted primary election spending limit or adjusted general election spending limit.
  - d. The dollar amounts in items (a) and (b), and the spending limits in item (c) are subject to adjustment of A.R.S. § 16-959.
  - e. Penalties imposed pursuant to this subsection shall not exceed twice the amount of expenditures not reported.
4. For purposes of A.A.C. R2-20-109(B)(3):
- a. Subject to A.R.S. § 16-901(43) and notwithstanding any rule to the contrary of that section, an entity shall not be found to have the predominant purpose of influencing elections unless, a preponderance of the evidence establishes that during a two-year legislative election cycle, the total reportable contributions made by the entity, in any combination, in a calendar year exceeds \$1,000 and is more than fifty percent (50%) of the entity's total spending during the election cycle.
    - i. For purposes of this provision, a "reportable contribution" or "reportable expenditure" shall be limited to a contribution or expenditure, as defined in title 16 of the Arizona revised statutes, that must be reported to the Arizona secretary of state, the Arizona citizens clean elections commission, or local filing officer in Arizona. A contribution or expenditure reported to the federal election commission or to the election authority of any other state, but not to the Arizona secretary of state, the Arizona citizens clean elections commission or a local filing officer in Arizona, shall not be considered a reportable contribution or reportable expenditure.
    - ii. For purposes of this provision, "total spending" shall not include volunteer time or fundraising and administrative expenses but shall include all other spending by the organization.
    - iii. For purposes of this provision, grants to other organizations shall be treated as follows:
      - (1) A grant made to a political committee or an organization organized under section 527 of the internal revenue code shall be counted in total spending and as a reportable contribution or reportable expenditure, unless expressly designated for use outside Arizona or for federal elections, in which case such spending shall be counted in total spending but not as a reportable contribution or reportable expenditure.
      - (2) If the entity making a grant takes reasonable steps to ensure that the transferee does not use such funds to make a reportable contribution or reportable expenditure, such a grant shall be counted in total spending but not as a reportable contribution or reportable expenditure.
    - iv. If the entity making a grant earmarks the grant for reportable contributions or reportable expenditures, knows the grant will be used to make reportable contributions or reportable expenditures, knows that a recipient will likely use a portion of the grant to make reportable contributions or reportable expenditures, or responds to a solicitation for reportable contributions or reportable expenditures, the grant shall be counted in total spending and the relevant portion of the grant as set forth in subsection (v) of this section shall count as a reportable contribution or reportable expenditure.
    - v. Notwithstanding subsections (iii) and (iv) the amount of a grant counted as a reportable contribution or reportable expenditure shall be limited to the lesser of the grant or the following:
      - (1) The amount that the recipient organization spends on reportable contributions and reportable expenditures, plus
      - (2) The amount that the recipient organization gives to third parties but not more than the amount that such third parties fund reportable contributions or reportable expenditures.
  - b. Notwithstanding section a above, the commission may nonetheless determine that an entity is not a political committee if, taking into account all the facts and circumstances of grants made by an entity, it is not persuaded that the preponderance of the evidence establishes that the entity is a political committee as defined in title 16 of Arizona Revised Statutes.

#### Historical Note

New Section adopted by exempt rulemaking at 6 A.A.R. 1567, effective June 21, 2000 (Supp. 00-2). Section repealed; new Section made by exempt rulemaking at 8 A.A.R. 588, effective October 17, 2001 (Supp. 02-1). Amended by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4). Amended by exempt rulemaking at 13 A.A.R. 3597, effective January 1, 2008 (Supp. 07-4). Amended by exempt rulemaking at 15 A.A.R. 1156, effective August 31, 2009 (Supp. 09-2). Amended by exempt rulemaking at 16 A.A.R. 152, effective January 29, 2010 (Supp. 10-1). Subsections R2-20-109(A), (A)(4), and (B) through (E) amended by exempt rulemaking at 19 A.A.R. 2923, effective October 6, 2011; Subsections R2-20-109(A) and (C)(2) amended by exempt rulemaking at 19 A.A.R. 2923, effective August 29, 2013; Subsection R2-20-109(C)(3) amended by exempt rulemaking at 19 A.A.R. 2923, effective January 1, 2014 (Supp. 13-3). Amended by exempt rulemaking at 19 A.A.R. 3519, effective September 27, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1329, effective May 22, 2014 (Supp. 14-2). Amended by exempt rulemaking at 20 A.A.R. 2804, effective September 11, 2014 (Supp. 14-3). Subsection R2-20-109(D) amended by final exempt rulemaking at 21 A.A.R. 3168 effective October 29, 2015; subsection R2-20-109(F) amended by final exempt rulemaking at 21 A.A.R. 3168 effective October 30, 2015 (Supp. 15-4). Amended by exempt rulemaking at 22 A.A.R. 2892, effective January 1, 2017 (Supp. 16-3). Amended by final exempt rulemaking at 23 A.A.R. 121, effective January 1, 2017 (Supp. 16-4). Section retained at the request of the Commission at 23 A.A.R. 1761 (Supp. 17-2, version 2). The Commission adopted and unanimously voted to reenact and republish this Section that was "currently in effect" for the purpose of public notice and clarity at 24 A.A.R. 109, effective December 14, 2017 (Supp. 17-4). Amended by final rulemaking at 27 A.A.R. 1568, with an immediate effective date of September 14, 2021 (Supp. 21-3).

## **R2-20-110. Participating Candidate Reporting Requirements**

- A.** All participating candidates shall file campaign finance reports that include all receipts and disbursements for their current campaign account as follows:
1. Expenditures for consulting, advising, or other such services to a candidate shall include a detailed description of what is included in the service, including an allocation of services to a particular election. When appropriate, the Commission may treat such expenditures as though made during the general election period.
  2. If a participating candidate makes an expenditure on behalf of the campaign using personal funds, the candidate's campaign shall reimburse the candidate within seven calendar days of the expenditure. After the 7 day period has passed, the expenditure shall be deemed an in-kind contribution subject to all applicable limits.
  3. A candidate may authorize an agent to purchase goods or services on behalf of such candidate, provided that:
    - a. Expenditures shall be reported as of the date that the agent promises, agrees, contracts or otherwise incurs an obligation to pay for the goods or services;
    - b. The candidate shall have sufficient funds in the candidate's campaign account to pay for the amount of such expenditure at the time it is made and all other outstanding obligations of the candidate's campaign committee; and
    - c. Within seven calendar days of the date upon which the amount of the expenditure is known, the candidate shall pay such amount from the candidate's campaign account to the agent who purchases the goods or services.
  4. A joint expenditure is made when two or more candidates agree to share the cost of goods or services. Candidates may make a joint expenditure on behalf of one or more other campaigns, but must be authorized in advance by the other candidates involved in the expenditure, and must be reimbursed within seven days. Participating candidates may participate in joint expenditures for the cost of goods and services with one or more candidates, subject to the following:
    - a. Joint expenditures must be allocated fairly among candidates. An allocated share of a joint expenditure paid by one candidate pursuant to such an agreement must be reimbursed within seven days.
    - b. Any violator of part (a) shall be liable for a penalty pursuant to R2-20-222, in addition to penalties prescribed by any other law.
    - c. If a fairly allocated share of any joint expenditure is not reimbursed to a candidate, the unreimbursed amount of the joint expenditure fairly allocated to that candidate shall be deemed a contribution to that candidate by the campaign committee of the candidate obligated to reimburse the share.
    - d. If a fairly allocated share of any joint expenditure is not reimbursed to a participating candidate, the candidate obligated to reimburse the share shall reimburse the fund for the unreimbursed amount of the joint expenditure fairly allocated to the obligated candidate, in addition to any penalty specified by law.
    - e. A candidate's payment for an advertisement, literature, material, campaign event or other activity shall be considered a joint expenditure including, but not limited to, the following criteria:
      - i. The activity includes express advocacy of the election or defeat of more than 2 candidates;
      - ii. The purpose of the material or activity is to promote or facilitate the election of a second candidate;
      - iii. The use and prominence of a second candidate or his or her name or likeness in the material or activity;
      - iv. The material or activity includes an expression by a second candidate of his or her view on issues brought up during the election campaign;
      - v. The timing of the material or activity in relation to the election of a second candidate;
      - vi. The distribution of the material or the activity is targeted to a second candidate's electorate; or
      - vii. The amount of control a second candidate has over the material or activity.
  5. For the purposes of the Act and Commission rules, a candidate or campaign shall be deemed to have made an expenditure as of the date upon which the candidate or campaign promises, agrees, contracts or otherwise incurs an obligation to pay for goods or services.
- B.** Timing of reporting expenditures.
1. Except as set forth in subsection (A)(2) above, a participating candidate shall report a contract, promise or agreement to make an expenditure resulting in an extension of credit as an expenditure, in an amount equal to the full future payment obligation, as of the date the contract, promise or agreement is made.
  2. In the alternative to reporting in accordance with subsection (A)(1) above, a participating candidate may report a contract, promise or agreement to make an expenditure resulting in an extension of credit as follows:
    - a. For a month-to-month or other such periodic contract or agreement that is terminable by a candidate at will and without any termination penalty or payment, the candidate may report an expenditure, in an amount equal to each future periodic payment, as of the date upon which the candidate's right to terminate the contract or agreement and avoid such future periodic payment elapses.
    - b. For a contract, promise or agreement to provide goods or services during the general election period that is contingent upon a candidate advancing to the general election period, the candidate may report an expenditure, in an amount equal to the general election period payment obligation, as of the date upon which such contingency is satisfied.
    - c. For a contract, promise or agreement to pay rent, utility charges or salaries payable to individuals employed by a candidate's campaign committee as staff, the candidate may report an expenditure, in an amount equal to each periodic payment, as of the date that is the sooner of (i) the date upon which payment is made; or (ii) the date upon which payment is due.
- C.** Reports and Refunds of Excess Monies by Participating Candidates.
1. In addition to any campaign finance report required by Chapter 6 of Title 16, Arizona Revised Statutes, participating candidates shall file the following campaign finance reports and dispose of excess monies as follows:
    - a. Prior to filing the application for funding pursuant to A.R.S. § 16-950, participating candidates shall file a campaign finance report with the names of the persons who have made qualifying contributions to the candidate.
    - b. At the end of the qualifying period, a participating candidate shall file a campaign finance report consisting of all early contributions received, including personal monies and the expenditures of such monies.
      - i. The campaign finance report shall be filed with the Secretary of State no later than five days after the last day of the qualifying period and shall include all campaign activity through the last day of the qualifying period.
      - ii. If the campaign finance report shows any amount of unspent monies, the participating candidate, within five days after filing the campaign finance report, shall remit all unspent contributions to the Fund, pursuant to A.R.S. § 16-945(B). Any unspent personal monies shall be returned to the candidate or the candidates' family member within five days.
  2. Each participating candidate shall file a campaign finance report consisting of all expenditures made in connection with an election, all contributions received in the election cycle in which such election occurs, and all payments made to the Clean Elections Fund. If the campaign finance report shows any amount unspent, the participating candidate, within five days after filing the campaign

finance report, shall send a check from the candidate's campaign account to the Commission in the amount of all unspent monies to be deposited in the Fund.

- a. The campaign finance report for the primary election shall be filed within five days after the primary election day and shall reflect all activity through the primary election day.
  - b. The campaign finance report for the general election shall be filed within five days after the general election day and shall reflect all activity through the general election day.
3. In the event that a participating candidate purchases goods or services from a subcontractor or other vendor through an agent pursuant to subsection (A)(3), the candidate's campaign finance report shall include the same detail as required in A.R.S. § 16-948(C) for each such subcontractor or other vendor. Such detail is also required when petty cash funds are used for such expenditures.

#### **Historical Note**

New Section adopted by exempt rulemaking at 6 A.A.R. 1567, effective June 21, 2000 (Supp. 00-2). Section repealed; new Section made by exempt rulemaking at 8 A.A.R. 588, effective October 17, 2001 (Supp. 02-1). Amended by exempt rulemaking at 19 A.A.R. 1693, effective May 23, 2013 (Supp. 13-2). Amended by final exempt rulemaking at 21 A.A.R. 1629, effective July 23, 2015 (Supp. 15-3). Section R2-20-110 renumbered to Section R2-20-114; new Section R2-20-110 made by exempt rulemaking at 22 A.A.R. 2897, effective January 1, 2017 (Supp. 16-3). Amended by final exempt rulemaking at 23 A.A.R. 124, effective January 1, 2017 (Supp. 16-4).

***Revised Editor's Note: The Office will not interpret the legality of any actions made by the Commission or the Governor's Regulatory Review Council as to whether the rules in R2-20-109 and R2-20-111 were effective at 23 A.A.R. 1761 or expired at 23 A.A.R. 1757 between the dates of June 7, and December 14, 2017. Those interested in that issue should consult counsel.***

### **R2-20-111. Non-participating Candidate Reporting Requirements**

#### **and Contribution Limits**

- A. Any person may file a complaint with the Commission alleging that any non-participating candidate or that candidate's campaign committee has failed to comply with or violated A.R.S. § 16-941(B). Complaints shall be processed as prescribed in Article 2 of these rules. In addition to those penalties outlined in R2-20-222(B), a non-participating candidate or candidate's campaign committee violating A.R.S. § 16-941(B) shall be subject to penalties prescribed in A.R.S. § 16-941(B) and A.R.S. § 16-942(B) and (C) as applicable:
- B. Penalties under A.R.S. § 16-942(B):
  1. For an election involving a candidate for statewide office, the civil penalty shall be \$300 per day.
  2. For an election involving a legislative candidate, the civil penalty shall be \$100 per day.
  3. The penalties in (B)(1) and (B)(2) shall be doubled if the amount not reported for a particular election cycle exceeds ten percent (10%) of the applicable one of the adjusted primary election spending limit or adjusted general election spending limit.
  4. The dollar amounts in items (B)(1) and (B)(2), and the spending limits in item (B)(3) are subject to adjustment of A.R.S. § 16-959.
- C. Penalties under A.R.S. § 16-942(C): Where a campaign finance report filed by a non-participating candidate or that candidate's campaign committee indicates a violation of A.R.S. § 16-941(B) that involves an amount in excess of ten percent (10%) of the sum of the adjusted primary election spending limit and the adjusted general election spending limits specified by A.R.S. § 16-961(G) and (H) as adjusted pursuant to A.R.S. § 16-959, that violation shall result in disqualification of a candidate or forfeiture of office.
- D. Penalties under A.R.S. § 16-941(B): Regardless of whether or not there is a violation of a reporting requirement, a person who violates A.R.S. § 16-941(B) is subject to a civil penalty of three times the amount of money that has been received, expended, or promised in violation of A.R.S. § 16-941(B) or three times the value in money for an equivalent of money or other things of value that have been received, expended, or promised in violation of A.R.S. § 16-941(B).
- E. The twenty percent reduction in A.R.S. § 16-941(B) applies to all campaign contributions limits on contributions that are permitted to be accepted by nonparticipating candidates.
- F. Contribution limits as adjusted by A.R.S. § 16-931 shall be the base level contribution limits subject to reduction pursuant to A.R.S. § 16-941(B).

#### **Historical Note**

New Section adopted by exempt rulemaking at 6 A.A.R. 1567, effective June 21, 2000 (Supp. 00-2). Section repealed; new Section made by exempt rulemaking at 8 A.A.R. 588, effective October 17, 2001 (Supp. 02-1). Amended by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4). Amended by exempt rulemaking at 13 A.A.R. 2434, effective August 27, 2007 (Supp. 07-2). Amended by exempt rulemaking at 13 A.A.R. 3597, effective January 1, 2008 (Supp. 07-4). Amended by exempt rulemaking at 15 A.A.R. 1156, effective August 31, 2009 (Supp. 09-2). Amended by final exempt rulemaking at 21 A.A.R. 1631, effective July 23, 2015 (Supp. 15-3). Section R2-20-111 renumbered to R2-20-115 at 22 A.A.R. 2904; new Section R2-20-111 made by exempt rulemaking at 22 A.A.R. 2899 effective January 1, 2017 (Supp. 16-3). Amended by final exempt rulemaking at 23 A.A.R. 126, effective January 1, 2017 (Supp. 16-4). Section retained at the request of the Commission at 23 A.A.R. 1761 (Supp. 17-2, version 2). The Commission unanimously adopted and voted to reenact and republish this Section that was "currently in effect" for the purpose of public notice and clarity, with amendments at 24 A.A.R. 111, effective December 14, 2017 (Supp. 17-4).

### **R2-20-112. Political Party Exceptions**

The provisions of A.R.S. § 16-911(B)(4) shall apply to a candidate, whether participating or nonparticipating, who becomes a nominee as defined in A.R.S. § 16-901(38).

#### **Historical Note**

New Section adopted by exempt rulemaking at 6 A.A.R. 1567, effective June 21, 2000 (Supp. 00-2). Section repealed; new Section made by exempt rulemaking at 8 A.A.R. 588, effective October 17, 2001 (Supp. 02-1). Section repealed by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4). New Section made by exempt rulemaking at 13 A.A.R. 3597, effective January 1, 2008 (Supp. 07-4). Amended by exempt rulemaking at 15 A.A.R. 1423, effective October 22, 2009 (Supp. 09-3). Amended by final exempt rulemaking at 23 A.A.R. 128, effective January 1, 2017 (Supp. 16-4).

### **R2-20-113. Candidate Statement Pamphlet**

- A. The Commission shall publish a candidate statement pamphlet in both the primary and general elections as required by A.R.S. § 16-956(A)(1). Commission staff shall send invitations for submission of a 200 word statement to every statewide and legislative candidate

who has qualified for the ballot. Statements submitted for the primary candidate statement pamphlet shall be used for the general candidate statement pamphlet unless otherwise stated by the candidate.

- B.** The following candidates will not be invited to submit a statement for the candidate statement pamphlet:
1. In the primary election: write-in candidates for the primary election, independent candidates, no party affiliation or unrecognized party candidates.
  2. In the general election: write in candidates.

**Historical Note**

New Section adopted by exempt rulemaking at 6 A.A.R. 1567, effective June 21, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 8 A.A.R. 588, effective October 17, 2001 (Supp. 02-1). New Section made by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4). Amended by exempt rulemaking at 13 A.A.R. 2434, effective August 27, 2007 (Supp. 07-2). Amended by exempt rulemaking at 13 A.A.R. 3597, effective January 1, 2008 (Supp. 07-4). Amended by exempt rulemaking at 15 A.A.R. 1156, effective August 31, 2009 (Supp. 09-2). Amended by exempt rulemaking at 15 A.A.R. 1423, effective October 22, 2009 (Supp. 09-3). Amended by exempt rulemaking at 15 A.A.R. 1567, effective September 2, 2009 (Supp. 09-3). Amended by exempt rulemaking at 16 A.A.R. 1200, effective January 8, 2010 (Supp. 10-2). Repealed by exempt rulemaking at 19 A.A.R. 1694, effective October 6, 2011 (Supp. 13-2). New Section made by final exempt rulemaking at 21 A.A.R. 1633, effective July 23, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 2118, effective July 29, 2019 (Supp. 19-3). Amended by final rulemaking at 26 A.A.R. 335, effective February 4, 2020; amendments made to subsection (A) were originally codified in Supp. 19-3 at 25 A.A.R. 2118 (Supp. 20-1).

**R2-20-114. Candidate Campaign Bank Account**

- A.** Each participating candidate shall designate a single campaign bank account for conducting campaign financial activity. During an election cycle, each participating candidate shall conduct all campaign financial activities through a single, current election campaign bank account and any petty cash accounts as are permitted by law.
- B.** A participating candidate may maintain a campaign bank account other than the current election campaign bank account described in subsection (A) if the other campaign bank account is for a campaign in a prior election cycle in which the candidate was not a participating candidate.
- C.** During the exploratory period, a candidate may receive debt-retirement contributions for a campaign during a prior election cycle if the funds are deposited in the bank account for that prior campaign. A candidate shall not deposit debt-retirement contributions into the current election campaign bank account.

**Historical Note**

New Section R2-20-114 renumbered from R2-20-110 by exempt rulemaking at 22 A.A.R. 2897 and 22 A.A.R. 2902, effective January 1, 2017 (Supp. 16-3).

**R2-20-115. Books and Records Requirements**

- A.** All candidates shall maintain, at a single location within the state, the books and records of financial transactions, and other information required by A.R.S. § 16-904.
- B.** All candidates shall ensure that the books and records of accounts and transactions of the candidate are recorded and preserved as follows:
1. The treasurer of a candidate's campaign committee is the custodian of the candidate's books and records of accounts and transactions, and shall keep a record of all of the following:
    - a. All contributions or other monies received by or on behalf of the candidate.
    - b. The identification of any individual or political committee that makes any contribution together with the date and amount of each contribution and the date of deposit into the candidate's campaign bank account.
    - c. Cumulative totals contributed by each individual or political committee.
    - d. The name and address of every person to whom any expenditure is made, and the date, amount and purpose or reason for the expenditure.
    - e. All periodic bank statements or other statements for the candidate's campaign bank account.
    - f. In the event that the campaign committee uses a petty cash account the candidate's campaign finance report shall include the same detail for each petty cash expenditure as required in A.R.S. § 16-948(C) for each vendor.
  2. No expenditure may be made for or on behalf of a candidate without the authorization of the treasurer or his or her designated agent.
  3. Unless specified by the contributor or contributors to the contrary, the treasurer shall record a contribution made by check, money order or other written instrument as a contribution by the person whose signature or name appears on the bottom of the instrument or who endorses the instrument before delivery to the candidate. If a contribution is made by more than one person in a single written instrument, the treasurer shall record the amount to be attributed to each contributor as specified.
  4. All contributions other than in-kind contributions and qualifying contributions must be made by a check drawn on the account of the actual contributor or by a money order or a cashier's check containing the name of the actual contributor or must be evidenced by a written receipt with a copy of the receipt given to the contributor and a copy maintained in the records of the candidate.
  5. The treasurer shall preserve all records set forth in subsection (B) and copies of all campaign finance reports required to be filed for three years after the filing of the campaign finance report covering the receipts and disbursements evidenced by the records.
  6. If requested by the attorney general, the county, city or town attorney or the filing officer, the treasurer shall provide any of the records required to be kept pursuant to this Section.
- C.** Any request to inspect a candidate's records under A.R.S. § 16-958(F) shall be sent to the candidate, with a copy to the Commission, 10 or more days before the proposed date of the inspection. If the request is made within two weeks before the primary or general election, the request shall be delivered at least two days before the proposed date of inspection. Every request shall state with reasonable particularity the records sought.
1. The inspection shall occur at a location agreed upon by the candidate and the person making the request. If no agreement can be reached, the inspection shall occur at the Commission office. The inspection shall occur during the Commission's regular business hours and shall be limited to a two-hour time period.
  2. The requesting party may obtain copies of records for a reasonable fee. The Commission shall not be responsible for making copies. The person in possession of the records shall produce copies within a reasonable time of the receipt of the copying request and fees.
  3. The Commission will not permit public inspection of records if it determines that the inspection is for harassment purposes.

4. If a person who requests to inspect a candidate's records under A.R.S. § 16-958(F) is denied such a request, the requesting party may notify the Commission. The Commission may enforce the public inspection request by issuing a subpoena pursuant to A.R.S. § 16-956(B) for the production of any books, papers, records, or other items sought in the public inspection request. The subpoena shall order the candidate to produce:
  - a. All papers, records, or other items sought in the public inspection request;
  - b. No later than two business days after the date of the subpoena; and
  - c. To the Commission's office during regular business hours.
5. Any person who believes that a candidate or a candidate's campaign committee has not complied with this Section may appeal to Superior Court.

**Historical Note**

New Section R2-20-115 renumbered from R2-20-111 by exempt rulemaking at 22 A.A.R. 2899 and 22 A.A.R. 2904, effective January 1, 2017 (Supp. 16-3).

**ARTICLE 2. COMPLIANCE AND ENFORCEMENT PROCEDURES**

**R2-20-201. Scope**

These rules provide procedures for processing possible violations of the Citizens Clean Elections Act.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-202. Initiation of Compliance Matters**

Compliance matters may be initiated by a complaint or on the basis of information ascertained by the Commission in the normal course of carrying out its statutory responsibilities.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-203. Complaints**

- A. Any person who believes that a violation of any statute or rule over which the Commission has jurisdiction has occurred or is about to occur may file a complaint in writing to the Executive Director.
- B. A complaint shall conform to the following:
  1. Provide the full name and address of the complainant; and
  2. Contents of the complaint shall be sworn to and signed in the presence of a notary public and shall be notarized.
- C. All statements made in a complaint are subject to the statutes governing perjury. The complaint shall differentiate between statements based upon personal knowledge and statements based upon information and belief.
- D. The complaint shall conform to the following provisions:
  1. Clearly identify as a respondent each person or entity who is alleged to have committed a violation;
  2. Statements which are not based upon personal knowledge shall be accompanied by an identification of the source of information which gives rise to the complainant's belief in the truth of such statements;
  3. Contain a clear and concise recitation of the facts which describe a violation of a statute or rule over which the Commission has jurisdiction; and
  4. Be accompanied by any documentation supporting the facts alleged if such documentation is known of, or available to, the complainant.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Amended by exempt rulemaking at 9 A.A.R. 3511, effective May 21, 2002 (Supp. 03-3). Amended by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4).

**R2-20-204. Initial Complaint Processing; Notification**

- A. Upon receipt of a complaint, the Administrative Counsel shall review the complaint for substantial compliance with the technical requirements of R2-20-203, and, if it complies with those requirements, shall within five days after receipt notify each respondent that the complaint has been filed, advise each respondent of Commission compliance procedures, and provide each respondent a copy of the complaint.
- B. If a complaint does not comply with the requirements of R2-20-203, the Administrative Counsel shall so notify the complainant and any person or entity identified therein as respondent, within the five-day period specified in subsection (A), that no action should be taken on the basis of that complaint. A copy of the complaint shall be provided with the notification to each respondent.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Amended by final exempt rulemaking at 21 A.A.R. 1634, effective July 23, 2015 (Supp. 15-3).

**R2-20-205. Opportunity for No Action on Complaint-generated Matters**

- A. A respondent shall be afforded an opportunity to demonstrate that no action should be taken on the basis of a complaint by submitting, within 5 days from receipt of a written copy of the complaint, a letter or memorandum setting forth reasons why the Commission should take no action.
- B. The Commission shall not take any action, or make any finding, against a respondent other than action dismissing the complaint, unless it has considered such response or unless no such response has been served upon the Commission within the 5 day period specified in subsection A.
- C. The respondent's response shall be sworn to and signed in the presence of a notary public and shall be notarized. The respondent's failure to respond in accordance with subsection A within 5 days of receiving the written copy of the complaint may be viewed as an admission to the allegations made in the complaint for purposes of the reason to believe finding pursuant to A.A.C. R2-20-206.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Amended by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4). Amended by final exempt rulemaking at 21 A.A.R. 1636, effective July 23, 2015 (Supp. 15-3).

**R2-20-206. Executive Director's Recommendation on Complaint-generated Matters**

- A. Following either the expiration of the 5 day period specified by A.A.C. R2-20-205 or the receipt of a response as specified by A.A.C. R2-20-205(A), whichever occurs first, the Executive Director:
1. May recommend to the Commission whether it should find reason to believe that a respondent has committed or is about to commit a violation of a statute or rule over which the Commission has jurisdiction;
  2. May recommend that the Commission find that there is no reason to believe that a violation of a statute or rule over which the Commission has jurisdiction has been committed or is about to be committed, or that the Commission otherwise dismiss a complaint without regard to the provisions of A.A.C. R2-20-205(A); or
  3. May close the complaint generated matter without a reason to believe recommendation from the Executive Director based upon Respondent complying with the statute or rule on which the complaint is founded and in such case shall notify the Commission.
- B. Neither the complainant nor the respondent has the right to appeal the Executive Director's recommendation made pursuant to subsection (A) because the recommendation is not an appealable agency action.
- C. If the complaint relates to a violation of A.R.S. § 16-941(B) by a non-participating candidate or that candidate's campaign committee, the Executive Director shall not proceed pursuant to R2-20-206(A) or R2-20-207(A), without first receiving Commission approval to initiate an inquiry.
- D. The respondent shall not have the right to appeal the Commission's decision to authorize an inquiry pursuant to subsection (C) because the Commission's decision whether or not to authorize an inquiry is not an appealable agency action.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Amended by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4). Amended by exempt rulemaking at 12 A.A.R. 758, effective February 15, 2006 (Supp. 06-1). Amended by exempt rulemaking at 20 A.A.R. 1332, effective May 22, 2014 (Supp. 14-2). Amended by final exempt rulemaking at 21 A.A.R. 1638, effective July 23, 2015 (Supp. 15-3).

**R2-20-207. Internally Generated Matters; Referrals**

- A. On the basis of information ascertained by the Commission in the normal course of carrying out its statutory responsibilities, or on the basis of a referral from an agency of the state, the Executive Director may recommend in writing that the Commission find reason to believe that a person or entity has committed or is about to commit a violation of a statute or rule over which the Commission has jurisdiction.
- B. If the Commission finds reason to believe that a violation of a statute or rule over which the Commission has jurisdiction has occurred or is about to occur, the Executive Director shall notify the respondent of the Commission's decision and shall include a copy of a staff report setting forth the legal basis and the alleged facts which support the Commission's action.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Amended by exempt rulemaking at 13 A.A.R. 3524, effective January 1, 2008 (Supp. 07-3).

**R2-20-208. Complaint Processing; Notification**

- A. If the Commission, either after reviewing a complaint-generated recommendation as described in R2-20-206 and any response of a respondent submitted pursuant to R2-20-205, or after reviewing an internally-generated recommendation as described in R2-20-207, determines by an affirmative vote of at least three of its members that it has reason to believe that a respondent has violated a statute or rule over which the Commission has jurisdiction, the Commission shall notify such respondent of the Commission's finding, setting forth the sections of the statute or rule alleged to have been violated and the alleged factual basis supporting the finding. In accordance with A.R.S. § 16-957(A), the Commission shall serve on the respondent an order requiring compliance within 14 days. During that period, the respondent may provide any explanation to the Commission, comply with the order, or enter into a public administrative settlement with the Commission.
- B. If the Commission finds no reason to believe that a violation of a statute or rule over which the Commission has jurisdiction has occurred, or otherwise terminates its proceedings, the Executive Director shall so notify both the complainant and respondent.
- C. The complainant may bring an action in Superior Court in accordance with A.R.S. § 16-957(C) if the Commission finds there is no reason to believe a violation of a statute or rule over which the Commission has jurisdiction has occurred or otherwise terminates its proceedings.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Amended by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4). Amended by exempt rulemaking at 12 A.A.R. 758, effective February 15, 2006 (Supp. 06-1).

**R2-20-209. Investigation**

- A. The Executive Director or any other person designated by the Executive Director shall conduct an investigation in any case in which the Commission finds reason to believe that a violation of a statute or rule over which the Commission has jurisdiction has occurred or is about to occur.
- B. The investigation may include, but is not limited to, field investigations, audits, and other methods of information gathering.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Section amended by final rulemaking at 26 A.A.R. 111, with a immediate effective of December 12, 2019 (Supp. 19-4). Amended by final rulemaking at 26 A.A.R. 542, effective March 9, 2020; the amendments to subsections (A) and (B) were originally codified in Supp. 19-4 at 26 A.A.R. 1111 (Supp. 20-1).

**R2-20-210. Written Questions Under Order**

The Commission may issue an order requiring any person to submit sworn, written answers to written questions and may specify a date by which such answers must be submitted to the Commission.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Amended by exempt rulemaking at 9 A.A.R. 3511, effective May 21, 2002 (Supp. 03-3).

**R2-20-211. Subpoenas and Subpoenas Duces Tecum; Depositions**

- A. The Commission may authorize its Executive Director or Assistant Attorney General to issue subpoenas requiring the attendance and testimony of any person by deposition and to issue subpoenas duces tecum for the production of documentary or other tangible evidence in connection with a deposition or otherwise.
- B. If the Commission orders oral testimony to be taken by deposition or for documents to be produced, the subpoena shall so state and shall advise the deponent or person subpoenaed that all testimony will be under oath. The Commission may authorize its Executive Director to take a deposition and have the power to administer oaths.
- C. The deponent shall have the opportunity to review and sign depositions taken pursuant to this rule.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Amended by exempt rulemaking at 13 A.A.R. 3524, effective January 1, 2008 (Supp. 07-3).

**R2-20-212. Repealed**

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Section repealed by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4).

**R2-20-213. Motions to Quash or Modify a Subpoena**

- A. Any person to whom a subpoena is directed may, prior to the time specified therein for compliance, but in no event more than five days after the date of receipt of such subpoena, apply to the Commission to quash or modify such subpoena, accompanying such application with a brief statement of the reasons therefore.
- B. The Commission may deny the application, quash the subpoena or modify the subpoena.
- C. The person subpoenaed and the Executive Director may agree to change the date, time, or place of a deposition or for the production of documents without affecting the force and effect of the subpoena, but such agreements shall be confirmed in writing.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Amended by exempt rulemaking at 13 A.A.R. 3524, effective January 1, 2008 (Supp. 07-3).

**R2-20-214. The Probable Cause to Believe Recommendation; Briefing Procedures**

- A. Upon completion of the investigation conducted pursuant to R2-20-209, the Executive Director shall prepare a brief setting forth his or her position on the factual and legal issues of the case and containing a recommendation on whether the Commission should find probable cause to believe that a violation of a statute or rule over which the Commission has jurisdiction has occurred or is about to occur.
- B. The Executive Director shall notify each respondent of the recommendation and enclose a copy of his or her brief.
- C. Within five days from receipt of the Executive Director's brief, the respondent may file a brief with the Commission setting forth the respondent's position on the factual and legal issues of the case.
- D. After reviewing the respondent's brief, the Executive Director shall promptly advise the Commission in writing whether he or she intends to proceed with the recommendation or to withdraw the recommendation from Commission consideration.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Amended by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4). Amended by exempt rulemaking at 12 A.A.R. 758, effective February 15, 2006 (Supp. 06-1).

**R2-20-215. Probable Cause to Believe Finding**

- A. If the Commission, after having found reason to believe and after following the procedures set forth in R2-20-214, determines by an affirmative vote of at least three of its members that there is probable cause to believe that a respondent has violated a statute or rule over which the Commission has jurisdiction, the Commission shall authorize the Executive Director to so notify the respondent by an order, that states the nature of the violation, pursuant to A.R.S. § 16-957.
- B. If the Commission finds no probable cause to believe that a violation of a statute or rule over which the Commission has jurisdiction has occurred or otherwise orders a termination of Commission proceedings, it shall authorize the Executive Director to notify both respondent and complainant by letter that the proceeding has ended. The Executive Director's letter also will inform the parties that the Commission is not precluded from taking action on this matter in the future if evidence is discovered which may alter the decision of the Commission.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Amended by exempt rulemaking at 9 A.A.R. 3511, effective May 21, 2002 (Supp. 03-3). Amended by exempt rulemaking at 13 A.A.R. 3524, effective January 1, 2008 (Supp. 07-3).

**R2-20-216. Conciliation**

- A. Upon a Commission finding of probable cause to believe that the respondent has violated a statute or rule over which the Commission has jurisdiction, the Executive Director shall attempt to settle the matter as authorized by A.R.S. § 16-957(A) by informal methods of administrative settlement or conciliation, and shall attempt to reach a tentative conciliation agreement with the respondent.
- B. A conciliation agreement pursuant to subsection (A) of this Section is not binding upon either party unless and until it is signed by the respondent and by the Executive Director upon approval by the affirmative vote of at least three members of the Commission.
- C. If a conciliation agreement is reached between the Commission and the respondent, the Executive Director shall send a copy of the signed agreement to both complainant and respondent.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Amended by exempt rulemaking at 9 A.A.R. 3511, effective May 21, 2002 (Supp. 03-3).

**R2-20-217. Enforcement Proceedings**

- A. Upon a finding of probable cause that the alleged violator remains out of compliance, the Executive Director may recommend to the Commission that the Commission authorize the issuance of an order and assessment of civil penalties pursuant to A.R.S. § 16-957(B).
- B. The Commission may, by an affirmative vote of at least three of its members, authorize the Executive Director to issue an order and assess civil penalties pursuant to A.R.S. § 16-957(B).

- C. Subsections (A) and (B) of this rule shall not preclude the Commission, upon request of a respondent, from entering into a conciliation agreement pursuant to R2-20-216 even after the Commission authorizes the Executive Director to issue an order and assess civil penalties pursuant to subsection (B). Any conciliation agreement reached under this subsection is subject to the provisions of R2-20-216(B) and shall have the same force and effect as a conciliation agreement reached under R2-20-216(D).

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Amended by exempt rulemaking at 9 A.A.R. 3511, effective May 21, 2002 (Supp. 03-3). Amended by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4). Amended by exempt rulemaking at 12 A.A.R. 758, effective February 15, 2006 (Supp. 06-1).

**R2-20-218. Repealed**

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Section repealed by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4).

**R2-20-219. Repealed**

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Section repealed by exempt rulemaking at 9 A.A.R. 3511, effective May 21, 2002 (Supp. 03-3).

**R2-20-220. Ex Parte Communications**

- A. In order to avoid the possibility of prejudice, real or apparent, to the public interest in enforcement actions pending before the Commission pursuant to its compliance procedures, except to the extent required for the disposition of ex parte matters as required by law (for example, during the normal course of an investigation or a conciliation effort), no interested person outside the agency shall make or cause to be made to any Commissioner or any member of any Commission staff any ex parte communication relative to the factual or legal merits of any enforcement action, nor shall any Commissioner or member of the Commission's staff make or entertain any such ex parte communications.
- B. This rule shall apply from the time a complaint is filed with the Commission or from the time that the Commission determines on the basis of information ascertained in the normal course of its statutory responsibilities that it has reason to believe that a violation of a statute or rule over which the Commission has jurisdiction has occurred or may occur, and remains in force until the Commission has finally concluded all action with respect to the matter in question.
- C. Nothing in this Section shall be construed to prohibit contact between a respondent or respondent's attorney and any attorney or the Administrative Counsel or the Assistant Attorney General in the course of representing the Commission or the respondent with respect to an enforcement proceeding or civil action. No statement made by a Commission attorney or staff member shall bind or estop the Commission.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-221. Representation by Counsel; Notification**

- A. If a respondent wishes to be represented by counsel with regard to any matter pending before the Commission, respondent shall so advise the Commission by sending a letter of representation signed by the respondent, which letter shall state the following:
1. The name, address, and telephone number of the counsel; and
  2. A statement authorizing such counsel to receive any and all notifications and other communications from the Commission on behalf of respondent.
- B. Upon receipt of a letter of representation, the Commission shall have no contact with respondent except through the designated counsel unless authorized in writing by respondent. The Commission will send a copy of this letter to the respondent's attorney.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-222. Civil Penalties**

- A. If the Commission has reason to believe by a preponderance of the evidence that a participating candidate is not in compliance with the Act or Commission rules, then in addition to other penalties under law, the Commission may decertify a candidate, deny or suspend funding, order repayment of funds, or impose a penalty not to exceed \$1,000 for a participating candidate for the legislature and 5,000 for a participating candidate for statewide office.
- B. If the Commission has reason to believe by a preponderance of the evidence that a person other than a participating candidate is not in compliance with the Act or Commission rules, then in addition to other penalties under law, the Commission may impose a penalty not to exceed \$1,000.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Amended by exempt rulemaking at 13 A.A.R. 3524, effective January 1, 2008 (Supp. 07-3). Amended by exempt rulemaking at 19 A.A.R. 1697, effective May 23, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3524, effective September 27, 2013 (Supp. 13-4).

**R2-20-223. Notice of Appealable Agency Action**

If the Commission makes a probable cause finding pursuant to R2-20-215 or decides to initiate an enforcement proceeding pursuant to R2-20-217, the Assistant Attorney General (AAG) shall draft and serve notice of an appealable agency action pursuant to A.R.S. § 41-1092.03 and § 41-1092.04 on the respondent. The notice shall identify the following:

1. The statute or rule violated and specific facts constituting the violation;
2. A description of the respondent's right to request a hearing and to request an informal settlement conference; and
3. A description of what the respondent may do if the respondent wishes to remedy the situation without appealing the Commission's decision.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Amended by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4). Amended by final exempt rulemaking at 21 A.A.R. 2921, effective July 1, 2011; filed in the Office October 27, 2015 (Supp. 15-4).

**R2-20-224. Request for an Administrative Hearing**

- A. The respondent must file a request for a hearing with the Commission within 30 days of receipt of the notice prescribed in R2-20-223.
- B. If the respondent requests a hearing, the AAG shall notify the Office of Administrative Hearings (OAH) of the appeal and shall coordinate a hearing date with the Commission's AAG and Commission staff that may be called as witnesses and OAH. The hearing must be held within 60 days after the notice of appeal is filed with the Commission.
- C. The AAG shall prepare and serve a notice of hearing on all parties to the appeal at least 30 days before the hearing date, unless an expedited hearing is requested and granted. The notice of hearing shall be drafted in accordance with A.R.S. § 41-1092.05(D).

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-225. Informal Settlement Conference**

- A. If the respondent requests an informal settlement conference, the informal settlement conference shall be held within 15 days after the Commission receives the request. A request for an informal settlement conference shall be in writing and must be filed with the Commission no later than 20 days before the hearing date. A person with the authority to act on behalf of the Commission must represent the Commission at the conference. The AAG shall attend the settlement conference, but shall not be the individual authorized to act on behalf of the Commission.
- B. The Commission representative shall notify the appellant in writing that the statements, either written or oral, made by the appellant at the conference, including a written document, created or expressed solely for the purpose of settlement negotiations, are inadmissible in any subsequent administrative hearing. The parties participating in the settlement conference waive their right to object to the participation of the agency representative in the final administrative decision.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-226. Administrative Hearing**

- A. If the matter continues to a hearing, the hearing shall be held in accordance with A.R.S. § 41-1092.07. The Administrative Law Judge (ALJ) must issue a written recommended decision within 20 days after the hearing is concluded.
- B. If the enforcement action occurs within six months of the primary or general election, the Commission will request an expedited review of the matter.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-227. Review of Administrative Decision by Commission**

- A. Within 30 days after the date OAH sends a copy of the ALJ's decision to the Commission, the Commission may review the ALJ's decision and accept, reject or modify the decision.
- B. If the Commission declines to review the ALJ's decision, the Commission shall serve a copy of the decision on all parties. If the Commission modifies or rejects the decision, the Commission shall file with OAH and serve on all parties, a copy of the ALJ's decision with the rejection or modification and a written justification setting forth the reasons for the rejection or modification. If the Commission accepts, rejects or modifies the decision, the Commission's decision will be certified as final.
- C. If the Commission does not accept, reject or modify the decision within 30 days after OAH sends the ALJ's decision to the Commission, the ALJ's decision will be certified as final.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-228. Judicial Review**

A party may appeal a final administrative decision pursuant to A.R.S. § 12-901 et seq. (Judicial Review of Administrative Decisions). A party does not have the right to judicial review unless that party first exhausts its administrative remedies by going through the above steps. After a hearing has been held and a final administrative decision has been entered pursuant to § 41-1092.08, a party is not required to file a motion for rehearing or review of the decision in order to exhaust the party's administrative remedies.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-229. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Section repealed by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4).

**R2-20-230. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Section repealed by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4).

**R2-20-231. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Section repealed by exempt rulemaking at 12 A.A.R. 758, effective February 15, 2006 (Supp. 06-1).

**ARTICLE 3. STANDARD OF CONDUCT FOR COMMISSIONERS AND EMPLOYEES****R2-20-301. Purpose and Applicability**

- A. The Commission is committed to implementing the Act in an honest, independent, and impartial fashion and to seeking to uphold public confidence in the integrity of the electoral system. To ensure public trust in the fairness and integrity of the Arizona elections process, all Commissioners and employees must observe the highest standards of conduct. This Article prescribes standards of ethical conduct for Commissioners and employees of the Commission relating to conflicts of interest arising from outside employment, private businesses, professional activities, political activities, and financial interests. The avoidance of misconduct and conflicts of interest on the part of the Commissioners and the employees through informed judgment is indispensable to the maintenance of these prescribed ethical standards. Attainment of these goals necessitates strict and absolute fairness and impartiality in the administration of the law.
- B. This Article applies to all persons included within the terms “employee” and “Commissioner” of the Commission.
- C. These Standards of Conduct shall be construed in accordance with any applicable laws, regulations, and agreements between the Commission and a labor organization.
- D. Pursuant to A.R.S. § 16-955(I), for three years after a Commissioner completes his or her tenure, Commissioners shall not seek or hold any public office, serve as an officer of any political committee, or employ or be employed as a lobbyist.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-302. Definitions**

The following terms apply in all Citizens Clean Elections Act matters:

1. “Commission” means the Citizens Clean Elections Commission of Arizona.
2. “Commissioner” means a voting member of the Commission, appointed pursuant to A.R.S. § 16-955.
3. “Conflict of interest” means a situation in which a Commissioner’s or an employee’s private interest is or appears to be inconsistent with the efficient and impartial conduct of his or her official duties and responsibilities.
4. “Employee” means an employee or staff member of the Commission.
5. “Former employee” means one who was, and is no longer, an employee of the Commission.
6. “Official responsibility” means the direct administrative or operating authority, whether intermediate or final, to approve, disapprove, or otherwise direct Commission action. Official responsibility may be exercised alone or with others and either personally or through subordinates.
7. “Outside employment” or “outside activity” means any work, service or other activity performed by a Commissioner or employee other than in the performance of the Commissioner’s or employee’s official employment duties. It includes such activities as writing and editing, publishing, teaching, lecturing, consulting, self-employment, and other services or work performed, with or without compensation.
8. “Person” means an individual, corporation, company, association, firm, partnership, society, joint stock company, political committee, or other group, organization, or institution.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-303. Notification to Commissioners and Employees**

The Executive Director shall provide to each Commissioner and employee of the Commission, upon commencement of his or her term or employment and at least annually thereafter, a copy of this Article and such other information regarding standards of conduct as the Commission and/or applicable law may prescribe.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Amended by exempt rulemaking at 13 A.A.R. 3527, effective January 1, 2008 (Supp. 07-3).

**R2-20-304. Interpretation and Advisory Service**

Commissioners or employees seeking advice and guidance on questions of conflict of interest and on other matters covered by this Article shall consult with the Commission’s Chair or Executive Director. The Commission’s Chair or Executive Director shall be consulted prior to the undertaking of any action that might violate this Article governing the conduct of Commissioners or employees.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Amended by exempt rulemaking at 13 A.A.R. 3527, effective January 1, 2008 (Supp. 07-3).

**R2-20-305. Reporting Suspected Violations**

- A. Commissioners and employees who have information, which causes them to believe that there has been a violation of a statute or a rule set forth in this Article, shall report promptly, in writing, such incident to the Commission’s Chair or Executive Director.
- B. When information available to the Commission indicates a conflict between the interests of a Commissioner or employee and the performance of his or her Commission duties, the Commissioner or employee shall be provided an opportunity to explain the conflict or appearance of conflict in writing.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-306. Disciplinary and Other Remedial Action**

- A. A violation of this Article by an employee may be cause for disciplinary action, which may be in addition to any penalty prescribed by law.
- B. When the Commission’s Executive Director determines that an employee may have or appears to have a conflict of interest, the Commission’s Executive Director may question the employee in the matter and gather other information. The Commission’s Executive Director and the employee’s supervisor shall discuss with the employee possible ways of eliminating the conflict or appearance of conflict. If the Commission’s Executive Director, after consultation with the employee’s supervisor, concludes that remedial action should be taken, he or she shall refer a statement to the Commission containing his or her recommendation for such action. The Commission, after consideration of the employee’s explanation and the results of any investigation, may direct appropriate remedial action as it deems necessary.
- C. Remedial action pursuant to subsection (B) of this Section may include, but is not limited to:
  1. Changes in assigned duties;

2. Divestment by the employee of his or her conflicting interest;
3. Disqualification for particular action; or
4. Disciplinary action.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-307. General Prohibited Conduct**

- A. A Commissioner or employee shall avoid any action whether or not specifically prohibited by this Section that might result in, or create the appearance of:
  1. Using public office for unlawful private gain;
  2. Giving favorable or unfavorable treatment to any person or organization due to any partisan or political consideration;
  3. Impeding Commission efficiency or economy;
  4. Losing impartiality.
  5. Making a Commission decision without Commission approval; or
  6. Adversely affecting the confidence of the public in the integrity of the Commission.
- B. A Commissioner or employee of the Commission shall not solicit or accept, directly or indirectly, any gift, gratuity, favor, entertainment, loan, or any other thing of monetary value, from a person who:
  1. Has, or is seeking to obtain, contractual or other business or financial relations with the Commission;
  2. Conducts operations or activities that are regulated or examined by the Commission; or
  3. Has an interest that may be substantially affected by the performance or nonperformance of the Commissioner or employee's official duty.
- C. Subsection (B) of this Section shall not apply in the following circumstances:
  1. When circumstances make it clear that obvious family or personal relationships, rather than the business of the persons concerned, are the motivating factors;
  2. To the acceptance of food, refreshments, and accompanying entertainment of nominal value in the ordinary course of a social occasion or a luncheon or dinner meeting or other function where a Commissioner or an employee is properly in attendance;
  3. To the acceptance of unsolicited advertising or promotional material or other items of nominal value such as pens, pencils, note pads, calendars; and
  4. To the acceptance of loans from banks or other financial institutions on customary terms to finance proper and usual activities, such as home mortgage loans.
- D. A Commissioner or an employee shall not solicit a contribution from another employee for a gift to an official superior, make a donation as a gift to an official superior, or accept a gift from an employee receiving less pay than himself or herself. However, this subsection does not prohibit a voluntary gift of nominal value or donation in a nominal amount made on a special occasion such as birthday, holiday, marriage, illness, or retirement.
- E. This Section does not preclude a Commissioner or employee from receipt of reimbursement, unless prohibited by law, for expenses of travel and such other necessary subsistence as is compatible with this Article for which no state payment or reimbursement is made. However, this Section does not allow a Commissioner or employee to be reimbursed, or payment to be made on his or her behalf, for excessive personal living expenses, gifts, entertainment, or other personal benefits, nor does it allow a Commissioner or employee to be reimbursed by a person for travel on official business under Commission orders when reimbursement is prescribed by statute.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-308. Outside Employment or Activities**

- A. A Commissioner or employee shall not engage in outside employment that is incompatible with the full discharge of his or her duties as a Commissioner or employee.
- B. Incompatible outside employment or other activities by Commissioners or employees include, but are not limited to:
  1. Outside employment or other activities that involve illegal activities;
  2. Outside employment or other activities that would give rise to a real or apparent conflict of interest situation even though no violation of a specific statutory provision was involved;
  3. Acceptance of a fee, compensation, gift, payment of expense, or any other thing of monetary value in circumstances where acceptance may result in, or create the appearance of, a conflict of interest;
  4. Outside employment or other activities that might bring discredit upon the state or Commission;
  5. Outside employment or other activities that establish relationships or property interests that may result in a conflict between the Commissioner's or the employee's private interests and official duties;
  6. Outside employment or other activities which would involve any contractor or subcontractor connected with any work performed for the Commission or would involve any person or organization in a position to gain advantage in its dealings with the state through the Commissioner's or employee's exercise of his or her official duties;
  7. Outside employment or other activities that may be construed by the public to be the official acts of the Commission. In any permissible outside employment, care shall be taken to ensure that names and titles of Commissioners and employees are not used to give the impression that the activity is officially endorsed or approved by the Commission or is part of the Commission's activities;
  8. Outside employment or other activities which would involve use by a Commissioner or employee of his or her official duty time; use of official facilities, including office space, machines, or supplies, at any time; or use of the services of other employees during their official duty hours;
  9. Outside employment or other activities which impair the Commissioner's or employee's mental or physical capacities to perform Commission duties and responsibilities in an acceptable manner; or
  10. Use of information obtained as a result of state employment that is not freely available to the general public or would not be made available upon request. However, written authorization for the use of any such information may be given when the Commission determines that such use would be in the public interest.
- C. Commissioners and employees shall not receive any salary or anything of monetary value from a private source as compensation for the Commissioner's or employee's services to the state.
- D. Commissioners and employees are encouraged to engage in teaching, lecturing, and writing that is not prohibited by law or this Article. However, Commissioners and employees shall not, either with or without compensation, engage in teaching or writing that is dependent

on information obtained as a result of his or her Commission employment, except when that information has been made available to the public or will be made available on request, or when the Commission gives written authorization for the use of nonpublic information on the basis that the use is in the public interest.

- E. This Section does not preclude a Commissioner or employee from participating in the activities of or acceptance of an award for meritorious public contribution or achievement given by a charitable, religious, professional, social, fraternal, nonprofit, educational, recreational, public service, or civic organization.
- F. An employee who intends to engage in outside employment shall obtain the approval of the Executive Director. The request shall include the name of the person, group, or organization for whom the work is to be performed, the nature of the services to be rendered, the proposed hours of work, or approximate dates of employment, and the employee's certification as to whether the outside employment (including teaching, writing, or lecturing) will depend in any way on information obtained as a result of the employee's official position. The employee will receive, from the Executive Director, written notice of approval or disapproval of any written request. A record of the decision shall be placed in each employee's official personnel folder.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-309. Financial Interests**

- A. Commissioners and employees shall not engage in, directly or indirectly, a financial transaction as a result of, or primarily relying on, information obtained through the Commissioner's or employee's duties or employment.
- B. Commissioners and employees shall not have a direct or indirect financial interest that conflicts substantially, or appears to conflict substantially, with the Commissioner's or employee's official duties and responsibilities, except in cases where the Commissioner or employee makes full disclosure, and disqualifies himself or herself from participating in any decisions, approval, disapproval, recommendation, the rendering of advice, investigation, or in any proceeding of the Commission in which the financial interest is or appears to be affected. Full disclosure by a Commissioner or employee will require that individual to submit a written statement to the Executive Director or Chair disclosing the particular financial interest which conflicts substantially, or appears to conflict substantially, with the Commissioner's or employee's duties and responsibilities.
- C. Commissioners and employees shall disqualify themselves from a proceeding in which the Commissioner's or employee's impartiality might reasonably be questioned, such as in a situation where the Commissioner or employee knows that he or she, or his or her family member, has an interest in the subject matter in controversy or is a party to the proceeding, or has any other interest that could be substantially affected by the outcome of the proceeding.
- D. This Section does not preclude a Commissioner or employee from having a financial interest or engaging in financial transactions to the same extent as a private citizen not employed by the Commission, as long as the Commissioner's or employee's financial interest does not conflict with official Commission duties.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-310. Political and Organization Activity**

- A. Due to the Commission's role in the political process, the following restrictions on political activities are required:
  - 1. Commissioners and employees shall not advocate for the election or defeat of a candidate, nor make contributions to a candidate, political party, or political committee subject to the jurisdiction of the Commission. Commissioners and employees, however, are not prohibited from signing candidate nomination petitions;
  - 2. Commissioners and employees shall not provide volunteer or paid services for a candidate, political party, or political committee subject to the jurisdiction of the Commission; and
  - 3. Commissioners and employees shall not display partisan buttons, badges, or other insignia on Commission premises.
- B. Employees on leave, leave without pay, or on furlough or terminal leave, even though the employees' resignations have been accepted, are subject to the restrictions of this Section. A separated employee who has received a lump-sum payment for annual leave, however, is not subject to the restrictions during the period covered by the lump-sum payment or thereafter, provided he or she does not return to state employment during that period. An employee is not permitted to take a leave of absence to work with a political candidate, committee, or organization or become a candidate for office despite any understanding that he or she will resign his or her position if nominated or elected.
- C. A Commissioner or employee is accountable for political activity by another person acting as his or her agent or under the Commissioner's or employee's direction or control if the Commissioner or employee is thus accomplishing what he or she may not lawfully do directly and openly.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-311. Membership in Associations**

Commissioners or employees who are members of nongovernmental associations or organizations shall avoid activities on behalf of those associations or organizations that are incompatible with their official positions.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-312. Use of State Property**

A Commissioner or employee shall not directly or indirectly use, or allow the use of, state property of any kind, including property leased to the state, for other than officially approved activities. Commissioners and employees have a positive duty to protect and conserve state property including equipment, supplies, and other property entrusted or issued to him or her.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**ARTICLE 4. AUDITS**

**R2-20-401. Purpose and Scope**

This article prescribes procedures for conducting examinations and audits of participating candidates' campaign finances.

#### **Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4).

Amended by exempt rulemaking at 19 A.A.R. 1699, effective October 6, 2011 (Supp. 13-2).

#### **R2-20-402. General**

The Commission may conduct an examination and audit of the receipts, disbursements, debts and obligations of each candidate. In addition, the Commission may conduct other examinations and audits as it deems necessary to carry out the provisions of the Act and regulations. Information obtained pursuant to any audit and examination may be used by the Commission as the basis, or partial basis, for its repayment determinations.

#### **Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4).

#### **R2-20-402.01. Audits of Participating Legislative Candidates**

To ensure compliance with the Act and Commission rules, the Commission shall conduct audits of all participating legislative candidates after each election. Candidates who win their primary election will not be subject to an audit until after the general election. Audits shall include the review of campaign finance reports for the entire election cycle and related documentation in accordance with procedures established by the Commission. The Commission may hire independent accounting firms to carry out the audits.

#### **Historical Note**

New Section made by exempt rulemaking at 13 A.A.R. 3529, effective January 1, 2008 (Supp. 07-3). Amended by exempt rulemaking at 19 A.A.R. 1700, effective October 6, 2011 (Supp. 13-2). Amended by final exempt rulemaking at 21 A.A.R. 1640, effective July 23, 2015 (Supp. 15-3). Amended by final exempt rulemaking at 23 A.A.R. 130, effective December 15, 2016 (Supp. 16-4).

Amended by final exempt rulemaking at 23 A.A.R. 2944, effective September 28, 2017 (Supp. 17-4).

#### **R2-20-402.02. Audits of Participating Statewide Candidates**

All participating statewide candidates shall be audited after each primary election period and each general election period.

#### **Historical Note**

New Section made by final exempt rulemaking at 23 A.A.R. 131, effective December 15, 2016 (Supp. 16-4).

#### **R2-20-403. Conduct of Fieldwork**

- A. The Commission will provide the candidate two days notice of the Commission's intention to commence fieldwork on the audit and examination. The Commission will conduct fieldwork at a site provided by the candidate. During or after fieldwork, the Commission may request additional or updated information, which expands the coverage dates of information previously provided. During or after fieldwork, the Commission may also request additional information that was created by or becomes available to the candidate that is of assistance in the Commission's audit. The candidate shall produce the additional or updated information no later than two days after service of the Commission's request.
- B. On the date scheduled for the commencement of fieldwork, the candidate shall facilitate the examination or audit by making records available in one central location, such as the Commission's office space, or shall provide the Commission with office space and records. The candidate shall be present at the site of the fieldwork. The candidate shall be familiar with the candidate's records and shall be available to the Commission to answer questions and to aid in locating records.
- C. If the candidate fails to provide adequate office space, personnel or records, the Commission may seek judicial intervention to enforce the request or assess other penalties.
- D. If, in the course of the examination or audit process, a dispute arises over the documentation sought, the candidate may seek review by the Commission of the issues raised. To seek review, the candidate shall submit a written statement within five days after the disputed Commission request is made, describing the dispute and indicating the candidate's proposed alternatives.

#### **Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4).

#### **R2-20-404. Preliminary Audit Report**

- A. After the completion of fieldwork, the auditors may prepare a written preliminary audit report, which will be provided to the candidate after it is reviewed by the Executive Director. The preliminary audit report may include:
  1. An evaluation of procedures and systems employed by the candidate to comply with applicable provisions of the Act and Commission rules,
  2. The accuracy of statements and campaign finance reports filed with the Secretary of State by the candidate, and
  3. Preliminary findings.
- B. The candidate may submit in writing within 10 days after receipt of the preliminary audit report, legal and factual materials disputing or commenting on the proposed findings contained in the preliminary audit report. In addition, the candidate shall submit any additional documentation requested by the Commission.
- C. If the preliminary audit report cannot be completed, the Commission shall notify the candidate in writing that the audit report will not be completed.

#### **Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4).

Amended by exempt rulemaking at 16 A.A.R. 1200, effective February 28, 2008 (Supp. 10-2).

#### **R2-20-405. Final Audit Report**

- A. Before voting on whether to approve and issue a final audit report, the Commission will consider any written legal and factual materials timely submitted by the candidate in accordance with R2-20-404. The Commission-approved final audit report may address issues other than those contained in the preliminary audit report.
- B. The final audit report may identify issues that warrant referral for possible enforcement proceedings.
- C. Addenda to the final audit report may be approved and issued by the Commission from time to time as circumstances warrant and as additional information becomes available. Such addenda may be based on follow-up fieldwork conducted, or information ascertained by

the Commission in the normal course of carrying out its responsibilities. The procedures set forth in R2-20-404 and subsections (A) and (B) will be followed in preparing such addenda.

**Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4).

**R2-20-406. Release of Audit Report**

- A. The Commission will consider the final audit report specified in R2-20-405 in an open meeting. The Commission will provide the candidate with copies of the final audit report to be considered in an open meeting 24 hours prior to the public meeting.
- B. Following Commission approval of the final audit report, the report will be forwarded to the candidate within five days after the public meeting.

**Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4).

**ARTICLE 5. RULEMAKING**

**R2-20-501. Purpose and Scope**

This Article prescribes the procedures for the submission, consideration, and disposition of rulemaking petitions filed with the Commission, establishes the conditions under which the Commission may identify and respond to petitions for rulemaking, and informs the public of the procedures the agency follows in response to such petitions.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-502. Procedural Requirements**

- A. Any interested person may file with the Commission a written petition for the issuance, amendment, or repeal of an administrative rule implementing any of the Citizens Clean Elections Act.
- B. The petition shall:
  - 1. Include the name and address of the petitioner or agent. An authorized agent of the petitioner may submit the petition, but the agent shall disclose the identity of his or her principal;
  - 2. Identify itself as a petition for the issuance, amendment, or repeal of a rule;
  - 3. Identify the specific Section of the regulations to be affected;
  - 4. Set forth the factual and legal grounds on which the petitioner relies, in support of the proposed action; and
  - 5. Be addressed and submitted to the Commission.
- C. The petition may include draft regulatory language that would effectuate the petitioner's proposal.
- D. The Commission may, in its discretion, treat a document that fails to conform to the format requirements of subsection (B) of this Section as a basis for rulemaking addressing issues raised in a petition.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-503. Processing of Petitions**

- A. Within 10 days of receiving a petition, the Commission shall send a letter to the petitioner acknowledging the receipt of the petition and informing the petitioner that the Commission will review and decide whether to deny or accept the petition. To assist in determining whether a rulemaking proceeding should be initiated, the Commission may publish a Notice of Availability on the Commission web site or otherwise post notice, stating that the petition is available for public inspection in the Commission's Office and that statements in support of or in opposition to the petition may be filed within a stated period after publication of the Notice of Availability.
- B. If the Commission decides a public hearing on the petition would help determine whether to commence a rulemaking proceeding, it will publish an appropriate notice of the hearing on the Commission web site or otherwise post notice, to notify interested persons and to invite their participation in the hearing.
- C. The Commission will consider all comments regarding whether rulemaking proceedings should be initiated.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-504. Disposition of Petitions**

- A. After considering the comments and any other information relevant to the subject matter of the petition, the Commission will decide whether to initiate rulemaking based on the filed petition.
- B. If the Commission decides to initiate rulemaking proceedings, it shall file a Notice of Proposed Rulemaking and the proposed rule, in the format prescribed in A.R.S. § 41-1022, with the Secretary of State's office for publication in the Arizona Administrative Register. After the Commission approves the proposed rule, the Commission will accept public comments on the proposed rule for 60 days. After consideration of the comments received in the 60-day comment period, the Commission may adopt the rule in open meeting.
- C. If the Commission decides not to initiate rulemaking, it will give notice of this action by publishing a Notice of Disposition on the Commission web site, or otherwise post notice, and by sending a letter to the petitioner. The Notice of Disposition will include a brief statement of the grounds for the Commission's decision.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-505. Commission Considerations**

The Commission's decision on the petition for rulemaking may include, but will not be limited to, the following considerations:

- 1. The Commission's statutory authority;
- 2. Policy considerations;
- 3. The desirability of proceeding on a case-by-case basis;
- 4. The necessity or desirability of statutory revision;
- 5. Available agency resources; and

6. Substantive policy statements.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-506. Administrative Record**

- A. The Commission record for the petition process consists of the following:
  1. The petition, including all attachments on which it relies, filed by the petitioner;
  2. Written comments on the petition that have been circulated to and considered by the Commission, including attachments submitted as a part of the comments;
  3. Agenda documents, in the form they are circulated to and considered by the Commission in the course of the petition process;
  4. All notices published on the Commission web site and in the Arizona Administrative Register, including the Notice of Availability and Notice of Disposition;
  5. The transcripts or audiotapes of any public hearing on the petition;
  6. All correspondence between the Commission and the petitioner, other commentators and state agencies pertaining to Commission consideration of the petition; and
  7. The Commission's decision on the petition, including all documents identified or filed by the Commission as part of the record relied on in reaching its final decision.
- B. The administrative record specified in subsection (A) of this Section is the exclusive record for the Commission's decision.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**ARTICLE 6. EX PARTE COMMUNICATIONS**

**R2-20-601. Purpose and Scope**

This Article prescribes procedures for handling ex parte communications made regarding Commission audits, investigations, and litigation. Rules governing such communications made in connection with Commission enforcement actions are found at R2-20-220.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-602. Definitions**

- A. "Ex parte communication" means any written or oral communication, by any person outside the agency to any Commissioner or any employee, which imparts information or argument regarding prospective Commission action or potential action concerning:
  1. Any ongoing audit;
  2. Any pending investigation; or
  3. Any litigation matter.
- B. "Ex parte communication" does not include the following communications:
  1. Public statements by any person in a public forum; or
  2. Statements or inquiries by any person limited to the procedural status of an open proceeding involving a Commission audit, investigation, or litigation matter.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-603. Audits, Investigations, and Litigation**

- A. In order to avoid the possibility of prejudice, real or apparent, in Commission decision making, no person outside the Commission shall make, or cause to be made, to any Commissioner or employee, any ex parte communication regarding any audit undertaken by the Commission or any pending or prospective Commission decision regarding any investigation or litigation, including whether to initiate, settle, appeal, or any other decision concerning an investigation or litigation matter.
- B. A Commissioner or employee who receives an oral ex parte communication concerning any matters addressed in subsection (A) of this Section shall attempt to prevent the communication. If unsuccessful in preventing the communication, the Commissioner or employee shall advise the person making the communication that he or she will not consider the communication and shall, as soon after the communication as is reasonably possible, but no later than three business days after the communication, or prior to the next Commission discussion of the matter, whichever is earlier, prepare a statement setting forth the substance and circumstances of the communication, and deliver the statement to the Executive Director for placement in the applicable case file.
- C. A Commissioner or employee who receives a written ex parte communication concerning any matters addressed in subsection (A) of this Section shall, as soon after the communication as is reasonably possible but no later than three business days after the communication, or prior to the next Commission discussion of the matter, whichever is earlier, deliver a copy of the communication to the Executive Director for placement in the applicable case file.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**R2-20-604. Sanctions**

Any person who becomes aware of a possible violation of this Article shall notify the Executive Director in writing of the facts and circumstances of the alleged violation. The Executive Director shall recommend to the Commission the appropriate action to be taken. The Commission shall determine the appropriate action by at least three votes.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1).

**ARTICLE 7. USE OF FUNDS AND REPAYMENT**

**R2-20-701. Purpose and Scope**

Notwithstanding any other provision of the rules to the contrary, a participating candidate shall not make any payment to a private organization that is exempt under section 501(a) of the internal revenue code and that is eligible to engage in activities to influence the

outcome of a candidate election, nor make any payment directly or indirectly to a political party; and subject to the foregoing, may spend clean elections monies only for reasonable and necessary expenses that are directly related to the campaign of that participating candidate.

#### Historical Note

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Amended by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4). Amended by final rulemaking at 26 A.A.R. 886, with an immediate effective date of February 27, 2020; the same amendments were filed and codified by final rulemaking at 26 A.A.R. 1259, with an immediate effective date of June 4, 2020 (Supp. 20-2).

#### **R2-20-702. Use of Campaign Funds**

- A. A participating candidate shall use funds in the candidate's current campaign account to pay for goods and services for direct campaign purposes only. Funds shall be disbursed and reported in accordance with A.R.S. § 16-948(C).
- B. Participating candidates may purchase fixed assets with a value not to exceed \$800. Fixed assets, including accessories, purchased with campaign funds that can be used for non-campaign purposes with a value of \$200 or more shall be turned into the Commission no later than 14 days after the primary election or the general election if the candidate was successful in the primary. For purposes of determining whether a fixed asset is valued at \$200 or more, the value shall include any accessories purchased for use with the fixed asset in question. A candidate may elect to keep an item by reimbursing the Commission for 80 percent of the original purchase price including the cost of accessories.
- C. During the primary election period, a participating candidate shall not make any expenditure greater than the difference between:
  1. The sum of early contributions received plus public funds disbursed through the primary election period; less
  2. All other expenditures made during and for the exploratory, qualifying and primary election periods.
- D. During the general election period, a participating candidate shall not make any expenditure greater than the difference between:
  1. The amount of public funds disbursed during and for the general election period; less
  2. All other expenditures made during and for the general election period.
- E. Transportation expenses.
  1. Except as otherwise provided in this subsection (D), the costs of transportation relating to the election of a participating statewide or legislative office candidate shall not be considered a direct campaign expense and shall not be reported by the candidate as expenditures or as in-kind contributions.
  2. If a participating candidate travels for campaign purposes in a privately owned automobile, the candidate may:
    - a. Use campaign funds to reimburse the owner of the automobile at a rate not to exceed the state mileage reimbursement rate in which event the reimbursement shall be considered a direct campaign expense and shall be reported as an expenditure and reported in the reporting period in which the expenditure was incurred. If a candidate chooses to use campaign funds to reimburse, the candidate shall keep an itinerary of the trip, including name and type of events(s) attended, miles traveled and the rate at which the reimbursement was made. This subsection applies to candidate owned automobiles in addition to any other automobile.
    - b. Use campaign funds to pay for direct fuel purchases for the candidate's automobile only and shall be reported. If a candidate chooses to use campaign funds for direct fuel purchases, the candidate shall keep an itinerary of the trip, including name and type of events(s) attended, miles traveled and the rate at which the reimbursement could have been made.
  3. Use of airplanes.
    - a. If a participating candidate travels for campaign purposes in a privately owned airplane, within 7 days from the date of travel, the candidate shall use campaign funds to reimburse the owner of the airplane at a rate of \$150 per hour of flying time, in which event the reimbursement shall be considered a direct campaign expense and shall be reported as an expenditure. If the owner of the airplane is unwilling or unable to accept reimbursement, the participating candidate shall remit to the fund an amount equal to \$150 per hour of flying time.
    - b. If a participating candidate travels for campaign purposes in a state-owned airplane, within 7 days from the date of travel, the candidate shall use campaign funds to reimburse the state for the portion allocable to the campaign in accordance with subsection 3a, above. The portion of the trip attributable to state business shall not be reimbursed. If payment to the State is not possible, the payment shall be remitted to the Clean Elections Fund.
  4. If a participating candidate rents a vehicle or purchases a ticket or fare on a commercial carrier for campaign purposes, the actual costs of such rental (including fuel costs), ticket or fare shall be considered a direct campaign expense and shall be reported as an expenditure.

#### Historical Note

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Section repealed; new Section made by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4). Amended by exempt rulemaking at 13 A.A.R. 3606, effective January 1, 2008 (Supp. 07-4). Amended by exempt rulemaking at 15 A.A.R. 1423, effective October 22, 2009 (Supp. 09-3). Amended by exempt rulemaking at 17 A.A.R. 1267, effective April 12, 2011 (Supp. 11-2). Since language in subsections R2-20-702(C)(3)(d)(i) and (ii) and R2-20-702(C)(4) and (5) are substantively identical, the Commission requested to remove the redundant language in R2-20-702(C)(3)(d)(i) and (ii) under A.R.S. § 41-1011(C), Office File No. M11-345, filed October 3, 2011 (Supp. 11-2). Amended by exempt rulemaking at 19 A.A.R. 1702, effective October 6, 2011 (Supp. 13-2). Amended by exempt rulemaking at 22 A.A.R. 2906, effective January 1, 2017 (Supp. 16-3). Amended by exempt rulemaking at 23 A.A.R. 2342, effective January 1, 2018 (Supp. 17-3). Amended by final rulemaking at 25 A.A.R. 2120, effective July 29, 2019 (Supp. 19-3). Amended by final rulemaking at 26 A.A.R. 309, with an immediate effective date of January 23, 2020 (Supp. 20-1). Amended by final rulemaking at 26 A.A.R. 1132, with an immediate effective date of May 11, 2020 (Supp. 20-2).

#### **R2-20-702.01. Use of Assets**

A participating candidate may use assets such as signs, pamphlets, and office equipment from a prior election cycle only after the candidate's current campaign pays for the assets in an amount equal to the fair market value of the assets, which amount shall in no event be less than one-fifth (1/5) the original purchase price of such assets. If the candidate was a participating candidate during the prior election cycle, the cash payment shall be made to the Fund. If the candidate was not a participating candidate during the prior election cycle, the cash payment shall be made to the prior campaign. If the prior campaign account of a nonparticipating candidate is closed, the payment shall be made to the candidate.

Notwithstanding any other provision of the rules to the contrary, a participating candidate shall not make any payment to a private organization that is exempt under section 501(a) of the internal revenue code and that is eligible to engage in activities to influence the

outcome of a candidate election, nor make any payment directly or indirectly to a political party.

#### **Historical Note**

New Section made by exempt rulemaking at 12 A.A.R. 758, effective February 15, 2006 (Supp. 06-1). Amended by exempt rulemaking at 13 A.A.R. 3606, effective January 1, 2008 (Supp. 07-4). Amended by exempt rulemaking at 15 A.A.R. 1156, effective August 31, 2009 (Supp. 09-2). Amended by final rulemaking at 26 A.A.R. 887, with an immediate effective date of March 9, 2020; the same amendments were filed and codified by final rulemaking at 26 A.A.R. 1261, with an immediate effective date of June 4, 2020 (Supp. 20-2).

#### **R2-20-703. Documentation for Direct Campaign Expenditures**

- A.** In addition to the general books and records requirements prescribed in R2-20-111, participating candidates shall comply with the following requirements:
1. All participating candidates shall have the burden of proving that expenditures made by the candidate were for direct campaign purposes. The candidate shall obtain and furnish to the Commission on request any evidence regarding direct campaign expenses made by the candidate as provided in subsection (A)(2).
  2. All participating candidates shall retain records with respect to each expenditure and receipt, including bank records, vouchers, worksheets, receipts, bills and accounts, journals, ledgers, fundraising solicitation material, accounting systems documentation, and any related materials documenting campaign receipts and disbursements, for a period of three years, and shall present these records to the Commission on request.
  3. All participating candidates shall maintain a list of all fixed assets whose purchase price exceeded \$200 when acquired by the campaign. The list shall include a brief description of each fixed asset, the purchase price, the date it was acquired, the method of disposition and the amount received in disposition.
- B.** Upon written request from a candidate, the Commission shall determine whether a planned campaign expenditure or fund-raising activity is permissible under the Act. To make a request, a candidate shall submit a written description of the planned expenditure or activity to the Commission. The Commission shall inform the candidate whether an enforcement action will be necessary if the candidate carries out the planned expenditure or activity. The Commission shall ensure that the candidate can rely on a “no action” letter. A “no action” letter applies only to the candidate who requested it.
- C.** Any expenditure made by the candidate or the candidate’s committee that cannot be documented as a direct expenditure shall promptly be repaid to the Fund with the candidate’s personal monies.

#### **Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Section repealed; new Section made by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4). Amended by exempt rulemaking at 12 A.A.R. 758, effective February 15, 2006 (Supp. 06-1). Amended by final exempt rulemaking at 21 A.A.R. 1641, effective July 23, 2015 (Supp. 15-3). Amended by final exempt rulemaking at 23 A.A.R. 133, effective January 1, 2017 (Supp. 16-4).

#### **R2-20-703.01. Campaign Consultants**

- A.** For purposes of this rule “Campaign Consultant” means any person paid by a participating candidate’s campaign or who provides services that are ordinarily charged to a person, except services provided for in A.R.S. § 16-911(6)(b).
- B.** A participating candidate may engage campaign consultants.
- C.** A participating candidate may only advance a campaign consultant for services such as consulting, communications, field employees, canvassers, mailers, auto-dialers, telephone town halls, electronic communications and other advertising purchases and other campaign service if an itemized invoice identifying the value of the services is provided directly to that particular candidate at the time of the advance payment.
1. Providing payment for such services as described in subsection (C) of this rule in the absence of an itemized invoice or advance payment for such services shall be deemed not to be a direct campaign expenditure.
  2. A participating candidate may advance payment for postage upon the receipt of a written estimate and so long as any balance is returned to the candidate if the advance exceeds the actual cost of postage.
  3. A participating candidate may advance payment for advertising that customarily requires pre-payment upon the receipt of a written estimate and so long as any balance is returned to the candidate if the advance exceeds the actual cost of the advertisement.
- D.** The Commission shall be included in the mail batch for all mailers and invitations. The Commission shall also be provided with documentation from the mail house, printer or other original source, showing the number of mailers printed and the number of households to which a mailer was sent. Failure to provide this information within 7 days after the mailer has been mailed may be considered as evidence the mailer was not for direct campaign purposes.
- E.** Notwithstanding any other provision of the rules to the contrary, a participating candidate shall not make any payment to a private organization that is exempt under section 501(a) of the internal revenue code and that is eligible to engage in activities to influence the outcome of a candidate election, nor make any payment directly or indirectly to a political party.

#### **Historical Note**

New Section made by exempt rulemaking at 23 A.A.R. 2344, effective July 20, 2017 (Supp. 17-3). Amended by final rulemaking at 26 A.A.R. 889, with an immediate effective date of March 16, 2020; the same amendments were filed and codified by final rulemaking at 26 A.A.R. 1263, with an immediate effective date of June 4, 2020 (Supp. 20-2).

#### **R2-20-704. Repayment**

- A.** In general, the Commission may determine that a participating candidate who has received payments from the Fund must repay the Fund as determined by the Commission.
1. A candidate who has received payments from the Fund shall pay the Fund any amounts that the Commission determines to be repayable. In making repayment determinations, the Commission may utilize information obtained from audits and examinations or otherwise obtained by the Commission in carrying out its responsibilities.
  2. The Commission will notify the candidate of any repayment determinations made under this Section as soon as possible.
  3. Once the candidate receives notice of the Commission’s repayment determination, the candidate should give preference to the repayment over all other outstanding obligations of the candidate, except for any taxes owed by the candidate.
  4. Repayments may be made only from the following sources: personal funds of the candidate, funds in the candidate’s current election campaign account, and any additional funds raised subject to the limitations and prohibitions of the Act.

5. The Commission may withhold the portion of funds required to be repaid from future payments to a participating candidate if the Commission has made a repayment determination.
- B.** The Commission may determine that a participating candidate who has received payments from the Fund must repay the Fund under any of the following circumstances:
1. Payments in excess of candidate's entitlement. If the Commission determines that any portion of the payments made to the candidate was in excess of the aggregate payments to which such candidate was entitled, it will so notify the candidate, and such candidate shall pay to the Fund an amount equal to such portion.
  2. Use of funds not for direct campaign expenses. If the Commission determines that any amount of any payment to an eligible candidate from the Fund was used for purposes other than direct campaign purposes described in R2-20-702, it will notify the candidate of the amount so used, and such candidate shall pay to the Fund an amount equal to such amount.
  3. Expenditures that were not documented in accordance with campaign finance reporting requirements, expended in violation of state or federal law, or used to defray expenses resulting from a violation of state or federal law, such as the payment of fines or penalties.
  4. Surplus. If the Commission determines that a portion of payments from the Fund remains unspent after all direct campaign expenses have been paid, it shall so notify the candidate, and such candidate shall pay the Fund that portion of surplus funds.
  5. Income on investment or other use of payments from the Fund. If the Commission determines that a candidate received any income as a result of an investment or other use of payments from the Fund, it shall so notify the candidate, and such candidate shall pay to the Fund an amount equal to the amount determined to be income, less any federal, state or local taxes on such income.
  6. Unlawful acceptance of contributions by an eligible candidate. If the Commission determines that a participating candidate accepted contributions, other than early contributions or qualifying contributions, it shall notify the candidate of the amount of contributions so accepted, and the candidate shall pay to the Fund an amount equal to such amount, plus any civil penalties assessed.
- C.** Repayment determination procedures. The Commission's repayment determination will be made in accordance with the following procedures:
1. Repayment determination. The Commission will send a repayment determination pursuant to Article 2, Compliance and Enforcement Procedures, and will set forth the legal and factual reasons for such determination, as well as the evidence upon which any such determination is based. The candidate shall repay, in accordance with subsection (D), the amount that the Commission has determined to be repayable.
  2. Administrative review of repayment determination. If a candidate disputes the Commission's repayment determination, he or she may request an administrative appeal of the determination in accordance with A.R.S. § 41-1092 et. seq.
- D.** Repayment period.
1. Within 30 days of service of the notice of the Commission's repayment determination, the candidate shall repay the amounts the Commission has determined must be repaid. Upon application by the candidate, the Commission may grant an extension of time in which to make repayment.
  2. If the candidate requests an administrative appeal of the Commission's repayment determination of this Section, the time for repayment will be suspended until the Commission has concluded its review of the Administrative Law Judge's (ALJ) decision. Within 30 days after service of the notice of the Commission's review of the ALJ's decision, the candidate shall repay the amounts that the Commission has determined to be repayable. Upon application by the candidate, the Commission may grant an extension of up to 30 days in which to make repayment.
  3. Interest shall be assessed on all repayments made after the initial 30-day repayment period or the 30-day repayment period established by this Section. The amount of interest due shall be the greater of:
    - a. An amount calculated in accordance with A.R.S. § 44-1201(A); or
    - b. The amount actually earned on the funds set aside or to be repaid under this Section.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Section repealed; new Section made by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4). Amended by final exempt rulemaking at 21 A.A.R. 1643, effective July 23, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 2122, effective July 29, 2019 (Supp. 19-3). Amended by final rulemaking at 26 A.A.R. 337, effective February 4, 2020; the amendment to subsection (A)(2) was originally codified in Supp. 19-3 at 25 A.A.R. 2020 (Supp. 20-1).

**R2-20-705. Additional Audits or Repayment Determinations**

- A.** The Commission may conduct an additional audit or examination of any candidate in any case in which the Commission finds reason to believe that a violation of a statute or regulation over which the Commission has jurisdiction has occurred or is about to occur.
- B.** The Commission may make additional repayment determinations after it has made an initial repayment determination pursuant to R2-20-704. The Commission may make additional repayment determinations where there exist facts not used as the basis for any previous determination. Any such additional repayment determination will be made in accordance with the provisions of this Article.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Section repealed; new Section made by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4).

**R2-20-706. Repealed**

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Section repealed by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4).

**R2-20-707. Repealed**

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Section repealed by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4).

**R2-20-708. Repealed**

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Section repealed by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4).

**R2-20-709. Repealed**

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Section repealed by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4).

**R2-20-710. Repealed**

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 588, effective November 27, 2001 (Supp. 02-1). Section repealed by exempt rulemaking at 11 A.A.R. 4518, effective May 28, 2005 (Supp. 05-4).

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## 16-948. Controls on participating candidates' campaign accounts

(Caution: 1998 Prop. 105 applies)

A. A participating candidate shall conduct all financial activity through a single campaign account of the candidate's campaign committee. A participating candidate shall not make any deposits into the campaign account other than those permitted under section 16-945 or 16-946.

B. A candidate may designate other persons with authority to withdraw monies from the candidate's campaign account. The candidate and any person so designated shall sign a joint statement under oath promising to comply with the requirements of this title.

C. The candidate or a person authorized under subsection B of this section shall pay monies from a participating candidate's campaign account directly to the person providing goods or services to the campaign and shall identify, on a report filed pursuant to article 1.4 of this chapter, the full name and street address of the person and the nature of the goods and services and compensation for which payment has been made. The following payments made directly or indirectly from a participating candidate's campaign account are unlawful contributions:

1. A payment made to a private organization that is exempt under section 501(a) of the internal revenue code and that is eligible to engage in activities to influence the outcome of a candidate election.

2. A payment made directly or indirectly to a political party.

D. Notwithstanding subsection C of this section, a campaign committee may establish one or more petty cash accounts, which in aggregate shall not exceed one thousand dollars at any time. No single expenditure shall be made from a petty cash account exceeding one hundred dollars.

E. Monies in a participating candidate's campaign account shall not be used to pay fines or civil penalties, for costs or legal fees related to representation before the commission, or for defense of any enforcement action under this chapter. Nothing in this subsection shall prevent a participating candidate from having a legal defense fund.

F. A participating candidate shall not use clean elections monies to purchase goods or services that bear a distinctive trade name, trademark or trade dress item, including a logo, that is owned by a business or other entity that is owned by that participating candidate or in which the candidate has a controlling interest. The use of goods or services that are prohibited by this subsection is deemed to be an unlawful in-kind contribution to the participating candidate.

## 16-956. Voter education and enforcement duties

(Caution: 1998 Prop. 105 applies)

A. The commission shall:

1. Develop a procedure for publishing a document or section of a document having a space of predefined size for a message chosen by each candidate. For the document that is delivered before the primary election, the document shall contain the names of every candidate for every statewide and legislative district office in that primary election without regard to whether the candidate is a participating candidate or a nonparticipating candidate. For the document that is delivered before the general election, the document shall contain the names of every candidate for every statewide and legislative district office in that general election without regard to whether the candidate is a participating candidate or a nonparticipating candidate. The commission shall deliver one copy of each document to every household that contains a registered voter. For the document that is delivered before the primary election, the delivery may be made over a period of days but shall be sent in time to be delivered to households before the earliest date for receipt by registered voters of any requested early ballots for the primary election. The commission may deliver the second document over a period of days but shall send the second document in order to be delivered to households before the earliest date for receipt by registered voters of any requested early ballots for the general election. The primary election and general election documents published by the commission shall comply with all of the following:

(a) For any candidate who does not submit a message pursuant to this paragraph, the document shall include with the candidate's listing the words "no statement submitted".

(b) The document shall have printed on its cover the words "citizens clean elections commission voter education guide" and the words "primary election" or "general election" and the applicable year. The document shall also contain at or near the bottom of the document cover in type that is no larger than one-half the size of the type used for "citizens clean elections commission voter education guide" the words "paid for by the citizens clean elections fund".

(c) In order to prevent voter confusion, the document shall be easily distinguishable from the publicity pamphlet that is required to be produced by the secretary of state pursuant to section 19-123.

2. Sponsor debates among candidates, in such manner as determined by the commission. The commission shall require participating candidates to attend and participate in debates and may specify by rule penalties for nonparticipation. The commission shall invite and permit nonparticipating candidates to participate in debates.

3. Prescribe forms for reports, statements, notices and other documents required by this article. The commission shall not require a candidate to use a reporting system other than the reporting system jointly approved by the commission and the office of the secretary of state.

4. Prepare and publish instructions setting forth methods of bookkeeping and preservation of records to facilitate compliance with this article and explaining the duties of persons and committees under this article.

5. Produce a yearly report describing the commission's activities and any recommendations for changes of law, administration or funding amounts and accounting for monies in the fund.

6. Adopt rules to implement the reporting requirements of section 16-958, subsections D and E.

7. Enforce this article, ensure that money from the fund is placed in candidate campaign accounts or otherwise spent as specified in this article and not otherwise, monitor reports filed pursuant to this chapter and financial records of candidates as needed and ensure that money required by this article to be paid to the fund is deposited in the fund. The commission shall not take action on any external complaint that is filed more than ninety days

after the postelection report is filed or ninety days after the completion of the canvass of the election to which the complaint relates, whichever is later.

B. The commission may subpoena witnesses, compel their attendance and testimony, administer oaths and affirmations, take evidence and require by subpoena the production of any books, papers, records or other items material to the performance of the commission's duties or the exercise of its powers.

C. The commission may adopt rules to carry out the purposes of this article and to govern procedures of the commission. The commission shall propose and adopt rules in public meetings, with at least sixty days allowed for interested parties to comment after the rules are proposed. The commission shall also file the proposed rule in the format prescribed in section 41-1022 with the secretary of state's office for publication in the Arizona administrative register. After consideration of the comments received in the sixty day comment period, the commission may adopt the rule in an open meeting. Any rules given final approval in an open meeting shall be filed in the format prescribed in section 41-1022 with the secretary of state's office for publication in the Arizona administrative register. Any rules adopted by the commission shall only be applied prospectively from the date the rule was adopted.

D. Rules adopted by the commission are not effective until January 1 in the year following the adoption of the rule, except that rules adopted by unanimous vote of the commission may be made immediately effective and enforceable.

E. If, in the view of the commission, the action of a particular candidate or committee requires immediate change to a commission rule, a unanimous vote of the commission is required. Any rule change made pursuant to this subsection that is enacted with less than a unanimous vote takes effect for the next election cycle.

F. Based on the results of the elections in any quadrennial election after 2002, and within six months after such election, the commission may adopt rules changing the number of qualifying contributions required for any office from those listed in section 16-950, subsection D by no more than twenty percent of the number applicable for the preceding election.

16-974. Citizens clean elections commission; powers and duties; rules

(Caution: 1998 Prop. 105 applies)

A. The commission is the primary agency authorized to implement and enforce this chapter. The commission may do any of the following:

1. Adopt and enforce rules.
2. Issue and enforce civil subpoenas, including third-party subpoenas.
3. Initiate enforcement actions.
4. Conduct fact-finding hearings and investigations.
5. Impose civil penalties for noncompliance, including penalties for late or incomplete disclosures and for any other violations of this chapter.
6. Seek legal and equitable relief in court as necessary.
7. Establish the records persons must maintain to support their disclosures.
8. Perform any other act that may assist in implementing this chapter.

B. If the commission imposes a civil penalty on a person and that person does not timely seek judicial review, the commission may file a certified copy of its order requiring payment of the civil penalty with the clerk of the superior court in any county of this state. The clerk shall treat the commission order in the same manner as a judgment of the superior court. A commission order filed pursuant to this subsection has the same effect as a judgment of the superior court and may be recorded, enforced or satisfied in the same manner. A filing fee is not required for an action filed under this subsection.

C. The commission shall establish disclaimer requirements for public communications by covered persons. A political action committee that complies with these requirements need not separately comply with the requirements prescribed in section 16-925, subsection B. Public communications by covered persons shall state, at a minimum, the names of the top three donors who directly or indirectly made the three largest contributions of original monies during the election cycle to the covered person. If it is not technologically possible for a public communication disseminated on the internet or by social media message, text message or short message service to provide all the information required by this subsection, the public communication must provide a means for viewers to obtain, immediately and easily, the required information without having to receive extraneous information.

D. The commission's rules and any commission enforcement actions pursuant to this chapter are not subject to the approval of or any prohibition or limit imposed by any other executive or legislative governmental body or official. Notwithstanding any law to the contrary, rules adopted pursuant to this chapter are exempt from title 41, chapters 6 and 6.1.

E. The commission shall establish a process to reimburse the secretary of state and any other agency that incurs costs to implement or enforce this chapter.

F. The commission may adjust the contribution and expenditure thresholds in this chapter to reflect inflation.

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)**  
Title 9, Chapter 22, Article 5



# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

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**MEETING DATE:** March 7, 2023

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** February 17, 2023

**SUBJECT:** Arizona Health Care Cost Containment System (AHCCCS)  
Title 9, Chapter 22, Article 5

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This Five-Year-Review Report (5YRR) from AHCCCS relates to rules in Title 9, Chapter 22 regarding Administration. Specifically, the report covers rules in Article 5 regarding general provisions and standards.

AHCCCS indicates they did not complete the proposed course of action in the prior 5YRR of these rules.

### **Proposed Action**

AHCCCS is proposing to amend two of their rules in order to make them more clear, concise, understandable, and consistent with other rules and statutes. AHCCCS indicates it plans to request an exemption from the Governor's office for the rulemaking moratorium and complete a rulemaking addressing the changes in the report by July 2023.

#### **1. Has the agency analyzed whether the rules are authorized by statute?**

Yes, the Department cites to both general and specific statutory authority.

2. **Summary of the agency's economic impact comparison and identification of stakeholders:**

According to the Administration, the prior rulemaking had a minimal impact on the state economy and small businesses and consumers because the changes to the rules were designed to help understand and use the rules.

The Administration identifies stakeholders as the AHCCCS Administration, AHCCCS contractors, healthcare providers, and AHCCCS members.

3. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

According to the Administration, the benefits of the rules outweigh the costs and impose the least burden and costs on those regulated. They further state that any costs are necessary to achieve the regulatory objective.

4. **Has the agency received any written criticisms of the rules over the last five years?**

No, AHCCCS indicates they did not receive any written criticisms to the rules.

5. **Has the agency analyzed the rules' clarity, conciseness, and understandability?**

Yes, the AHCCCS indicates the rules are overall clear, concise, and understandable with the exception of the following:

**R9-22-502** - Pre-existing Conditions

6. **Has the agency analyzed the rules' consistency with other rules and statutes?**

Yes, AHCCCS indicates the rules are consistent with other rules and statutes with the exception of the following:

**R9-22-505** - Standards, Licensure, and Certification for Providers of Hospital and Medical Services

7. **Has the agency analyzed the rules' effectiveness in achieving its objectives?**

Yes, AHCCCS indicates the rules are effective in achieving their objectives.

8. **Has the agency analyzed the current enforcement status of the rules?**

Yes, AHCCCS indicates the rules are enforced as written.

9. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

No, AHCCCS indicates the rules are not more stringent than federal law, 42 CFR Part 482.

10. **For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

Not applicable. The rules do not require the issuance of a general permit or license.

11. **Conclusion**

As mentioned above, AHCCCS is proposing to amend two of their rules in order to make them more clear, concise, understandable, and consistent with other rules and statutes. AHCCCS plans to request an exemption from the rule moratorium from the Governor's Office no later than July 2023.

Council Staff recommends approval of this report.

December 28, 2022

Ms. Nicole Sornsins, Chair  
Governor's Regulatory Review Council  
100 N. 15<sup>th</sup> Ave, Suite 305  
Phoenix, AZ 85007

Dear Ms. Sornsins:

Pursuant to requirements in R1-6-301, attached is a copy of the 5-Year Review Report for Title 9, Chapter 22, Article 5. The report includes all of the documentation required by R1-6-301 (C) and (D).

As required by A.R.S. § 41-1056, the Administration certifies that the agency is in compliance with A.R.S. § 41-1091.

If you need any further information regarding this report, please contact Stephanie Elzenga, Office of the General Counsel at (602) 417-4232.

Sincerely,



Kasey Rogg  
Assistant Director

Attachments



R9-22-505	Federal regulation requires hospitals that participate in Medicaid to meet Medicare conditions of participation which are set forth in 42 CFR Parts 441 and 482. Medicare standards also permit deemed status through accreditation by national accreditation organizations which are not limited to the Joint Commission on Accreditation of Healthcare Organization (JCAHO). Therefore, the regulation should be updated to read that the referenced hospitals may be accredited by “a national accreditation organization.” In addition, we recommend removal of the specific dates of the regulations which are incorporated by reference.
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5. **Are the rules enforced as written?** Yes  No

6. **Are the rules clear, concise, and understandable?** Yes  No

Rule	Explanation
R9-22-502	Recommending a change from “psychiatric condition” to “behavioral health condition” so verbiage is consistent between the rules and AHCCCS publications. In addition, “behavioral health condition” allows for a broader coverage of conditions.

7. **Has the agency received written criticisms of the rules within the last five years?** Yes  No

8. **Economic, small business, and consumer impact comparison:**

The prior EIS stated that the impact would be minimal on the state economy, small businesses, and consumers because the changes were designed to understand and use the rules. Similarly, the changes suggested in this report will not have an economic impact because the phrasing aligns with current AHCCCS policy and is a broadening, instead of restricting, changes to the text of the rule.

9. **Has the agency received any business competitiveness analyses of the rules?** Yes  No

10. **Has the agency completed the course of action indicated in the agency’s previous five-year-review report?** The proposed course of action in the prior 5YRR was not enacted, therefore those recommended changes are incorporated here.

11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

The benefits of these rules outweigh the costs, impose the least burden and cost on those regulated, and any costs are necessary to achieve the regulatory objective.

12. **Are the rules more stringent than corresponding federal laws?** Yes  No

Federal law 42 CFR Part 482 (which also refers to Part 488) allows for hospitals to meet Medicare certification requirements when accredited by national accreditation organizations. Therefore, we recommend aligning the rule with the federal provision by not limiting the national accreditation organization to JCAHO.

13. **For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

No permit, license, or authorization applies.

14. **Proposed course of action**

AHCCCS plans to make a change from “psychiatric condition” to “behavioral health condition” so verbiage is consistent between the rules and AHCCCS publications in R9-22-502. AHCCCS also plans to change than the current requirement in regulation to read “accredited through a nationally recognized accreditation organization.” In addition, AHCCCS plans to remove the incorporation of federal regulations by reference in R9-22-505. AHCCCS plans to make the above changes by requesting an exemption from the Governor’s office for the rulemaking moratorium within 120 days following GRRC’s approval of this report.

**Historical Note**

New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

**ARTICLE 5. GENERAL PROVISIONS AND STANDARDS****R9-22-501. General Provisions and Standards - Related Definitions**

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“Quality management” means a process used by professional health personnel through a formal program involving multiple organizational components and committees to:

- Assess the degree to which services provided conform to desired medical standards and practices; and
- Quality improvement or maintenance of care and services.

“Quality Improvement” means a process designed to achieve, through ongoing measurements and intervention, significant improvement that is sustained over time, in the areas of clinical care and non-clinical care and is expected to have a favorable effect on health outcomes and member satisfaction. Quality Improvement includes focusing organizational efforts on improving performance and utilizing data to develop intervention strategies to improve performance and outcomes.

“Utilization management/review” means a methodology used by professional health personnel to assess the medical indications, appropriateness, and efficiency of care provided. Utilization management applies to a contractor’s process to evaluate and approve or deny the medical necessity, appropriateness, efficacy and efficiency of health care services, procedures, or settings. Utilization review includes processes for prior authorization, concurrent review, retrospective review, and case management.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-501 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-501 repealed, former Section R9-22-502 renumbered and adopted without change as Section R9-22-501 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-501 repealed, former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-502. Pre-existing Conditions**

- A. A contractor shall not impose a pre-existing condition exclusion with respect to covered services.
- B. A contractor or subcontractor shall not adopt or use any procedure to identify a person who has an existing or anticipated medical or psychiatric condition in order to discourage or exclude the person from enrolling in the contractor’s health plan or encourage the person to enroll in another health plan.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-502 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-502 renumbered without change as Section R9-22-501, former Sec-

tion R9-22-503 renumbered and amended as Section R9-22-502 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-502 repealed, new Section R9-22-502 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4). Amended by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

**R9-22-503. Provider Requirements Regarding Records**

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. A provider shall maintain and upon request, make available to a contractor and to the Administration, financial and medical records relating to payment 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. Providers shall provide one copy of a medical record at no cost if requested by the member.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-503 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-503 renumbered and amended as Section R9-22-502, new Section R9-22-503 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective May 30, 1986 (Supp. 86-3). Amended subsection (D) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (F) and (G) effective December 22, 1987 (Supp. 87-4). Amended subsection (I) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). New Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-504. Marketing; Prohibition Against Inducements; Misrepresentations; Discrimination; Sanctions**

- A. A contractor or the contractor’s marketing representative shall not offer or give any form of compensation or reward, or engage in any behavior or activity that may be reasonably construed as coercive, to induce or procure AHCCCS enrollment with the contractor. Any marketing solicitation offering a benefit, good, or service in excess of the covered services in Article 2 is deemed an inducement.
- B. A marketing representative shall not misrepresent itself, the contracting health plan represented, or the AHCCCS program, through false advertising, false statements, or in any other manner to induce a member of another contractor to enroll in the represented health plan. Violations of this subsection include, but are not limited to, false or misleading claims, inferences, or representations such as:
  1. A member will lose benefits under the AHCCCS program or lose any other health or welfare benefits to which a member is legally entitled, if the member does not enroll in the represented contracting health plan;

## Arizona Health Care Cost Containment System - Administration

2. Marketing representatives are employees of the state or representatives of the Administration, a county, or any health plan other than the health plan by which they are employed, or by which they are reimbursed; and
  3. The represented health plan is recommended or endorsed as superior to its competition by any state or county agency, or any organization, unless the organization has certified its endorsement in writing to the health plan and the Administration.
- C.** A marketing representative shall not engage in any marketing or pre-enrollment practice that discriminates against a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.
- D.** The Administration shall hold a contractor responsible for a violation of this Section resulting from the performance of any marketing representative, subcontractor, agent, program, or process under the contractor's employ or direction and shall impose contract sanctions on the contractor as specified in contract.
- E.** A contractor shall produce and distribute informational materials that are approved by the Administration to each enrolled member or designated representative after the contractor receives notification of enrollment from the Administration. The contractor shall ensure that the informational materials include, at a minimum:
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;
  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.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-504 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-504 repealed, former Section R9-22-505 renumbered and adopted without change as Section R9-22-504 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-504 repealed, former Section R9-22-528 renumbered and amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-505. Standards, Licensure, and Certification for Providers of Hospital and Medical Services**

A provider shall not provide hospital or medical services to a member unless the provider is licensed by the Arizona Department of Health Services and meets the requirements in 42 CFR 441 and 482, as of October 1, 2007, and 42 CFR 456 Subpart C, as of October 1, 2007, 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 as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-505 adopted as an emergency expired, former Section R9-22-506 adopted as an emergency now adopted, amended and renumbered as Section R9-22-505 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-505 renumbered without change as Section R9-22-504, new Section R9-22-505 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-505 renumbered and amended as Section R9-22-509, former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5). Editorial correction, spelling of "paraphernalia" in subsection (A) (Supp. 87-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). New Section made by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-506. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-506 adopted as an emergency adopted, amended and renumbered as Section R9-22-505, former Section R9-22-507 adopted as an emergency now adopted, amended and renumbered as Section R9-22-506 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-506 repealed, new Section R9-22-506 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-506 repealed, new Section R9-22-506 adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (D) effective December 22, 1987 (Supp. 87-4). Repealed effective April 13, 1990 (Supp. 90-2). New Section adopted effective December 13, 1993 (Supp. 93-4). Repealed effective December 8, 1997 (Supp. 97-4).

**R9-22-507. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-507 adopted as an emergency adopted, amended and renumbered as Section R9-22-506, former Section R9-22-508 adopted as an emergency now adopted, amended and renumbered as Section R9-22-507 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-507 repealed, new Section R9-22-507 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-508. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-508 adopted as an emergency adopted, amended and renumbered as Section R9-22-507, former Section R9-22-509 adopted as an emergency now adopted, amended and renumbered as Section R9-22-508 as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective December 8, 1997 (Supp. 97-4).

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Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-509. Transition and Coordination of Member Care**

A. A contractor shall assist in the transition of members to and from other AHCCCS contractors.

1. Both the receiving and relinquishing contractor shall:
  - a. Coordinate with the other contractor to facilitate and schedule appointments for medically necessary services for the transitioned member within the Administration's timelines specified in the contract. If requested by the Administration, a contractor shall submit the policies and procedures regarding transition of members to the Administration for review and approval;
  - b. Assist in the referral of transitioned members to other community health agencies or county medical assistance programs for medically necessary services not covered by the Administration, as appropriate; and
  - c. Develop policies and procedures to be followed when transitioning members who have significant medical conditions; are receiving ongoing services; or have, at the time of the transition, received prior authorization or approval for undelivered, specific services.
2. The relinquishing contractor shall notify the receiving contractor of relevant information about the member's medical condition and current treatment regimens within the timelines defined in contract;
3. The relinquishing contractor shall forward medical records and other relevant materials to the receiving contractor. The relinquishing contractor shall bear the cost of reproducing and forwarding medical records and other relevant materials;
4. Within the timelines specified in contract, the receiving contractor shall ensure that the member selects or is assigned to a primary care provider, and provide the member with:
  - a. Information regarding the contractor's providers,
  - b. Emergency numbers, and
  - c. Instructions about how to obtain services.

B. A contractor shall not use a county or noncontracting provider health resource alternative to diminish the contractor's contractual responsibility or accountability for providing the full scope of covered services. The Administration may impose sanctions as described in contract if a contractor makes referrals to other agencies or programs to reduce expenses incurred by the contractor on behalf of its members.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-509 adopted as an emergency adopted, amended and renumbered as Section R9-22-508, former Section R9-22-510 adopted as an emergency now adopted and renumbered as Section R9-22-509 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-509 repealed, former Section R9-22-505 renumbered and amended as Section R9-22-509 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-510. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-510 adopted as an emergency adopted and renumbered as Section R9-22-509, former Section R9-22-511 adopted as an emergency now adopted, amended and renumbered as Section R9-22-510 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-510 repealed, new Section R9-22-510 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-511. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-511 adopted as an emergency adopted, amended and renumbered as Section R9-22-510, former Section R9-22-512 adopted as an emergency now adopted, amended and renumbered as Section R9-22-511 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-511 repealed, new Section R9-22-511 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-512. Release of Safeguarded Information**

- A. The Administration, contractors, providers, and noncontracting providers shall limit the release of safeguarded information to persons or agencies for the following purposes in accordance with 45 CFR 160 and 45 CFR 164, October 1, 2004, and 42 CFR 431.300 through 431.307, 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:
1. Official purposes directly related to the administration of the AHCCCS program including:
    - a. Establishing eligibility and post-eligibility treatment of income, as applicable;
    - b. Determining the amount of medical assistance;
    - c. Providing services for members;
    - d. Performing evaluations and analysis of AHCCCS operations;
    - e. Filing liens on property as applicable;
    - f. Filing claims on estates, as applicable; and
    - g. Filing, negotiating, and settling medical liens and claims.
  2. Law enforcement. The Administration may release safeguarded information without the applicant's or member's written or verbal consent, for the purpose of conducting or assisting an investigation, prosecution, or criminal or civil proceeding related to the administration of the AHCCCS program.
  3. The Administration may release safeguarded member information to a review committee in accordance with the provisions of A.R.S. § 36-2917, without the consent of the applicant or member.
- B. Except as provided in subsection (A), the Administration, contractors, providers, and noncontracting providers shall disclose safeguarded information only to:
1. An applicant;
  2. A member;

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3. An unemancipated minor, with written permission of a parent, custodial relative, or designated representative, if:
    - a. An Administration employee, authorized representative, or responsible caseworker is present during the examination of the safeguarded information; or
    - b. After written notification to the provider, and at a reasonable time and place.
  4. Persons authorized by the applicant or member; or
  5. A court order or subpoena compliant with 45 CFR 164.512(e), 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.** The Administration, contractors, providers, and noncontracting providers shall safeguard identifiable information, protected health information as specified in 45 CFR 160, and information obtained in the course of application for or re-determination of eligibility concerning an applicant or member, that includes, but is not limited to the following:
1. Name and address;
  2. Social Security number;
  3. Social and economic conditions or circumstances;
  4. Agency evaluation of personal information;
  5. Medical data and information concerning medical services received, including diagnosis and history of disease or disability;
  6. State Data Exchange (SDX) tapes, and other types of information received from outside sources for the purpose of verifying income eligibility and amount of medical assistance payments; and
  7. Any information received in connection with the identification of legally liable third-party resources.
- D.** The restriction upon disclosure of information in this Section does not apply to:
1. De-identified information as described by 45 CFR 164.514, October 1, 2004, incorporated by reference in subsection (A); or
  2. A disclosure, in response to a request for information, that complies with 45 CFR 160 and 45 CFR 164, October 1, 2004, and 42 CFR 431.300 through 431.307, October 1, 2004, incorporated by reference in subsection (A).
- E.** A provider shall furnish records requested by the Administration or a contractor to the Administration or the contractor at no charge.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-512 adopted as an emergency adopted, amended and renumbered as Section R9-22-511, former Section R9-22-513 adopted as an emergency now adopted and renumbered as Section R9-22-512 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-512 repealed, new Section R9-22-512 adopted effective October 1, 1985 (Supp. 85-5).  
 Amended effective December 13, 1993 (Supp. 93-4).  
 Amended effective December 8, 1997 (Supp. 97-4).  
 Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-513. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-513 adopted as an emergency adopted and renumbered as Section R9-22-512, former Section R9-22-514 adopted as an emergency now adopted, amended and renumbered as Section R9-22-513 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-513 repealed, former Section R9-22-526 renumbered and amended as Section R9-22-513 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-514. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-514 adopted as an emergency adopted, amended and renumbered as Section R9-22-513, former Section R9-22-515 adopted as an emergency now adopted, amended and renumbered as Section R9-22-514 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-514 repealed, former Section R9-22-517 renumbered and amended as Section R9-22-514 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-515. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-515 adopted as an emergency adopted, amended and renumbered as Section R9-22-514, former Section R9-22-517 adopted as an emergency now adopted, amended and renumbered as Section R9-22-515 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-515 repealed, former Section R9-22-522 renumbered and amended as Section R9-22-515 effective October 1, 1985 (Supp. 85-5). Repealed effective December 8, 1997 (Supp. 97-4).

**R9-22-516. Renumbered****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-516 adopted as an emergency expired, former Section R9-22-518 adopted as an emergency now adopted, amended and renumbered as Section R9-22-516 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-516 renumbered as Section R9-22-513 effective October 1, 1985 (Supp. 85-5).

**R9-22-517. Renumbered****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-517 adopted as an emergency adopted, amended and renumbered as Section R9-22-515, former Section R9-22-519 adopted as an emergency now adopted and renumbered and amended as Section R9-22-

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517 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-517 renumbered and amended as Section R9-22-514 effective October 1, 1985 (Supp. 85-5).

**R9-22-518. Information to Enrolled Members**

- A.** Each contractor shall produce and distribute printed informational materials to each member or family unit no later than 10 days of receipt of notification of enrollment from the Administration. The contractor shall ensure that the informational materials meet the requirements specified in the contractor's current contract.
- B.** A contractor shall provide a member with the name, address, and telephone number of the member's primary care provider no later than 10 days from the date of enrollment. The contractor shall include information on how the member may change primary care providers.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-518 adopted as an emergency adopted, amended and renumbered as Section R9-22-516, former Section R9-22-520 adopted as an emergency now adopted, amended and renumbered as Section R9-22-518 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-518 repealed, new Section R9-22-518 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-519. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-519 adopted as an emergency adopted, amended and renumbered as Section R9-22-517, former Section R9-22-521 adopted as an emergency now adopted, amended and renumbered as Section R9-22-519 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-519 repealed, new Section R9-22-519 adopted effective October 1, 1985 (Supp. 85-5). Repealed effective December 8, 1997 (Supp. 97-4).

**R9-22-520. Expired****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-520 adopted as an emergency adopted, amended and renumbered as Section R9-22-518, former Section R9-22-522 adopted as an emergency now adopted, amended and renumbered as Section R9-22-520 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-520 repealed, new Section R9-22-520 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). 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).

**R9-22-521. Program Compliance Audits**

- A.** The Administration shall conduct an onsite program compliance audit of a contractor at least once every three years during the term of the Administration's contract with the contractor.

The Administration may conduct, without prior notice, inspections of contractor facilities or perform other elements of a program compliance audit.

- B.** An audit team may perform any or all of the following procedures:

1. Conduct private interviews and group conferences with members, physicians, other health professionals, and members of the contractor's administrative staff including, but not limited to, the contractor's principal management persons;
2. Examine records, books, reports, and papers of the contractor and any management company, and all providers or subcontractors providing health care and other services. The examination may include, but need not be limited to: minutes of medical staff meetings, peer review and quality of care review records, duty rosters of medical personnel, appointment records, written procedures for the internal operation of the health plan, contracts and correspondence with members and with providers of health care services and other services to the plan, and additional documentation deemed necessary by the Administration to review the quality of medical care.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-521 adopted as an emergency adopted, amended and renumbered as Section R9-22-519, former Section R9-22-523 adopted as an emergency now adopted, amended and renumbered as Section R9-22-521 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-521 repealed, new Section R9-22-521 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

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

**R9-22-522. Quality Management/Utilization Management (QM/UM) Requirements**

- A.** A contractor shall comply with Quality Management/Utilization Management (QM/UM) requirements specified in this Section and in contract. The contractor shall ensure compliance with QM/UM requirements that are accomplished through delegation or subcontract with another party.
- B.** In addition to any requirements specified in contract, a contractor shall:
1. Submit to the Administration a written QM/UM plan that includes a description of the systems, methodologies, protocols, and procedures to be used in:
    - a. Monitoring and evaluating the types of services provided,
    - b. Identifying the numbers and costs of services provided,
    - c. Assessing and improving the quality and appropriateness of care and services,

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- d. Evaluating the outcome of care provided to members, and
- e. Determining the actions necessary to improve service delivery;
2. Submit the QM/UM plan to the Administration on an annual basis within timelines specified in contract. If the QM/UM plan is changed during the year, the contractor shall submit the revised plan to the Administration before implementation;
3. Receive approval from the Administration before implementing the initial or revised QM/UM plan;
4. Ensure that a QM/UM committee operates under the control of the contractor's medical director and includes representation from medical and executive management personnel. The committee shall:
  - a. Oversee the development, revision, and implementation of the QM/UM plan; and
  - b. Ensure that there are qualified QM/UM personnel and sufficient resources to implement the contractor's QM/UM activities; and
5. Ensure that the QM/UM activities include at least:
  - a. Prior authorization for non-emergency or scheduled hospital admissions;
  - b. Concurrent review of inpatient hospitalization;
  - c. Retrospective review of hospital claims;
  - d. Program and provider audits designed to detect over- or under-utilization, service delivery effectiveness, and outcome;
  - e. Medical records audits;
  - f. Surveys to determine satisfaction of members;
  - g. Assessment of the adequacy and qualifications of the contractor's provider network;
  - h. Review and analysis of QM/UM data;
  - i. Measurement of performance using objective quality indicators;
  - j. Ensuring individual and systemic quality of care;
  - k. Integrating quality throughout the organization;
  - l. Process improvement;
  - m. Credentialing a provider network;
  - n. Resolving quality of care grievances; and
  - o. Quality improvement activities focused on improving the quality of care and the efficient, cost-effective delivery and utilization of services.
- C. A member's primary care provider shall maintain medical records that:
  1. Conform to professional medical standards and practices for documentation of medical diagnostic and treatment data;
  2. Facilitate follow-up treatment; and
  3. Permit professional medical review and medical audit processes.
- D. Within 30 days following termination of the contract between a subcontractor and a contractor, the subcontractor or the subcontractor's designee shall forward to the primary care provider medical records or copies of medical records of all members assigned to the subcontractor or for whom the subcontractor has provided services.
- E. The Administration shall monitor each contractor and the contractor's providers to ensure compliance with Administration QM/UM requirements and adherence to the contractor's QM/UM plan.
  1. A contractor and the contractor's providers shall cooperate with the Administration in the performance of the Administration's QM/UM monitoring activities; and
2. A contractor and the contractor's providers shall develop and implement mechanisms for correcting deficiencies identified through the Administration's QM/UM monitoring.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-522 adopted as an emergency adopted, amended and renumbered as Section R9-22-520, former Section R9-22-524 adopted as an emergency now adopted and renumbered as Section R9-22-522 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-522 renumbered and amended as Section R9-22-515, new Section R9-22-522 adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-523. Expired****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-523 adopted as an emergency adopted, amended and renumbered as Section R9-22-521, former Section R9-22-525 adopted as an emergency now adopted, amended and renumbered as Section R9-22-523 as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). 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).

**R9-22-524. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-524 adopted as an emergency adopted and renumbered as Section R9-22-522, former Section R9-22-526 adopted as an emergency now adopted, amended and renumbered as Section R9-22-524 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-524 repealed, new Section R9-22-524 adopted effective October 1, 1985 (Supp. 85-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-525. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-525 adopted as an emergency adopted, amended and renumbered as Section R9-22-523, former Section R9-22-527 adopted as an emergency now adopted, amended and renumbered as Section R9-22-525 as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1985 (Supp. 85-5).

**R9-22-526. Renumbered**

**Historical Note**

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of the permanent rule identical to the emergency (Supp. 83-3). Former Section R9-22-526 repealed, new Section R9-22-526 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-1).

**R9-22-527. Renumbered****Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5).

**R9-22-528. Renumbered****Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-528 renumbered and amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5).

**R9-22-529. Renumbered****Historical Note**

Adopted as Section R9-22-529 effective October 1, 1985, then renumbered as Section R9-22-1002 effective October 1, 1985 (Supp. 85-5).

**ARTICLE 6. RFP AND CONTRACT PROCESS****R9-22-601. General Provisions**

- A. The Director has full operational authority to adopt rules for the RFP process and the award of contracts under A.R.S. § 36-2906.
- B. This Article applies to the award of contracts under A.R.S. §§ 36-2904 and 36-2906 to provide services under A.R.S. § 36-2907 and the expenditure of public monies by the Administration pertaining to covered services when the procurement so states. The Administration shall establish conflict-of-interest safeguards for officers and employees of this state with responsibilities relating to contracts that comply with 42 U.S.C. 1396u-2(d)(3).
- C. The Administration is exempt from the procurement code under A.R.S. § 41-2501.
- D. The Administration and contractors shall retain all contract records for five years under A.R.S. § 36-2903 and dispose of the records under A.R.S. § 41-2550.
- E. The following terms are defined as related to this Article: "Procurement file" means the official records file of the Director whether located in the Office of the Director or at the public procurement unit. The procurement file shall include in electronic or paper form a list of notified vendors, final solicitation, solicitation amendments, bids/offers, final proposal revisions, clarifications, and final evaluation report.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-601 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 424,

effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

**R9-22-602. RFP**

- A. RFP content. The Administration shall include the following items in any RFP under this Article:
  1. Instructions and information to an offeror concerning the proposal submission including:
    - a. The deadline for submitting a proposal,
    - b. The address of the office at which a proposal is to be received,
    - c. The period during which the RFP remains open, and
    - d. Any special instructions and information;
  2. The scope of covered services under Article 2 of this Chapter and A.R.S. §§ 36-2906 and 36-2907, covered populations, geographic coverage, service and performance requirements, and a delivery or performance schedule;
  3. The contract terms and conditions, including bonding or other security requirements, if applicable;
  4. The factors used to evaluate a proposal;
  5. The location and method of obtaining documents that are incorporated by reference in the RFP;
  6. A requirement that the offeror acknowledge receipt of all RFP amendments issued by the Administration;
  7. The type of contract to be used and a copy of a proposed contract form or provisions;
  8. The length of the contract service;
  9. A requirement for cost or pricing data;
  10. The minimum RFP requirements; and
  11. A provision requiring an offeror to certify that a submitted proposal does not involve collusion or other anti-competitive practices.
- B. Proposal process.
  1. After the deadline for submitting proposals, the Administration may open a proposal publicly and announce and record the name of the offeror. The Administration shall keep all other information contained in a proposal confidential. The Administration shall open a proposal for public inspection after contract award unless the Administration determines that disclosure is not in the best interest of the state.
  2. The Administration shall evaluate a proposal based on the GSA and the evaluation factors listed in the RFP.
  3. The Administration may initiate discussions with a responsive and responsible offeror to clarify and assure full understanding of an offeror's proposal. The Administration shall provide an offeror fair treatment with respect to discussion and revision of a proposal. The Administration shall not disclose information derived from a proposal submitted by a competing offeror.
  4. The Administration shall allow for the adjustment of covered services by expansion, deletion, segregation, or combination in order to secure the most financially advantageous proposals for the state.
  5. The Administration may conduct an investigation of a person or organization who has ownership or management interests in corporate offerors or affiliated corporate organizations of an offeror.
  6. The Administration may issue a written request for best and final offers. The Administration shall state in the request the date, time, and place for the submission of best and final offers.
  7. The Administration shall not request best and final offers more than once unless the Administration determines that it is advantageous to the state to request additional best

### 36-2903.01. Additional powers and duties; report; definition

A. The director of the Arizona health care cost containment system administration may adopt rules that provide that the system may withhold or forfeit payments to be made to a noncontracting provider by the system if the noncontracting provider fails to comply with this article, the provider agreement or rules that are adopted pursuant to this article and that relate to the specific services rendered for which a claim for payment is made.

B. The director shall:

1. Prescribe uniform forms to be used by all contractors. The rules shall require a written and signed application by the applicant or an applicant's authorized representative, or, if the person is incompetent or incapacitated, a family member or a person acting responsibly for the applicant may obtain a signature or a reasonable facsimile and file the application as prescribed by the administration.

2. Enter into an interagency agreement with the department to establish a streamlined eligibility process to determine the eligibility of all persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). At the administration's option, the interagency agreement may allow the administration to determine the eligibility of certain persons, including those defined pursuant to section 36-2901, paragraph 6, subdivision (a).

3. Enter into an intergovernmental agreement with the department to:

(a) Establish an expedited eligibility and enrollment process for all persons who are hospitalized at the time of application.

(b) Establish performance measures and incentives for the department.

(c) Establish the process for management evaluation reviews that the administration shall perform to evaluate the eligibility determination functions performed by the department.

(d) Establish eligibility quality control reviews by the administration.

(e) Require the department to adopt rules, consistent with the rules adopted by the administration for a hearing process, that applicants or members may use for appeals of eligibility determinations or redeterminations.

(f) Establish the department's responsibility to place sufficient eligibility workers at federally qualified health centers to screen for eligibility and at hospital sites and level one trauma centers to ensure that persons seeking hospital services are screened on a timely basis for eligibility for the system, including a process to ensure that applications for the system can be accepted on a twenty-four hour basis, seven days a week.

(g) Withhold payments based on the allowable sanctions for errors in eligibility determinations or redeterminations or failure to meet performance measures required by the intergovernmental agreement.

(h) Recoup from the department all federal fiscal sanctions that result from the department's inaccurate eligibility determinations. The director may offset all or part of a sanction if the department submits a corrective action plan and a strategy to remedy the error.

4. By rule establish a procedure and time frames for the intake of grievances and requests for hearings, for the continuation of benefits and services during the appeal process and for a grievance process at the contractor level. Notwithstanding sections 41-1092.02, 41-1092.03 and 41-1092.05, the administration shall develop rules to establish the procedure and time frame for the informal resolution of grievances and appeals. A grievance that is not related to a claim for payment of system covered services shall be filed in writing with and received by the administration or the prepaid capitated provider or program contractor not later than sixty days after the date of the adverse action, decision or policy implementation being grieved. A grievance that is related to a claim for payment of system covered services must be filed in writing and received by the administration or the prepaid capitated provider or program contractor within twelve months after the date of service, within twelve months

after the date that eligibility is posted or within sixty days after the date of the denial of a timely claim submission, whichever is later. A grievance for the denial of a claim for reimbursement of services may contest the validity of any adverse action, decision, policy implementation or rule that related to or resulted in the full or partial denial of the claim. A policy implementation may be subject to a grievance procedure, but it may not be appealed for a hearing. The administration is not required to participate in a mandatory settlement conference if it is not a real party in interest. In any proceeding before the administration, including a grievance or hearing, persons may represent themselves or be represented by a duly authorized agent who is not charging a fee. A legal entity may be represented by an officer, partner or employee who is specifically authorized by the legal entity to represent it in the particular proceeding.

5. Apply for and accept federal funds available under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) in support of the system. The application made by the director pursuant to this paragraph shall be designed to qualify for federal funding primarily on a prepaid capitated basis. Such funds may be used only for the support of persons defined as eligible pursuant to title XIX of the social security act or the approved section 1115 waiver.

6. At least thirty days before the implementation of a policy or a change to an existing policy relating to reimbursement, provide notice to interested parties. Parties interested in receiving notification of policy changes shall submit a written request for notification to the administration.

7. In addition to the cost sharing requirements specified in subsection D, paragraph 4 of this section:

(a) Charge monthly premiums up to the maximum amount allowed by federal law to all populations of eligible persons who may be charged.

(b) Implement this paragraph to the extent permitted under the federal deficit reduction act of 2005 and other federal laws, subject to the approval of federal waiver authority and to the extent that any changes in the cost sharing requirements under this paragraph would permit this state to receive any enhanced federal matching rate.

C. The director is authorized to apply for any federal funds available for the support of programs to investigate and prosecute violations arising from the administration and operation of the system. Available state funds appropriated for the administration and operation of the system may be used as matching funds to secure federal funds pursuant to this subsection.

D. The director may adopt rules or procedures to do the following:

1. Authorize advance payments based on estimated liability to a contractor or a noncontracting provider after the contractor or noncontracting provider has submitted a claim for services and before the claim is ultimately resolved. The rules shall specify that any advance payment shall be conditioned on the execution before payment of a contract with the contractor or noncontracting provider that requires the administration to retain a specified percentage, which shall be at least twenty percent, of the claimed amount as security and that requires repayment to the administration if the administration makes any overpayment.

2. Defer liability, in whole or in part, of contractors for care provided to members who are hospitalized on the date of enrollment or under other circumstances. Payment shall be on a capped fee-for-service basis for services other than hospital services and at the rate established pursuant to subsection G of this section for hospital services or at the rate paid by the health plan, whichever is less.

3. Deputize, in writing, any qualified officer or employee in the administration to perform any act that the director by law is empowered to do or charged with the responsibility of doing, including the authority to issue final administrative decisions pursuant to section 41-1092.08.

4. Notwithstanding any other law, require persons eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section 36-2981, paragraph 6 to be financially responsible for any cost sharing requirements established in a state plan or a section 1115 waiver and approved by the centers for medicare and

medicaid services. Cost sharing requirements may include copayments, coinsurance, deductibles, enrollment fees and monthly premiums for enrolled members, including households with children enrolled in the Arizona long-term care system.

E. The director shall adopt rules that further specify the medical care and hospital services that are covered by the system pursuant to section 36-2907.

F. In addition to the rules otherwise specified in this article, the director may adopt necessary rules pursuant to title 41, chapter 6 to carry out this article. Rules adopted by the director pursuant to this subsection shall consider the differences between rural and urban conditions on the delivery of hospitalization and medical care.

G. For inpatient hospital admissions and outpatient hospital services on and after March 1, 1993, the administration shall adopt rules for the reimbursement of hospitals according to the following procedures:

1. For inpatient hospital stays from March 1, 1993 through September 30, 2014, the administration shall use a prospective tiered per diem methodology, using hospital peer groups if analysis shows that cost differences can be attributed to independently definable features that hospitals within a peer group share. In peer grouping the administration may consider such factors as length of stay differences and labor market variations. If there are no cost differences, the administration shall implement a stop loss-stop gain or similar mechanism. Any stop loss-stop gain or similar mechanism shall ensure that the tiered per diem rates assigned to a hospital do not represent less than ninety percent of its 1990 base year costs or more than one hundred ten percent of its 1990 base year costs, adjusted by an audit factor, during the period of March 1, 1993 through September 30, 1994. The tiered per diem rates set for hospitals shall represent no less than eighty-seven and one-half percent or more than one hundred twelve and one-half percent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1994 through September 30, 1995 and no less than eighty-five percent or more than one hundred fifteen percent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1995 through September 30, 1996. For the periods after September 30, 1996 no stop loss-stop gain or similar mechanisms shall be in effect. An adjustment in the stop loss-stop gain percentage may be made to ensure that total payments do not increase as a result of this provision. If peer groups are used, the administration shall establish initial peer group designations for each hospital before implementation of the per diem system. The administration may also use a negotiated rate methodology. The tiered per diem methodology may include separate consideration for specialty hospitals that limit their provision of services to specific patient populations, such as rehabilitative patients or children. The initial per diem rates shall be based on hospital claims and encounter data for dates of service November 1, 1990 through October 31, 1991 and processed through May of 1992. The administration may also establish a separate reimbursement methodology for claims with extraordinarily high costs per day that exceed thresholds established by the administration.

2. For rates effective on October 1, 1994, and annually through September 30, 2011, the administration shall adjust tiered per diem payments for inpatient hospital care by the data resources incorporated market basket index for prospective payment system hospitals. For rates effective beginning on October 1, 1999, the administration shall adjust payments to reflect changes in length of stay for the maternity and nursery tiers.

3. Through June 30, 2004, for outpatient hospital services, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to the covered charges. Beginning on July 1, 2004 through June 30, 2005, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to covered charges. If the hospital increases its charges for outpatient services filed with the Arizona department of health services pursuant to chapter 4, article 3 of this title, by more than 4.7 percent for dates of service effective on or after July 1, 2004, the hospital specific cost-to-charge ratio will be reduced by the amount that it exceeds 4.7 percent. If charges exceed 4.7 percent, the effective date of the increased charges will be the effective date of the adjusted Arizona health care cost containment system cost-to-charge ratio. The administration shall develop the methodology for a capped fee-for-service schedule and a statewide cost-to-charge ratio. Any covered outpatient service not included in the capped fee-for-service schedule shall be reimbursed by applying the statewide cost-to-charge ratio that is based on the services not included in the capped fee-for-service schedule. Beginning on July 1, 2005, the administration shall reimburse clean claims with dates of service on or after July 1, 2005, based on the capped fee-for-service schedule or the statewide cost-to-charge

ratio established pursuant to this paragraph. The administration may make additional adjustments to the outpatient hospital rates established pursuant to this section based on other factors, including the number of beds in the hospital, specialty services available to patients and the geographic location of the hospital.

4. Except if submitted under an electronic claims submission system, a hospital bill is considered received for purposes of this paragraph on initial receipt of the legible, error-free claim form by the administration if the claim includes the following error-free documentation in legible form:

- (a) An admission face sheet.
- (b) An itemized statement.
- (c) An admission history and physical.
- (d) A discharge summary or an interim summary if the claim is split.
- (e) An emergency record, if admission was through the emergency room.
- (f) Operative reports, if applicable.
- (g) A labor and delivery room report, if applicable.

Payment received by a hospital from the administration pursuant to this subsection or from a contractor either by contract or pursuant to section 36-2904, subsection I is considered payment by the administration or the contractor of the administration's or contractor's liability for the hospital bill. A hospital may collect any unpaid portion of its bill from other third-party payors or in situations covered by title 33, chapter 7, article 3.

5. For services rendered on and after October 1, 1997, the administration shall pay a hospital's rate established according to this section subject to the following:

- (a) If the hospital's bill is paid within thirty days of the date the bill was received, the administration shall pay ninety-nine percent of the rate.
- (b) If the hospital's bill is paid after thirty days but within sixty days of the date the bill was received, the administration shall pay one hundred percent of the rate.
- (c) If the hospital's bill is paid any time after sixty days of the date the bill was received, the administration shall pay one hundred percent of the rate plus a fee of one percent per month for each month or portion of a month following the sixtieth day of receipt of the bill until the date of payment.

6. In developing the reimbursement methodology, if a review of the reports filed by a hospital pursuant to section 36-125.04 indicates that further investigation is considered necessary to verify the accuracy of the information in the reports, the administration may examine the hospital's records and accounts related to the reporting requirements of section 36-125.04. The administration shall bear the cost incurred in connection with this examination unless the administration finds that the records examined are significantly deficient or incorrect, in which case the administration may charge the cost of the investigation to the hospital examined.

7. Except for privileged medical information, the administration shall make available for public inspection the cost and charge data and the calculations used by the administration to determine payments under the tiered per diem system, provided that individual hospitals are not identified by name. The administration shall make the data and calculations available for public inspection during regular business hours and shall provide copies of the data and calculations to individuals requesting such copies within thirty days of receipt of a written request. The administration may charge a reasonable fee for the provision of the data or information.

8. The prospective tiered per diem payment methodology for inpatient hospital services shall include a mechanism for the prospective payment of inpatient hospital capital related costs. The capital payment shall

include hospital specific and statewide average amounts. For tiered per diem rates beginning on October 1, 1999, the capital related cost component is frozen at the blended rate of forty percent of the hospital specific capital cost and sixty percent of the statewide average capital cost in effect as of January 1, 1999 and as further adjusted by the calculation of tier rates for maternity and nursery as prescribed by law. Through September 30, 2011, the administration shall adjust the capital related cost component by the data resources incorporated market basket index for prospective payment system hospitals.

9. For graduate medical education programs:

(a) Beginning September 30, 1997, the administration shall establish a separate graduate medical education program to reimburse hospitals that had graduate medical education programs that were approved by the administration as of October 1, 1999. The administration shall separately account for monies for the graduate medical education program based on the total reimbursement for graduate medical education reimbursed to hospitals by the system in federal fiscal year 1995-1996 pursuant to the tiered per diem methodology specified in this section. The graduate medical education program reimbursement shall be adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement. Subject to legislative appropriation, on an annual basis, each qualified hospital shall receive a single payment from the graduate medical education program that is equal to the same percentage of graduate medical education reimbursement that was paid by the system in federal fiscal year 1995-1996. Any reimbursement for graduate medical education made by the administration shall not be subject to future settlements or appeals by the hospitals to the administration. The monies available under this subdivision shall not exceed the fiscal year 2005-2006 appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement, except for monies distributed for expansions pursuant to subdivision (b) of this paragraph.

(b) The monies available for graduate medical education programs pursuant to this subdivision shall not exceed the fiscal year 2006-2007 appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement. Graduate medical education programs eligible for such reimbursement are not precluded from receiving reimbursement for funding under subdivision (c) of this paragraph. Beginning July 1, 2006, the administration shall distribute any monies appropriated for graduate medical education above the amount prescribed in subdivision (a) of this paragraph in the following order or priority:

(i) For the direct costs to support the expansion of graduate medical education programs established before July 1, 2006 at hospitals that do not receive payments pursuant to subdivision (a) of this paragraph. These programs must be approved by the administration.

(ii) For the direct costs to support the expansion of graduate medical education programs established on or before October 1, 1999. These programs must be approved by the administration.

(c) The administration shall distribute to hospitals any monies appropriated for graduate medical education above the amount prescribed in subdivisions (a) and (b) of this paragraph for the following purposes:

(i) For the direct costs of graduate medical education programs established or expanded on or after July 1, 2006. These programs must be approved by the administration.

(ii) For a portion of additional indirect graduate medical education costs for programs that are located in a county with a population of less than five hundred thousand persons at the time the residency position was created or for a residency position that includes a rotation in a county with a population of less than five hundred thousand persons at the time the residency position was established. These programs must be approved by the administration.

(d) The administration shall develop, by rule, the formula by which the monies are distributed.

(e) Each graduate medical education program that receives funding pursuant to subdivision (b) or (c) of this paragraph shall identify and report to the administration the number of new residency positions created by the funding provided in this paragraph, including positions in rural areas. The program shall also report information related to the number of funded residency positions that resulted in physicians locating their practices in this state. The administration shall report to the joint legislative budget committee by February 1 of each year on the number of new residency positions as reported by the graduate medical education programs.

(f) Local, county and tribal governments and any university under the jurisdiction of the Arizona board of regents may provide monies in addition to any state general fund monies appropriated for graduate medical education in order to qualify for additional matching federal monies for providers, programs or positions in a specific locality and costs incurred pursuant to a specific contract between the administration and providers or other entities to provide graduate medical education services as an administrative activity. Payments by the administration pursuant to this subdivision may be limited to those providers designated by the funding entity and may be based on any methodology deemed appropriate by the administration, including replacing any payments that might otherwise have been paid pursuant to subdivision (a), (b) or (c) of this paragraph had sufficient state general fund monies or other monies been appropriated to fully fund those payments. These programs, positions, payment methodologies and administrative graduate medical education services must be approved by the administration and the centers for medicare and medicaid services. The administration shall report to the president of the senate, the speaker of the house of representatives and the director of the joint legislative budget committee on or before July 1 of each year on the amount of money contributed and number of residency positions funded by local, county and tribal governments, including the amount of federal matching monies used.

(g) Any funds appropriated but not allocated by the administration for subdivision (b) or (c) of this paragraph may be reallocated if funding for either subdivision is insufficient to cover appropriate graduate medical education costs.

10. Notwithstanding section 41-1005, subsection A, paragraph 9, the administration shall adopt rules pursuant to title 41, chapter 6 establishing the methodology for determining the prospective tiered per diem payments that are in effect through September 30, 2014.

11. For inpatient hospital services rendered on or after October 1, 2011, the prospective tiered per diem payment rates are permanently reset to the amounts payable for those services as of October 1, 2011 pursuant to this subsection.

12. The administration shall adopt a diagnosis-related group based hospital reimbursement methodology consistent with title XIX of the social security act for inpatient dates of service on and after October 1, 2014. The administration may make additional adjustments to the inpatient hospital rates established pursuant to this section for hospitals that are publicly operated or based on other factors, including the number of beds in the hospital, the specialty services available to patients, the geographic location and diagnosis-related group codes that are made publicly available by the hospital pursuant to section 36-437. The administration may also provide additional reimbursement for extraordinarily high cost cases that exceed a threshold above the standard payment. The administration may also establish a separate payment methodology for specific services or hospitals serving unique populations.

H. The director may adopt rules that specify enrollment procedures, including notice to contractors of enrollment. The rules may provide for varying time limits for enrollment in different situations. The administration shall specify in contract when a person who has been determined eligible will be enrolled with that contractor and the date on which the contractor will be financially responsible for health and medical services to the person.

I. The administration may make direct payments to hospitals for hospitalization and medical care provided to a member in accordance with this article and rules. The director may adopt rules to establish the procedures by which the administration shall pay hospitals pursuant to this subsection if a contractor fails to make timely payment to a hospital. Such payment shall be at a level determined pursuant to section 36-2904, subsection H

or I. The director may withhold payment due to a contractor in the amount of any payment made directly to a hospital by the administration on behalf of a contractor pursuant to this subsection.

J. The director shall establish a special unit within the administration for the purpose of monitoring the third-party payment collections required by contractors and noncontracting providers pursuant to section 36-2903, subsection B, paragraph 10 and subsection F and section 36-2915, subsection E. The director shall determine by rule:

1. The type of third-party payments to be monitored pursuant to this subsection.
2. The percentage of third-party payments that is collected by a contractor or noncontracting provider and that the contractor or noncontracting provider may keep and the percentage of such payments that the contractor or noncontracting provider may be required to pay to the administration. Contractors and noncontracting providers must pay to the administration one hundred percent of all third-party payments that are collected and that duplicate administration fee-for-service payments. A contractor that contracts with the administration pursuant to section 36-2904, subsection A may be entitled to retain a percentage of third-party payments if the payments collected and retained by a contractor are reflected in reduced capitation rates. A contractor may be required to pay the administration a percentage of third-party payments that are collected by a contractor and that are not reflected in reduced capitation rates.

K. The administration shall establish procedures to apply to the following if a provider that has a contract with a contractor or noncontracting provider seeks to collect from an individual or financially responsible relative or representative a claim that exceeds the amount that is reimbursed or should be reimbursed by the system:

1. On written notice from the administration or oral or written notice from a member that a claim for covered services may be in violation of this section, the provider that has a contract with a contractor or noncontracting provider shall investigate the inquiry and verify whether the person was eligible for services at the time that covered services were provided. If the claim was paid or should have been paid by the system, the provider that has a contract with a contractor or noncontracting provider shall not continue billing the member.

2. If the claim was paid or should have been paid by the system and the disputed claim has been referred for collection to a collection agency or referred to a credit reporting bureau, the provider that has a contract with a contractor or noncontracting provider shall:

- (a) Notify the collection agency and request that all attempts to collect this specific charge be terminated immediately.

- (b) Advise all credit reporting bureaus that the reported delinquency was in error and request that the affected credit report be corrected to remove any notation about this specific delinquency.

- (c) Notify the administration and the member that the request for payment was in error and that the collection agency and credit reporting bureaus have been notified.

3. If the administration determines that a provider that has a contract with a contractor or noncontracting provider has billed a member for charges that were paid or should have been paid by the administration, the administration shall send written notification by certified mail or other service with proof of delivery to the provider that has a contract with a contractor or noncontracting provider stating that this billing is in violation of federal and state law. If, twenty-one days or more after receiving the notification, a provider that has a contract with a contractor or noncontracting provider knowingly continues billing a member for charges that were paid or should have been paid by the system, the administration may assess a civil penalty in an amount equal to three times the amount of the billing and reduce payment to the provider that has a contract with a contractor or noncontracting provider accordingly. Receipt of delivery signed by the addressee or the addressee's employee is prima facie evidence of knowledge. Civil penalties collected pursuant to this subsection shall be deposited in the state general fund. Section 36-2918, subsections C, D and F, relating to the imposition, collection and enforcement of civil penalties, apply to civil penalties imposed pursuant to this paragraph.

L. The administration may conduct postpayment review of all claims paid by the administration and may recoup any monies erroneously paid. The director may adopt rules that specify procedures for conducting postpayment review. A contractor may conduct a postpayment review of all claims paid by the contractor and may recoup monies that are erroneously paid.

M. Subject to title 41, chapter 4, article 4, the director or the director's designee may employ and supervise personnel necessary to assist the director in performing the functions of the administration.

N. The administration may contract with contractors for obstetrical care who are eligible to provide services under title XIX of the social security act.

O. Notwithstanding any other law, on federal approval the administration may make disproportionate share payments to private hospitals, county operated hospitals, including hospitals owned or leased by a special health care district, and state operated institutions for mental disease beginning October 1, 1991 in accordance with federal law and subject to legislative appropriation. If at any time the administration receives written notification from federal authorities of any change or difference in the actual or estimated amount of federal funds available for disproportionate share payments from the amount reflected in the legislative appropriation for such purposes, the administration shall provide written notification of such change or difference to the president and the minority leader of the senate, the speaker and the minority leader of the house of representatives, the director of the joint legislative budget committee, the legislative committee of reference and any hospital trade association within this state, within three working days not including weekends after receipt of the notice of the change or difference. In calculating disproportionate share payments as prescribed in this section, the administration may use either a methodology based on claims and encounter data that is submitted to the administration from contractors or a methodology based on data that is reported to the administration by private hospitals and state operated institutions for mental disease. The selected methodology applies to all private hospitals and state operated institutions for mental disease qualifying for disproportionate share payments.

P. Disproportionate share payments made pursuant to subsection O of this section include amounts for disproportionate share hospitals designated by political subdivisions of this state, tribal governments and universities under the jurisdiction of the Arizona board of regents. Subject to the approval of the centers for medicare and medicaid services, any amount of federal funding allotted to this state pursuant to section 1923(f) of the social security act and not otherwise spent under subsection O of this section shall be made available for distribution pursuant to this subsection. Political subdivisions of this state, tribal governments and universities under the jurisdiction of the Arizona board of regents may designate hospitals eligible to receive disproportionate share payments in an amount up to the limit prescribed in section 1923(g) of the social security act if those political subdivisions, tribal governments or universities provide sufficient monies to qualify for the matching federal monies for the disproportionate share payments.

Q. Notwithstanding any law to the contrary, the administration may receive confidential adoption information to determine whether an adopted child should be terminated from the system.

R. The adoption agency or the adoption attorney shall notify the administration within thirty days after an eligible person receiving services has placed that person's child for adoption.

S. If the administration implements an electronic claims submission system, it may adopt procedures pursuant to subsection G of this section requiring documentation different than prescribed under subsection G, paragraph 4 of this section.

T. In addition to any requirements adopted pursuant to subsection D, paragraph 4 of this section, notwithstanding any other law, subject to approval by the centers for medicare and medicaid services, beginning July 1, 2011, members eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section 36-2981, paragraph 6 shall pay the following:

1. A monthly premium of fifteen dollars, except that the total monthly premium for an entire household shall not exceed sixty dollars.

2. A copayment of five dollars for each physician office visit.
3. A copayment of ten dollars for each urgent care visit.
4. A copayment of thirty dollars for each emergency department visit.

U. Subject to the approval of the centers for medicare and medicaid services, political subdivisions of this state, tribal governments and any university under the jurisdiction of the Arizona board of regents may provide to the Arizona health care cost containment system administration monies in addition to any state general fund monies appropriated for critical access hospitals in order to qualify for additional federal monies. Any amount of federal monies received by this state pursuant to this subsection shall be distributed as supplemental payments to critical access hospitals.

V. For the purposes of this section, "disproportionate share payment" means a payment to a hospital that serves a disproportionate share of low-income patients as described by 42 United States Code section 1396r-4.

36-2907. Covered health and medical services; modifications; related delivery of service requirements; definition

A. Subject to the limitations and exclusions specified in this section, contractors shall provide the following medically necessary health and medical services:

1. Inpatient hospital services that are ordinarily furnished by a hospital for the care and treatment of inpatients and that are provided under the direction of a physician or a primary care practitioner. For the purposes of this section, inpatient hospital services exclude services in an institution for tuberculosis or mental diseases unless authorized under an approved section 1115 waiver.
2. Outpatient health services that are ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. Outpatient health services include services provided by or under the direction of a physician or a primary care practitioner, including occupational therapy.
3. Other laboratory and X-ray services ordered by a physician or a primary care practitioner.
4. Medications that are ordered on prescription by a physician or a dentist licensed pursuant to title 32, chapter 11. Persons who are dually eligible for title XVIII and title XIX services must obtain available medications through a medicare licensed or certified medicare advantage prescription drug plan, a medicare prescription drug plan or any other entity authorized by medicare to provide a medicare part D prescription drug benefit.
5. Medical supplies, durable medical equipment, insulin pumps and prosthetic devices ordered by a physician or a primary care practitioner. Suppliers of durable medical equipment shall provide the administration with complete information about the identity of each person who has an ownership or controlling interest in their business and shall comply with federal bonding requirements in a manner prescribed by the administration.
6. For persons who are at least twenty-one years of age, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses.
7. Early and periodic health screening and diagnostic services as required by section 1905(r) of title XIX of the social security act for members who are under twenty-one years of age.
8. Family planning services that do not include abortion or abortion counseling. If a contractor elects not to provide family planning services, this election does not disqualify the contractor from delivering all other covered health and medical services under this chapter. In that event, the administration may contract directly with another contractor, including an outpatient surgical center or a noncontracting provider, to deliver family planning services to a member who is enrolled with the contractor that elects not to provide family planning services.
9. Podiatry services that are performed by a podiatrist who is licensed pursuant to title 32, chapter 7 and ordered by a primary care physician or primary care practitioner.
10. Nonexperimental transplants approved for title XIX reimbursement.
11. For persons who are at least twenty-one years of age, emergency dental care and extractions in an annual amount of not more than one thousand dollars per member.
12. Ambulance and nonambulance transportation, except as provided in subsection G of this section.
13. Hospice care.
14. Orthotics, if all of the following apply:

(a) The use of the orthotic is medically necessary as the preferred treatment option consistent with medicare guidelines.

(b) The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition.

(c) The orthotic is ordered by a physician or primary care practitioner.

B. The limitations and exclusions for health and medical services provided under this section are as follows:

1. Circumcision of newborn males is not a covered health and medical service.

2. For eligible persons who are at least twenty-one years of age:

(a) Outpatient health services do not include speech therapy.

(b) Prosthetic devices do not include hearing aids, dentures, bone-anchored hearing aids or cochlear implants. Prosthetic devices, except prosthetic implants, may be limited to twelve thousand five hundred dollars per contract year.

(c) Percussive vests are not covered health and medical services.

(d) Durable medical equipment is limited to items covered by medicare.

(e) Nonexperimental transplants do not include pancreas-only transplants.

(f) Bariatric surgery procedures, including laparoscopic and open gastric bypass and restrictive procedures, are not covered health and medical services.

C. The system shall pay noncontracting providers only for health and medical services as prescribed in subsection A of this section and as prescribed by rule.

D. The director shall adopt rules necessary to limit, to the extent possible, the scope, duration and amount of services, including maximum limitations for inpatient services that are consistent with federal regulations under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)). To the extent possible and practicable, these rules shall provide for the prior approval of medically necessary services provided pursuant to this chapter.

E. The director shall make available home health services in lieu of hospitalization pursuant to contracts awarded under this article. For the purposes of this subsection, "home health services" means the provision of nursing services, home health aide services or medical supplies, equipment and appliances that are provided on a part-time or intermittent basis by a licensed home health agency within a member's residence based on the orders of a physician or a primary care practitioner. Home health agencies shall comply with the federal bonding requirements in a manner prescribed by the administration.

F. The director shall adopt rules for the coverage of behavioral health services for persons who are eligible under section 36-2901, paragraph 6, subdivision (a). The administration acting through the regional behavioral health authorities shall establish a diagnostic and evaluation program to which other state agencies shall refer children who are not already enrolled pursuant to this chapter and who may be in need of behavioral health services. In addition to an evaluation, the administration acting through regional behavioral health authorities shall also identify children who may be eligible under section 36-2901, paragraph 6, subdivision (a) or section 36-2931, paragraph 5 and shall refer the children to the appropriate agency responsible for making the final eligibility determination.

G. The director shall adopt rules for the provision of transportation services and rules providing for copayment by members for transportation for other than emergency purposes. Subject to approval by the centers for

medicare and medicaid services, nonemergency medical transportation shall not be provided except for stretcher vans and ambulance transportation. Prior authorization is required for transportation by stretcher van and for medically necessary ambulance transportation initiated pursuant to a physician's direction. Prior authorization is not required for medically necessary ambulance transportation services rendered to members or eligible persons initiated by dialing telephone number 911 or other designated emergency response systems.

H. The director may adopt rules to allow the administration, at the director's discretion, to use a second opinion procedure under which surgery may not be eligible for coverage pursuant to this chapter without documentation as to need by at least two physicians or primary care practitioners.

I. If the director does not receive bids within the amounts budgeted or if at any time the amount remaining in the Arizona health care cost containment system fund is insufficient to pay for full contract services for the remainder of the contract term, the administration, on notification to system contractors at least thirty days in advance, may modify the list of services required under subsection A of this section for persons defined as eligible other than those persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). The director may also suspend services or may limit categories of expense for services defined as optional pursuant to title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) for persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). Such reductions or suspensions do not apply to the continuity of care for persons already receiving these services.

J. Additional, reduced or modified hospitalization and medical care benefits may be provided under the system to enrolled members who are eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

K. All health and medical services provided under this article shall be provided in the geographic service area of the member, except:

1. Emergency services and specialty services provided pursuant to section 36-2908.

2. That the director may permit the delivery of health and medical services in other than the geographic service area in this state or in an adjoining state if the director determines that medical practice patterns justify the delivery of services or a net reduction in transportation costs can reasonably be expected. Notwithstanding the definition of physician as prescribed in section 36-2901, if services are procured from a physician or primary care practitioner in an adjoining state, the physician or primary care practitioner shall be licensed to practice in that state pursuant to licensing statutes in that state similar to title 32, chapter 13, 15, 17 or 25 and shall complete a provider agreement for this state.

L. Covered outpatient services shall be subcontracted by a primary care physician or primary care practitioner to other licensed health care providers to the extent practicable for purposes including, but not limited to, making health care services available to underserved areas, reducing costs of providing medical care and reducing transportation costs.

M. The director shall adopt rules that prescribe the coordination of medical care for persons who are eligible for system services. The rules shall include provisions for the transfer of patients, the transfer of medical records and the initiation of medical care.

N. For the purposes of this section, "ambulance" has the same meaning prescribed in section 36-2201.

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)**  
Title 9, Chapter 28, Article 5



# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

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**MEETING DATE:** March 7, 2023

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** February 17, 2023

**SUBJECT:** Arizona Health Care Cost Containment System (AHCCCS)  
Title 9, Chapter 28, Article 5

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This Five-Year-Review Report (5YRR) from AHCCCS relates to rules in Title 9, Chapter 28 regarding the Arizona Long-Term Care System. Specifically, the report covers Article 5 regarding Program Contractor and Provider Standards.

AHCCCS indicates they did not complete the proposed course of action in the last 5YRR of these rules, and indicates they are proposing those changes in this report.

### **Proposed Action**

AHCCCS is proposing to amend some of the rules in order to make them more clear, concise, understandable, and consistent with other rules and statutes. AHCCCS indicates it plans to request an exemption from the rule moratorium from the Governor's Office no later July 2023.

#### **1. Has the agency analyzed whether the rules are authorized by statute?**

Yes, AHCCCS cites to both general and specific statutory authority.

2. **Summary of the agency's economic impact comparison and identification of stakeholders:**

According to the Administration, the prior rulemaking had a minimal impact on the state economy and small businesses and consumers because the changes to the rules were designed to help understand and use the rules.

The Administration identifies stakeholders as the AHCCCS Administration, AHCCCS program contractors, healthcare providers, and AHCCCS members.

3. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

According to the Administration, the benefits of the rules outweigh the costs and impose the least burden and costs on those regulated. They further state that any costs are necessary to achieve the regulatory objective.

4. **Has the agency received any written criticisms of the rules over the last five years?**

No, AHCCCS indicates they did not receive any written criticisms to the rules.

5. **Has the agency analyzed the rules' clarity, conciseness, and understandability?**

Yes, AHCCCS indicates the rules are overall clear, concise, understandable with the exception of the following:

**R9-28-503** - Licensure and Certification for Long-Term Care Institutional Facilities

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

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

6. **Has the agency analyzed the rules' consistency with other rules and statutes?**

Yes, AHCCCS indicates the rules are consistent with other rules and statutes with the exception of the following:

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

7. **Has the agency analyzed the rules' effectiveness in achieving its objectives?**

Yes, AHCCCS indicates the rules are effective in achieving their objectives.

8. **Has the agency analyzed the current enforcement status of the rules?**

Yes, AHCCCS indicates the rules are enforced as written.

**9. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

No, AHCCCS indicates the rules are not more stringent than federal law, 42 CFR Part 482 and 488.

**10. For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

Not applicable. The rules do not require the issuance of a general permit or license.

**11. Conclusion**

As mentioned above, AHCCCS plans to amend some of their rules in order to make them more clear, concise, understandable, and consistent with other rules and statutes. AHCCCS indicates it plans to request an exemption from the rule moratorium from the Governor's Office no later July 2023.

Council Staff recommends approval of this report.

December 28, 2022

Ms. Nicole Sornsin, Chair  
Governor's Regulatory Review Council  
100 N. 15<sup>th</sup> Ave, Suite 305  
Phoenix, AZ 85007

Dear Ms. Sornsin:

Pursuant to requirements in R1-6-301, attached is a copy of the 5-Year Review Report for Title 9, Chapter 28, Article 5. The report includes all of the documentation required by R1-6-301 (C) and (D).

As required by A.R.S. § 41-1056, the Administration certifies that the agency is in compliance with A.R.S. § 41-1091.

If you need any further information regarding this report, please contact Stephanie Elzenga, Office of the General Counsel at (602) 417-4232.

Sincerely,



Kasey Rogg  
Assistant Director

Attachments

**Arizona Health Care Cost Containment System (AHCCCS)  
5 YEAR REVIEW REPORT  
A.A.C. Title 9, Chapter 28, Article 5  
December 2022**

**1. Authorization of the rule by existing statutes**

General Statutory Authority: A.R.S. § 36-2932(M).

Specific Statutory Authority: A.R.S. § 36-2903, 36-2939, 36-2938.

**2. The objective of each rule:**

Rule	Objective
R9-28-501	Provides definitions related to the general provisions within Article 5 that a program contractor must follow.
R9-28-501.01	Provides requirements for services to treat pre-existing conditions.
R9-28-502	Provides the requirement for a provider or program contractor to maintain records for 5 years and make them available to the Administration.
R9-28-503	Provides licensure and certification requirements for Long-term Care Institutional Facilities.
R9-28-504	Provides licensure and certification requirements for HCBS Providers.
R9-28-505	Provides licensure and certification requirements for providers of hospital and medical services.
R9-28-506	Provides requirements for a spouse to be a paid caregiver for personal care services.
R9-28-507	Provides general requirements for program contractors.
R9-28-508	Provides general requirements for Self-directed Attendant Care (SDAC).
R9-28-509	Provides general requirements for the Agency with Choice program.
R9-28-510	Provides case management requirements.
R9-28-511	Provides quality management and utilization management requirements.
R9-28-513	Provides cross-referenced requirements regarding when the Administration will conduct program compliance audits.
R9-28-514	Provides cross-referenced requirements for the release of safeguarded information.

**3. Are the rules effective in achieving their objectives?**

Yes X No

4. **Are the rules consistent with other rules and statutes?** Yes  No

R9-28-505	Federal regulation requires hospitals that participate in Medicaid to meet Medicare conditions of participation which are set forth in 42 CFR Parts 441 and 482. Medicare standards also permit deemed status through accreditation by national accreditation organizations which are not limited to the Joint Commission on Accreditation of Healthcare Organization (JCAHO). Therefore, the regulation should be updated to read that the referenced hospitals may be accredited by “a national accreditation organization.” In addition, we recommend removal of the specific dates of the regulations which are incorporated by reference.
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5. **Are the rules enforced as written?** Yes  No

6. **Are the rules clear, concise, and understandable?** Yes  No

Rule	Explanation
R9-28-503	Recommending a change from ICF-MR to ICFIID to comply with AHCCCS policy and federal regulations.
R9-28-504	Recommending changes to clearly align specifications since these contracts are not always between the provider and AHCCCS: “4. A person providing a homemaker service shall meet the requirements specified in contract; 5. A person providing a personal care service shall meet the requirements specified in contract;” Cross-reference to R9-33-107 needs to be updated to R9-33-102 and strike reference to R6-6-714 as it has expired. Cross-reference under R9-28-504(B)(10) changed to 9 A.A.C. 8, Article 1. Cross-reference under R9-28-504(B)(12) must be changed to 9 A.A.C. 25 for licensure requirement for emergency medical services. Where the term “speech therapist” exists it needs to be changed to “speech pathologist” per 42 CFR 440.100(c)(2), and “speech therapy” as “speech-language pathology” per A.R.S. §36-1901(23) and 9A.A.C. 16, Article 2.
R9-28-506	Remove part of B(6)(c) which reads, “or registered with AHCCCS as an independent provider;” because independent providers cannot register with AHCCCS in this context anymore.

7. **Has the agency received written criticisms of the rules within the last five years?** Yes \_\_\_ No X

8. **Economic, small business, and consumer impact comparison:**

The prior EIS stated that the impact would be minimal on the state economy and small businesses and consumers because the changes were designed to understand and use these rules. Similarly, the changes suggested in this report will not have an economic impact because the phrasing aligns with current AHCCCS policy and are a broadening, instead of restricting, change to the text of the rule.

9. **Has the agency received any business competitiveness analyses of the rules?** Yes \_\_\_ No X

10. **Has the agency completed the course of action indicated in the agency's previous five-year-review report?**

The proposed course of action in the prior 5YRR was not enacted, therefore those recommended changes are incorporated here.

11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

The benefits of these rules outweigh the costs, impose the least burden and cost on those regulated, and any costs are necessary to achieve the regulatory objective.

12. **Are the rules more stringent than corresponding federal laws?** Yes \_\_\_ No X

Federal law 42 CFR Part 482 (which also refers to Part 488) allows for hospitals to meet Medicare certification requirements when accredited by national accreditation organizations. Therefore, we recommend aligning the rule with the federal provision by not limiting the national accreditation organization to JCAHO.

13. **For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

No permit, license, or authorization applies.

14. **Proposed course of action**

AHCCCS plans to make the above changes by requesting an exemption from the Governor's office for the rulemaking moratorium within 120 days following GRRC's approval of this report.

## Arizona Health Care Cost Containment System – Arizona Long-term Care System

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 an American Indian 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). Amended by final rulemaking at 20 A.A.R. 234, effective January 7, 2014 (Supp. 14-1).

**R9-28-416. Enrollment with the Fee-for-Service (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.
- C.** The Administration shall enroll a member in the AHCCCS fee-for-service program if the member is eligible for ALTCS services during the prior quarter period.

**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). Amended by final rulemaking at 20 A.A.R. 234, effective January 7, 2014 (Supp. 14-1).

**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 shall disenroll a member immediately when the member voluntarily withdraws from the ALTCS program.
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). Amended by final rulemaking at 20 A.A.R. 234, effective January 7, 2014 (Supp. 14-1).

**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

## Arizona Health Care Cost Containment System – Arizona Long-term Care System

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:
  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

## Arizona Health Care Cost Containment System – Arizona Long-term Care System

(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 cueing 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 registered 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.

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- 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.
- 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.

**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.
  - “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

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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).

**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**

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**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**

36-2903. Arizona health care cost containment system; administrator; powers and duties of director and administrator; exemption from attorney general representation; definition

A. The Arizona health care cost containment system is established consisting of contracts with contractors for the provision of hospitalization and medical care coverage to members. Except as specifically required by federal law and by section 36-2909, the system is only responsible for providing care on or after the date that the person has been determined eligible for the system, and is only responsible for reimbursing the cost of care rendered on or after the date that the person was determined eligible for the system.

B. An agreement may be entered into with an independent contractor, subject to title 41, chapter 23, to serve as the statewide administrator of the system. The administrator has full operational responsibility, subject to supervision by the director, for the system, which may include any or all of the following:

1. Development of county-by-county implementation and operation plans for the system that include reasonable access to hospitalization and medical care services for members.
2. Contract administration and oversight of contractors, including certification instead of licensure for title XVIII and title XIX purposes.
3. Provision of technical assistance services to contractors and potential contractors.
4. Development of a complete system of accounts and controls for the system including provisions designed to ensure that covered health and medical services provided through the system are not used unnecessarily or unreasonably including but not limited to inpatient behavioral health services provided in a hospital. Periodically the administrator shall compare the scope, utilization rates, utilization control methods and unit prices of major health and medical services provided in this state in comparison with other states' health care services to identify any unnecessary or unreasonable utilization within the system. The administrator shall periodically assess the cost effectiveness and health implications of alternate approaches to the provision of covered health and medical services through the system in order to reduce unnecessary or unreasonable utilization.
5. Establishment of peer review and utilization review functions for all contractors.
6. Assistance in the formation of medical care consortiums to provide covered health and medical services under the system for a county.
7. Development and management of a contractor payment system.
8. Establishment and management of a comprehensive system for assuring the quality of care delivered by the system.
9. Establishment and management of a system to prevent fraud by members, subcontracted providers of care, contractors and noncontracting providers.
10. Coordination of benefits provided under this article to any member. The administrator may require that contractors and noncontracting providers are responsible for the coordination of benefits for services provided under this article. Requirements for coordination of benefits by noncontracting providers under this section are limited to coordination with standard health insurance and disability insurance policies and similar programs for health coverage.
11. Development of a health education and information program.
12. Development and management of an enrollment system.
13. Establishment and maintenance of a claims resolution procedure to ensure that ninety per cent of the clean claims shall be paid within thirty days of receipt and ninety-nine per cent of the remaining clean claims shall be

paid within ninety days of receipt. For the purposes of this paragraph, "clean claims" has the same meaning prescribed in section 36-2904, subsection G.

14. Establishment of standards for the coordination of medical care and patient transfers pursuant to section 36-2909, subsection B.

15. Establishment of a system to implement medical child support requirements, as required by federal law. The administration may enter into an intergovernmental agreement with the department of economic security to implement this paragraph.

16. Establishment of an employee recognition fund.

17. Establishment of an eligibility process to determine whether a medicare low income subsidy is available to persons who want to apply for a subsidy as authorized by title XVIII.

C. If an agreement is not entered into with an independent contractor to serve as statewide administrator of the system pursuant to subsection B of this section, the director shall ensure that the operational responsibilities set forth in subsection B of this section are fulfilled by the administration and other contractors as necessary.

D. If the director determines that the administrator will fulfill some but not all of the responsibilities set forth in subsection B of this section, the director shall ensure that the remaining responsibilities are fulfilled by the administration and other contractors as necessary.

E. The administrator or any direct or indirect subsidiary of the administrator is not eligible to serve as a contractor.

F. Except for reinsurance obtained by contractors, the administrator shall coordinate benefits provided under this article to any eligible person who is covered by workers' compensation, disability insurance, a hospital and medical service corporation, a health care services organization, an accountable health plan or any other health or medical or disability insurance plan including coverage made available to persons defined as eligible by section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e), or who receives payments for accident-related injuries, so that any costs for hospitalization and medical care paid by the system are recovered from any other available third party payors. The administrator may require that contractors and noncontracting providers are responsible for the coordination of benefits for services provided under this article. Requirements for coordination of benefits by noncontracting providers under this section are limited to coordination with standard health insurance and disability insurance policies and similar programs for health coverage. The system shall act as payor of last resort for persons eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2974 or section 36-2981, paragraph 6 unless specifically prohibited by federal law. By operation of law, eligible persons assign to the system and a county rights to all types of medical benefits to which the person is entitled, including first party medical benefits under automobile insurance policies based on the order of priorities established pursuant to section 36-2915. The state has a right to subrogation against any other person or firm to enforce the assignment of medical benefits. The provisions of this subsection are controlling over the provisions of any insurance policy that provides benefits to an eligible person if the policy is inconsistent with the provisions of this subsection.

G. Notwithstanding subsection E of this section, the administrator may subcontract distinct administrative functions to one or more persons who may be contractors within the system.

H. The director shall require as a condition of a contract with any contractor that all records relating to contract compliance are available for inspection by the administrator and the director subject to subsection I of this section and that such records be maintained by the contractor for five years. The director shall also require that these records be made available by a contractor on request of the secretary of the United States department of health and human services, or its successor agency.

I. Subject to existing law relating to privilege and protection, the director shall prescribe by rule the types of information that are confidential and circumstances under which such information may be used or released, including requirements for physician-patient confidentiality. Notwithstanding any other provision of law, such rules shall be designed to provide for the exchange of necessary information among the counties, the administration and the department of economic security for the purposes of eligibility determination under this article. Notwithstanding any law to the contrary, a member's medical record shall be released without the member's consent in situations or suspected cases of fraud or abuse relating to the system to an officer of the state's certified Arizona health care cost containment system fraud control unit who has submitted a written request for the medical record.

J. The director shall prescribe rules that specify methods for:

1. The transition of members between system contractors and noncontracting providers.
2. The transfer of members and persons who have been determined eligible from hospitals that do not have contracts to care for such persons.

K. The director shall adopt rules that set forth procedures and standards for use by the system in requesting county long-term care for members or persons determined eligible.

L. To the extent that services are furnished pursuant to this article, and unless otherwise required pursuant to this chapter, a contractor is not subject to title 20.

M. As a condition of the contract with any contractor, the director shall require contract terms as necessary in the judgment of the director to ensure adequate performance and compliance with all applicable federal laws by the contractor of the provisions of each contract executed pursuant to this chapter. Contract provisions required by the director shall include at a minimum the maintenance of deposits, performance bonds, financial reserves or other financial security. The director may waive requirements for the posting of bonds or security for contractors that have posted other security, equal to or greater than that required by the system, with a state agency for the performance of health service contracts if funds would be available from such security for the system on default by the contractor. The director may also adopt rules for the withholding or forfeiture of payments to be made to a contractor by the system for the failure of the contractor to comply with a provision of the contractor's contract with the system or with the adopted rules. The director may also require contract terms allowing the administration to operate a contractor directly under circumstances specified in the contract. The administration shall operate the contractor only as long as it is necessary to assure delivery of uninterrupted care to members enrolled with the contractor and accomplish the orderly transition of those members to other system contractors, or until the contractor reorganizes or otherwise corrects the contract performance failure. The administration shall not operate a contractor unless, before that action, the administration delivers notice to the contractor and provides an opportunity for a hearing in accordance with procedures established by the director. Notwithstanding the provisions of a contract, if the administration finds that the public health, safety or welfare requires emergency action, it may operate as the contractor on notice to the contractor and pending an administrative hearing, which it shall promptly institute.

N. The administration for the sole purpose of matters concerning and directly related to the Arizona health care cost containment system and the Arizona long-term care system is exempt from section 41-192.

O. Notwithstanding subsection F of this section, if the administration determines that according to federal guidelines it is more cost-effective for a person defined as eligible under section 36-2901, paragraph 6, subdivision (a) to be enrolled in a group health insurance plan in which the person is entitled to be enrolled, the administration may pay all of that person's premiums, deductibles, coinsurance and other cost sharing obligations for services covered under section 36-2907. The person shall apply for enrollment in the group health insurance plan as a condition of eligibility under section 36-2901, paragraph 6, subdivision (a).

P. The total amount of state monies that may be spent in any fiscal year by the administration for health care shall not exceed the amount appropriated or authorized by section 35-173 for all health care purposes. This

article does not impose a duty on an officer, agent or employee of this state to discharge a responsibility or to create any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose.

Q. Notwithstanding section 36-470, a contractor or program contractor may receive laboratory tests from a laboratory or hospital-based laboratory for a system member enrolled with the contractor or program contractor subject to all of the following requirements:

1. The contractor or program contractor shall provide a written request to the laboratory in a format mutually agreed to by the laboratory and the requesting health plan or program contractor. The request shall include the member's name, the member's plan identification number, the specific test results that are being requested and the time periods and the quality improvement activity that prompted the request.

2. The laboratory data may be provided in written or electronic format based on the agreement between the laboratory and the contractor or program contractor. If there is no contract between the laboratory and the contractor or program contractor, the laboratory shall provide the requested data in a format agreed to by the noncontracted laboratory.

3. The laboratory test results provided to the member's contractor or program contractor shall only be used for quality improvement activities authorized by the administration and health care outcome studies required by the administration. The contractors and program contractors shall maintain strict confidentiality about the test results and identity of the member as specified in contractual arrangements with the administration and pursuant to state and federal law.

4. The administration, after collaboration with the department of health services regarding quality improvement activities, may prohibit the contractors and program contractors from receiving certain test results if the administration determines that a serious potential exists that the results may be used for purposes other than those intended for the quality improvement activities. The department of health services shall consult with the clinical laboratory licensure advisory committee established by section 36-465 before providing recommendations to the administration on certain test results and quality improvement activities.

5. The administration shall provide contracted laboratories and the department of health services with an annual report listing the quality improvement activities that will require laboratory data. The report shall be updated and distributed to the contracting laboratories and the department of health services when laboratory data is needed for new quality improvement activities.

6. A laboratory that complies with a request from the contractor or program contractor for laboratory results pursuant to this section is not subject to civil liability for providing the data to the contractor or program contractor. The administration, the contractor or a program contractor that uses data for reasons other than quality improvement activities is subject to civil liability for this improper use.

R. For the purposes of this section, "quality improvement activities" means those requirements, including health care outcome studies specified in federal law or required by the centers for medicare and medicaid services or the administration, to improve health care outcomes.

36-2932. Arizona long-term care system; powers and duties of the director; expenditure limitation

A. The Arizona long-term care system is established. The system includes the management and delivery of hospitalization, medical care, institutional services and home and community based services to members through the administration, the program contractors and providers pursuant to this article together with federal participation under title XIX of the social security act. The director in the performance of all duties shall consider the use of existing programs, rules and procedures in the counties and department where appropriate in meeting federal requirements.

B. The administration has full operational responsibility for the system, which shall include the following:

1. Contracting with and certification of program contractors in compliance with all applicable federal laws.
2. Approving the program contractors' comprehensive service delivery plans pursuant to section 36-2940.
3. Providing by rule for the ability of the director to review and approve or disapprove program contractors' requests for proposals for providers and provider subcontracts.
4. Providing technical assistance to the program contractors.
5. Developing a uniform accounting system to be implemented by program contractors and providers of institutional services and home and community based services.
6. Conducting quality control on eligibility determinations and preadmission screenings.
7. Establishing and managing a comprehensive system for assuring the quality of care delivered by the system as required by federal law.
8. Establishing an enrollment system.
9. Establishing a member case management tracking system.
10. Establishing and managing a method to prevent fraud by applicants, members, eligible persons, program contractors, providers and noncontracting providers as required by federal law.
11. Coordinating benefits as provided in section 36-2946.
12. Establishing standards for the coordination of services.
13. Establishing financial and performance audit requirements for program contractors, providers and noncontracting providers.
14. Prescribing remedies as required pursuant to 42 United States Code section 1396r. These remedies may include the appointment of temporary management by the director, acting in collaboration with the director of the department of health services, in order to continue operation of a nursing care institution providing services pursuant to this article.
15. Establishing a system to implement medical child support requirements, as required by federal law. The administration may enter into an intergovernmental agreement with the department of economic security to implement this paragraph.
16. Establishing requirements and guidelines for the review of trusts for the purposes of establishing eligibility for the system pursuant to section 36-2934.01 and posteligibility treatment of income pursuant to subsection L of this section.

17. Accepting the delegation of authority from the department of health services to enforce rules that prescribe minimum certification standards for adult foster care providers pursuant to section 36-410, subsection B. The administration may contract with another entity to perform the certification functions.

18. Assessing civil penalties for improper billing as prescribed in section 36-2903.01, subsection K.

C. For nursing care institutions and hospices that provide services pursuant to this article, the director shall contract periodically as deemed necessary and as required by federal law for a financial audit of the institutions and hospices that is certified by a certified public accountant in accordance with generally accepted auditing standards or conduct or contract for a financial audit or review of the institutions and hospices. The director shall notify the nursing care institution and hospice at least sixty days before beginning a periodic audit. The administration shall reimburse a nursing care institution or hospice for any additional expenses incurred for professional accounting services obtained in response to a specific request by the administration. On request, the director of the administration shall provide a copy of an audit performed pursuant to this subsection to the director of the department of health services or that person's designee.

D. Notwithstanding any other provision of this article, the administration may contract by an intergovernmental agreement with an Indian tribe, a tribal council or a tribal organization for the provision of long-term care services pursuant to section 36-2939, subsection A, paragraphs 1, 2, 3 and 4 and the home and community based services pursuant to section 36-2939, subsection B, paragraph 2 and subsection C, subject to the restrictions in section 36-2939, subsections D and E for eligible members.

E. The director shall require as a condition of a contract that all records relating to contract compliance are available for inspection by the administration subject to subsection F of this section and that these records are maintained for five years. The director shall also require that these records are available on request of the secretary of the United States department of health and human services or its successor agency.

F. Subject to applicable law relating to privilege and protection, the director shall adopt rules prescribing the types of information that are confidential and circumstances under which that information may be used or released, including requirements for physician-patient confidentiality. Notwithstanding any other law, these rules shall provide for the exchange of necessary information among the program contractors, the administration and the department for the purposes of eligibility determination under this article.

G. The director shall adopt rules to specify methods for the transition of members into, within and out of the system. The rules shall include provisions for the transfer of members, the transfer of medical records and the initiation and termination of services.

H. The director shall adopt rules that provide for withholding or forfeiting payments made to a program contractor if it fails to comply with a provision of its contract or with the director's rules.

I. The director shall:

1. Establish by rule the time frames and procedures for all grievances and requests for hearings consistent with section 36-2903.01, subsection B, paragraph 4.

2. Apply for and accept federal monies available under title XIX of the social security act in support of the system. In addition, the director may apply for and accept grants, contracts and private donations in support of the system.

3. Not less than thirty days before the administration implements a policy or a change to an existing policy relating to reimbursement, provide notice to interested parties. Parties interested in receiving notification of policy changes shall submit a written request for notification to the administration.

J. The director may apply for federal monies available for the support of programs to investigate and prosecute violations arising from the administration and operation of the system. Available state monies appropriated for

the administration of the system may be used as matching monies to secure federal monies pursuant to this subsection.

K. The director shall adopt rules that establish requirements of state residency and qualified alien status as prescribed in section 36-2903.03. The administration shall enforce these requirements as part of the eligibility determination process. The rules shall also provide for the determination of the applicant's county of residence for the purpose of assignment of the appropriate program contractor.

L. The director shall adopt rules in accordance with the state plan regarding posteligibility treatment of income and resources that determine the portion of a member's income that shall be available for payment for services under this article. The rules shall provide that a portion of income may be retained for:

1. A personal needs allowance for members receiving institutional services of at least fifteen per cent of the maximum monthly supplemental security income payment for an individual or a personal needs allowance for members receiving home and community based services based on a reasonable assessment of need.
2. The maintenance needs of a spouse or family at home in accordance with federal law. The minimum resource allowance for the spouse or family at home is twelve thousand dollars adjusted annually by the same percentage as the percentage change in the consumer price index for all urban consumers (all items; United States city average) between September 1988 and the September before the calendar year involved.
3. Expenses incurred for noncovered medical or remedial care that are not subject to payment by a third party payor.

M. In addition to the rules otherwise specified in this article, the director may adopt necessary rules pursuant to title 41, chapter 6 to carry out this article. Rules adopted by the director pursuant to this subsection may consider the differences between rural and urban conditions on the delivery of services.

N. The director shall not adopt any rule or enter into or approve any contract or subcontract that does not conform to federal requirements or that may cause the system to lose any federal monies to which it is otherwise entitled.

O. The administration, program contractors and providers may establish and maintain review committees dealing with the delivery of care. Review committees and their staff are subject to the same requirements, protections, privileges and immunities prescribed pursuant to section 36-2917.

P. If the director determines that the financial viability of a nursing care institution or hospice is in question, the director may require a nursing care institution and a hospice providing services pursuant to this article to submit quarterly financial statements within thirty days after the end of its financial quarter unless the director grants an extension in writing before that date. Quarterly financial statements submitted to the department shall include the following:

1. A balance sheet detailing the institution's assets, liabilities and net worth.
2. A statement of income and expenses, including current personnel costs and full-time equivalent statistics.

Q. The director may require monthly financial statements if the director determines that the financial viability of a nursing care institution or hospice is in question. The director shall prescribe the requirements of these statements.

R. The total amount of state monies that may be spent in any fiscal year by the administration for long-term care shall not exceed the amount appropriated or authorized by section 35-173 for that purpose. This article shall not be construed to impose a duty on an officer, agent or employee of this state to discharge a responsibility or to create any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose.



### 36-2938. Case management; definition

A. The director shall adopt rules establishing a uniform statewide case management program to ensure the most appropriate placement and cost effective delivery of services to members by the program contractors pursuant to this article. The case management program shall include the development by the program contractor of a long-term care service plan for each member. This plan shall include a cost benefit analysis for institutional or home and community based services. In developing this plan, the program contractor may use the information obtained from the preadmission screening conducted pursuant to section 36-2936 to determine the types of services a member should receive.

B. Each program contractor shall provide continual case management services to members in compliance with the uniform statewide case management program established pursuant to subsection A of this section.

C. Except for retroactive coverage, a program contractor shall only provide payment or reimbursement for services provided pursuant to this article under referral from its case management unit.

D. For the purposes of this section, "case management" means a service that will direct members to the most appropriate amount, duration and type of services and continually monitor and reassess a member's need for services provided pursuant to this article.

### 36-2939. Long-term care system services

A. The following services shall be provided by the program contractors to members who are determined to need institutional services pursuant to this article:

1. Nursing facility services other than services in an institution for tuberculosis or mental disease.
2. Notwithstanding any other law, behavioral health services if these services are not duplicative of long-term care services provided as of January 30, 1993 under this subsection and are authorized by the program contractor through the long-term care case management system. If the administration is the program contractor, the administration may authorize these services.
3. Hospice services. For the purposes of this paragraph, "hospice" means a program of palliative and supportive care for terminally ill members and their families or caregivers.
4. Case management services as provided in section 36-2938.
5. Health and medical services as provided in section 36-2907.
6. Dental services in an annual amount of not more than one thousand dollars per member.

B. In addition to the services prescribed in subsection A of this section, the department, as a program contractor, shall provide the following services if appropriate to members who have a developmental disability as defined in section 36-551 and are determined to need institutional services pursuant to this article:

1. Intermediate care facility services for a member who has a developmental disability as defined in section 36-551. For purposes of this article, a facility shall meet all federally approved standards and may only include the Arizona training program facilities, a state owned and operated service center, state owned or operated community residential settings and private facilities that contract with the department.
2. Home and community based services that may be provided in a member's home, at an alternative residential setting as prescribed in section 36-591 or at other behavioral health alternative residential facilities licensed by the department of health services and approved by the director of the Arizona health care cost containment system administration and that may include:
  - (a) Home health, which means the provision of nursing services, home health aide services or medical supplies, equipment and appliances, that are provided on a part-time or intermittent basis by a licensed home health agency within a member's residence based on a physician's orders and in accordance with federal law. Physical therapy, occupational therapy, or speech and audiology services provided by a home health agency may be provided in accordance with federal law. Home health agencies shall comply with federal bonding requirements in a manner prescribed by the administration.
  - (b) Home health aide, which means a service that provides intermittent health maintenance, continued treatment or monitoring of a health condition and supportive care for activities of daily living provided within a member's residence.
  - (c) Homemaker, which means a service that provides assistance in the performance of activities related to household maintenance within a member's residence.
  - (d) Personal care, which means a service that provides assistance to meet essential physical needs within a member's residence.
  - (e) Day care for persons with developmental disabilities, which means a service that provides planned care supervision and activities, personal care, activities of daily living skills training and habilitation services in a group setting during a portion of a continuous twenty-four-hour period.

- (f) Habilitation, which means the provision of physical therapy, occupational therapy, speech or audiology services or training in independent living, special developmental skills, sensory-motor development, behavior intervention, and orientation and mobility in accordance with federal law.
- (g) Respite care, which means a service that provides short-term care and supervision available on a twenty-four-hour basis.
- (h) Transportation, which means a service that provides or assists in obtaining transportation for the member.
- (i) Other services or licensed or certified settings approved by the director.

C. In addition to services prescribed in subsection A of this section, home and community based services may be provided in a member's home, in an adult foster care home as prescribed in section 36-401, in an assisted living home or assisted living center as defined in section 36-401 or in a level one or level two behavioral health alternative residential facility approved by the director by program contractors to all members who do not have a developmental disability as defined in section 36-551 and are determined to need institutional services pursuant to this article. Members residing in an assisted living center must be provided the choice of single occupancy. The director may also approve other licensed residential facilities as appropriate on a case-by-case basis for traumatic brain injured members. Home and community based services may include the following:

1. Home health, which means the provision of nursing services, home health aide services or medical supplies, equipment and appliances, that are provided on a part-time or intermittent basis by a licensed home health agency within a member's residence based on a physician's orders and in accordance with federal law. Physical therapy, occupational therapy, or speech and audiology services provided by a home health agency may be provided in accordance with federal law. Home health agencies shall comply with federal bonding requirements in a manner prescribed by the administration.
2. Home health aide, which means a service that provides intermittent health maintenance, continued treatment or monitoring of a health condition and supportive care for activities of daily living provided within a member's residence.
3. Homemaker, which means a service that provides assistance in the performance of activities related to household maintenance within a member's residence.
4. Personal care, which means a service that provides assistance to meet essential physical needs within a member's residence.
5. Adult day health, which means a service that provides planned care supervision and activities, personal care, personal living skills training, meals and health monitoring in a group setting during a portion of a continuous twenty-four-hour period. Adult day health may also include preventive, therapeutic and restorative health related services that do not include behavioral health services.
6. Habilitation, which means the provision of physical therapy, occupational therapy, speech or audiology services or training in independent living, special developmental skills, sensory-motor development, behavior intervention, and orientation and mobility in accordance with federal law.
7. Respite care, which means a service that provides short-term care and supervision available on a twenty-four-hour basis.
8. Transportation, which means a service that provides or assists in obtaining transportation for the member.
9. Home delivered meals, which means a service that provides for a nutritious meal that contains at least one-third of the recommended dietary allowance for an individual and that is delivered to the member's residence.
10. Other services or licensed or certified settings approved by the director.

D. The amount of money expended by program contractors on home and community based services pursuant to subsection C of this section shall be limited by the director in accordance with the federal monies made available to this state for home and community based services pursuant to subsection C of this section. The director shall establish methods for the allocation of monies for home and community based services to program contractors and shall monitor expenditures on home and community based services by program contractors.

E. Notwithstanding subsections A, B, C and F of this section, no service may be provided that does not qualify for federal monies available under title XIX of the social security act or the section 1115 waiver.

F. In addition to services provided pursuant to subsections A, B and C of this section, the director may implement a demonstration project to provide home and community based services to special populations, including persons with disabilities who are eighteen years of age or younger, are medically fragile, reside at home and would be eligible for supplemental security income for the aged, blind or disabled or the state supplemental payment program, except for the amount of their parent's income or resources. In implementing this project, the director may provide for parental contributions for the care of their child.

G. Subject to section 36-562, the administration by rule shall prescribe a deductible schedule for programs provided to members who are eligible pursuant to subsection B of this section, except that the administration shall implement a deductible based on family income. In determining deductible amounts and whether a family is required to have deductibles, the department shall use adjusted gross income. Families whose adjusted gross income is at least four hundred percent and less than or equal to five hundred percent of the federal poverty guidelines shall have a deductible of two percent of adjusted gross income. Families whose adjusted gross income is more than five hundred percent of adjusted gross income shall have a deductible of four percent of adjusted gross income. Only families whose children are under eighteen years of age and who are members who are eligible pursuant to subsection B of this section may be required to have a deductible for services. For the purposes of this subsection, "deductible" means an amount a family, whose children are under eighteen years of age and who are members who are eligible pursuant to subsection B of this section, pays for services, other than departmental case management and acute care services, before the department will pay for services other than departmental case management and acute care services.

**DEPARTMENT OF HEALTH SERVICES**  
Title 9, Chapter 6, Article 8



# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

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**MEETING DATE:** March 7, 2023

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** February 17, 2023

**SUBJECT:** Arizona Department of Health Services  
Title 9, Chapter 6, Article 8

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This Five-Year-Review Report (5YRR) from the Department of Health Services relates to rules in Title 9, Chapter 6 regarding Communicable Diseases and Infestations. Specifically, the report covers Article 8 regarding Assaults on Hospital Employees, Public Safety Employees and Volunteers.

In the last 5YRR of these rules the Department proposed to amend some of their rules through expedited rulemaking. The Department completed the proposed course of action by final expedited rulemaking which became effective September 11, 2018.

### **Proposed Action**

The Department indicates the rules are overall clear, concise, understandable, effective, and consistent with other rules and statutes, and therefore is not proposing any changes to the rules.

**1. Has the agency analyzed whether the rules are authorized by statute?**

Yes, the Department cites to both general and specific statutory authority.

2. **Summary of the agency's economic impact comparison and identification of stakeholders:**

Following amendments to definitions in 2018 and 2020, the Department has determined that the rules are effective and clear, concise, and understandable; additionally, the benefits related to public health outweigh any potential costs associated with the rulemaking. Such costs occur because of increased reporting requirements and mandated precautions, and making exclusion criteria more stringent for certain diseases. The Department believes that the costs and benefits identified in the EIS are generally consistent with the actual costs and benefits of the rules.

Stakeholders were identified as The Department, local health agencies, prosecuting attorneys, health care institutions and providers, correctional facilities, schools and child care establishments, operators of food establishments, clinical laboratories, and individuals in contact with or infected with communicable diseases.

3. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Department believes the costs of the amended rules were minimal and provided a benefit to employees, volunteers, and the general public while imposing the least burden and costs to persons regulated by the rules, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective.

4. **Has the agency received any written criticisms of the rules over the last five years?**

No, the Department indicates they did not receive any written criticisms to the rules.

5. **Has the agency analyzed the rules' clarity, conciseness, and understandability?**

Yes, the Department indicates the rules are overall clear, concise, and understandable.

6. **Has the agency analyzed the rules' consistency with other rules and statutes?**

Yes, the Department indicates the rules are consistent with other rules and statutes.

7. **Has the agency analyzed the rules' effectiveness in achieving its objectives?**

Yes, the Department indicates the rules are effective in achieving their objectives.

8. **Has the agency analyzed the current enforcement status of the rules?**

Yes, the Department indicates the rules are enforced as written.

9. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

Not applicable. There are no corresponding federal laws to the rules.

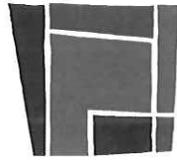
10. **For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

Not applicable. The rules do not require the issuance of a general permit or license.

11. **Conclusion**

As mentioned above, the Department is not proposing any changes to rules unless a threat to public health or safety arises.

Council staff finds the rules to be overall clear, concise, understandable, and effective. Council staff recommends approval of this report.



# ARIZONA DEPARTMENT OF HEALTH SERVICES

January 5, 2023

**VIA: E-MAIL: [grrc@azdoa.gov](mailto:grrc@azdoa.gov)**

Nicole Sornsin, Chairperson  
Governor's Regulatory Review Council  
Arizona Department of Administration  
100 North 15th Avenue, Suite 305  
Phoenix, Arizona 85007

RE: ADHS, A.A.C. Title 9, Chapter 6, Article 8 Five Year Review Report

Dear Ms. Sornsin:

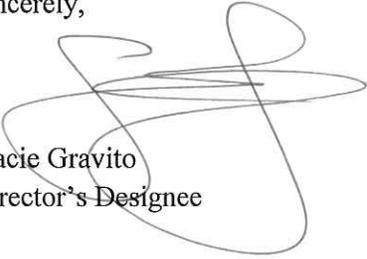
Please find enclosed the Five-Year Review Report from the Arizona Department of Health Services (Department) for A.A.C. Title 9, Chapter 6 Communicable Diseases and Infestations, Article 8 Assaults on Hospital Employees, Public Safety Employees and Volunteers, or State Hospital Employees which is due on February 28, 2023.

The Department reviewed the following rules in A.A.C. Title 9, Chapter 6, Article 8 with the intention that those rules do not expire under A.R.S. § 41-1056(J).

The Department hereby certifies compliance with A.R.S. § 41-1091.

For questions about this report, please contact Emily Carey at 602-542-5121 or [emily.carey@azdhs.gov](mailto:emily.carey@azdhs.gov).

Sincerely,

  
Stacie Gravito  
Director's Designee

RL: tk  
Enclosures

Douglas A. Ducey | Governor Don Herrington | Interim Director



ARIZONA DEPARTMENT  
OF HEALTH SERVICES

**Arizona Department of Health Services**

**Five-Year-Review Report**

**Title 9. – Health Services**

**Chapter 6. – Department of Health Services – Communicable Diseases and Infestations**

**Article 8. – Assaults on Hospital Employees, Public Safety Employees and Volunteers,  
or State Hospital Employees**

**February 2023**

**1. Authorization of the rule by existing statutes:**

Authorizing statutes: A.R.S. §§ 36-132(A)(1), 36-136(A)(7), and 36-136(G)

Implementing statutes: A.R.S. §§ 13-1210 and 36-136(I)(1)

**2. The objective of each rule:**

<b>Rule</b>	<b>Objective</b>
R9-6-801	To define terms used in the Article to enable the reader to understand clearly the requirements in the Article.
R9-6-802	To establish procedures for providing notification of court-ordered test results to applicable persons, and specific additional requirements related to court-ordered test results, such as confidentiality and reporting in accordance with A.A.C. Title 9, Chapter 6.

**3. Are the rules effective in achieving their objectives?**

**Yes  No**

*If not, please identify the rule(s) that is not effective and provide an explanation for why the rule(s) is not effective.*

<b>Rule</b>	<b>Explanation</b>

**4. Are the rules consistent with other rules and statutes?**

**Yes  No**

*If not, please identify the rule(s) that is not consistent. Also, provide an explanation and identify the provisions that are not consistent with the rule.*

<b>Rule</b>	<b>Explanation</b>

**5. Are the rules enforced as written?**

**Yes  No**

*If not, please identify the rule(s) that is not enforced as written and provide an explanation of the issues with enforcement. In addition, include the agency’s proposal for resolving the issue.*

Rule	Explanation

6. **Are the rules clear, concise, and understandable?** Yes  No

*If not, please identify the rule(s) that is not clear, concise, or understandable and provide an explanation as to how the agency plans to amend the rule(s) to improve clarity, conciseness, and understandability.*

Rule	Explanation

7. **Has the agency received written criticisms of the rules within the last five years?** Yes  No

*If yes, please fill out the table below:*

Commenter	Comment	Agency's Response

8. **Economic, small business, and consumer impact comparison (summary):**

Arizona Revised Statutes (A.R.S.) § 36-136(I)(1) requires the Arizona Department of Health Services (Department) to “define and prescribe reasonably necessary measures for detecting, reporting, preventing and controlling communicable and preventable diseases.” A.R.S. § 13-1210 authorizes a public safety employee or volunteer, an Arizona State Hospital (ASH) employee, or the employing entity to petition for court-ordered testing of the blood of the alleged perpetrator of an assault on a public safety employee, volunteer, or an ASH employee. The Department has adopted rules in the Arizona Administrative Code (A.A.C.) Title 9, Chapter 6, Article 8, effective April 1, 2008, to implement these statutes. As part of the regular rulemaking, the Department submitted an economic, small business, and consumer impact statement (EIS) to the Council as part of the Final Rulemaking package. The EIS designated annual cost/revenue changes as minimal when less than \$1,000, moderate when between \$1,000 and \$10,000, and substantial when \$10,000 or greater in additional costs or revenues. The Department determined that the number of reports according to A.R.S. § 13-1415, court-ordered tests received annually by the Department has not increased over the last five years. By analogy, the Department believes that it is likely that the annual number of court-ordered tests, according to A.R.S. § 13-1210, has not increased over the last five years.

As part of an expedited rulemaking based on the 2018 five-year-review-report at 24 A.A.R. 2758, the rules in R9-6-801 definitions were amended, effective September 11, 2018. The definitions were amended to adhere to A.R.S. § 13-1210 revision to include ASH employees as an individual to receive testing notifications. The definition of “public safety employee or volunteer” was removed due to being redundant with the revised definition of “named employee or volunteer.” The rules in R9-6-802 were also amended to be consistent with the changes made to the definitions in R9-6-801 that were revised or removed. The Department believes the costs of

these amended rules were minimal and provided a benefit to employees, volunteers, and the general public.

The rules were last amended by expedited rulemaking found at 26 A.A.R. 1065, effective May 7, 2020. The rule in R9-6-801 was amended to add in “hospital employee” to the definition of a “named employee or volunteer.” This revision was to comply with Laws 2019, Ch. 97, which amended A.R.S. § 13-1210 to include a hospital employee to those who may “petition the court for an order authorizing testing of another person for the human immunodeficiency virus, common blood borne diseases or other diseases specified in the petition.” This revision of the definition provided a clearer and more understandable definition for the reader. The Department believes the costs of these amended rules were minimal and provided a benefit to employees, volunteers, and the general public.

After an analysis of the rules in Article 8, the Department has determined that the rules are effective and clear, concise, and understandable. The Department’s enforcement of the rules is consistent with A.R.S. § 13-1210, and the rules are continuing to be utilized as written. The Department believes that the costs and benefits identified in the EIS are generally consistent with the actual costs and benefits of the rules.

9. **Has the agency received any business competitiveness analyses of the rules?** Yes \_\_\_ No

10. **Has the agency completed the course of action indicated in the agency’s previous five-year-review report?**

*Please state what the previous course of action was and if the agency did not complete the action, please explain why not.*

In the 2018 five-year-review-report, the Department proposed to amend the rules in an expedited rulemaking. The Department completed this course of action by final expedited rulemaking at 24 A.A.R. 2758, effective September 11, 2018.

11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

The Department continues to use the rules without increased cost or burden. The Department believes that the rules impose the least burden and costs to persons regulated by the rules, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective.

12. **Are the rules more stringent than corresponding federal laws?** Yes \_\_\_ No

*Please provide a citation for the federal law(s). And if the rule(s) is more stringent, is there statutory authority to exceed the requirements of federal law(s)?*

The rules are not related to any federal laws.

13. **For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

The rules do not require the issuance of a regulatory permit, license, or agency authorization.

14. **Proposed course of action:**

*If possible, please identify a month and year by which the agency plans to complete the course of action.*

The Department believes the rules are sufficient to protect public health and does not plan to amend the rules in 9 A.A.C. 6, Article 8 unless a threat to public health or safety arises that would require amending the rules.

## **ARTICLE 8. ASSAULTS ON HOSPITAL EMPLOYEES, PUBLIC SAFETY EMPLOYEES AND VOLUNTEERS, OR STATE HOSPITAL EMPLOYEES**

### **R9-6-801. Definitions**

In addition to the definitions in A.R.S. § 13-1210 and R9-6-101, the following definitions apply in this Article unless otherwise specified:

1. "Employer" means an individual in the senior leadership position with an agency or entity for which a named employee or volunteer works or that individual's designee.
2. "Named employee or volunteer" means one of the following who is listed as the assaulted individual in a petition, filed under A.R.S. § 13-1210 and granted by a court:
  - a. Hospital employee,
  - b. Public safety employee or volunteer, or
  - c. Arizona State Hospital employee.
3. "Occupational health provider" means a physician, physician assistant, registered nurse practitioner, or registered nurse, as defined in A.R.S. § 32-1601, who provides medical services for work-related health conditions for an agency or entity for which a named employee or volunteer works.

#### **Historical Note**

Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Amended and readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted without change as an emergency effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Adopted without change as a permanent rule effective May 22, 1989. Amended as an emergency effective June 26, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Emergency amendment readopted without change effective October 17, 1989 (Supp. 89-4). Amended effective September 19, 1990 (Supp. 90-3). Renumbered to R9-6-401 effective October 19, 1993 (Supp. 93-4). New Section made by final rulemaking at 8 A.A.R. 5214, effective February 1, 2003 (Supp. 02-4). Amended by final rulemaking at 14 A.A.R. 1502, effective April 1, 2008 (Supp. 08-2). Amended by final expedited rulemaking at 24 A.A.R. 2758, effective September 11, 2018 (Supp. 18-3). Amended by final expedited rulemaking at 26 A.A.R. 1065, with an immediate effective date of May 7, 2020 (Supp. 20-2).

### **R9-6-802. Notice of Test Results**

- A.** Within 10 working days after the date of receipt of a laboratory report for a test ordered by a health care provider as a result of a court order issued under A.R.S. § 13-1210, the ordering health care provider shall:
  1. If the test is conducted on the blood of a court-ordered subject who is incarcerated or detained:
    - a. Provide a written copy of the laboratory report to the chief medical officer of the correctional facility in which the court-ordered subject is incarcerated or detained; and
    - b. Notify the occupational health provider in writing of the results of the test; and
  2. If the test is conducted on the blood of a court-ordered subject who is not incarcerated or detained:
    - a. Unless the court-ordered subject is deceased, notify the court-ordered subject as specified in subsection (D);
    - b. If requested by the court-ordered subject, provide a written copy of the laboratory report to the court-ordered subject; and
    - c. Notify the occupational health provider in writing of the results of the test.
- B.** Within five working days after the date of receipt of a laboratory report for a court-ordered subject who is incarcerated or detained, the chief medical officer of the correctional facility in which the court-ordered subject is incarcerated or detained shall:
  1. Notify the court-ordered subject as specified in subsection (D);
  2. If requested by the court-ordered subject, provide a written copy of the laboratory report to the court-ordered subject; and
  3. Notify the officer in charge of the correctional facility as specified in subsection (E).
- C.** Within five working days after an occupational health provider receives written notice of test results as required in subsection (A), the occupational health provider shall notify:
  1. The named employee or volunteer as specified in subsection (D); and
  2. The employer as specified in subsection (E).
- D.** An individual who provides notice to a court-ordered subject or named employee or volunteer as required under subsection (A), (B), or (C) shall describe the test results and provide or arrange for the court-ordered subject or named employee or volunteer to receive the following information about each agent for which the court-ordered subject was tested:
  1. A description of the disease or syndrome caused by the agent, including its symptoms;
  2. A description of how the agent is transmitted to others;
  3. The average window period for the agent;
  4. An explanation that a negative test result does not rule out infection and that retesting for the agent after the average window period has passed is necessary to rule out infection;

5. Measures to reduce the likelihood of transmitting the agent to others and that it is necessary to continue the measures until a negative test result is obtained after the average window period has passed or until an infection, if detected, is eliminated;
  6. That it is necessary to notify others that they may be or may have been exposed to the agent by the individual receiving notice;
  7. The availability of assistance from local health agencies or other resources; and
  8. The confidential nature of the court-ordered subject's test results.
- E.** An individual who provides notice to the officer in charge of a correctional facility, as required under subsection (B), or to an employer, as required under subsection (C), shall describe the test results and provide or arrange for the officer in charge of the facility or the employer to receive the following information about each agent for which a court-ordered subject's test results indicate the presence of infection:
1. A description of the disease or syndrome caused by the agent, including its symptoms;
  2. A description of how the agent is transmitted to others;
  3. Measures to reduce the likelihood of transmitting the agent to others;
  4. The availability of assistance from local health agencies or other resources; and
  5. The confidential nature of the court-ordered subject's test results.
- F.** An individual who provides notice under this Section shall not provide a copy of the laboratory report to anyone other than the court-ordered subject and, if the court-ordered subject is incarcerated or detained, the chief medical officer of the correctional facility in which the court-ordered subject is incarcerated or detained.
- G.** An individual who provides notice under this Section shall protect the confidentiality of the court-ordered subject's personal identifying information and test results.
- H.** A health care provider who orders a test on the blood of a court-ordered subject who is not incarcerated or detained may, at the time the court-ordered subject is seen by the ordering health care provider, present the court-ordered subject with a telephone number and instruct the court-ordered subject to contact the ordering health care provider after a stated period of time for notification of the test results.
- I.** A health care provider who orders a test has not satisfied the obligation of the health care provider to notify under subsection (A) if:
1. The health care provider provides a telephone number and instructions, as allowed by subsection (H), for a court-ordered subject to contact the ordering health care provider and receive the information specified in subsection (D); and
  2. The court-ordered subject does not contact the ordering health care provider.
- J.** A health care provider who orders a test on a court-ordered subject's blood shall comply with all applicable reporting requirements contained in this Chapter.

#### **Historical Note**

Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Amended and readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted without change as an emergency effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Adopted without change as a permanent rule effective May 22, 1989 (Supp. 89-2). Amended effective September 19, 1990 (Supp. 90-3). Amended as an emergency effective August 8, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency expired. Emergency amendments re-adopted without change effective November 19, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-4). Emergency expired. Emergency amendments re-adopted without change effective February 28, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-1). Emergency expired. Renumbered to R9-6-402 effective October 19, 1993 (Supp. 93-4). New Section made by final rulemaking at 8 A.A.R. 5214, effective February 1, 2003 (Supp. 02-4). Amended by final rulemaking at 14 A.A.R. 1502, effective April 1, 2008 (Supp. 08-2). Amended by final expedited rulemaking at 24 A.A.R. 2758, effective September 11, 2018 (Supp. 18-3).

## Authorizing Statutes

### 36-132. Department of health services; functions; contracts

A. The department, in addition to other powers and duties vested in it by law, shall:

1. Protect the health of the people of the state.
2. Promote the development, maintenance, efficiency and effectiveness of local health departments or districts of sufficient population and area that they can be sustained with reasonable economy and efficient administration, provide technical consultation and assistance to local health departments or districts, provide financial assistance to local health departments or districts and services that meet minimum standards of personnel and performance and in accordance with a plan and budget submitted by the local health department or districts to the department for approval, and recommend the qualifications of all personnel.
3. Collect, preserve, tabulate and interpret all information required by law in reference to births, deaths and all vital facts, and obtain, collect and preserve information relating to the health of the people of this state and the prevention of diseases as may be useful in the discharge of functions of the department not in conflict with chapter 3 of this title and sections 36-693, 36-694 and 39-122.
4. Operate such sanitariums, hospitals or other facilities assigned to the department by law or by the governor.
5. Conduct a statewide program of health education relevant to the powers and duties of the department, prepare educational materials and disseminate information as to conditions affecting health, including basic information for the promotion of good health on the part of individuals and communities, and prepare and disseminate technical information concerning public health to the health professions, local health officials and hospitals. In cooperation with the department of education, the department of health services shall prepare and disseminate materials and give technical assistance for the purpose of education of children in hygiene, sanitation and personal and public health, and provide consultation and assistance in community organization to counties, communities and groups of people.
6. Administer or supervise a program of public health nursing, prescribe the minimum qualifications of all public health nurses engaged in official public health work, and encourage and aid in coordinating local public health nursing services.
7. Encourage and aid in coordinating local programs concerning control of preventable diseases in accordance with statewide plans that shall be formulated by the department.
8. Encourage and aid in coordinating local programs concerning maternal and child health, including midwifery, antepartum and postpartum care, infant and preschool health and the health of schoolchildren, including special fields such as the prevention of blindness and conservation of sight and hearing.
9. Encourage and aid in the coordination of local programs concerning nutrition of the people of this state.
10. Encourage, administer and provide dental health care services and aid in coordinating local programs concerning dental public health, in cooperation with the Arizona dental association. The department may bill and receive payment for costs associated with providing dental health care services and shall deposit the monies in the oral health fund established by section 36-138.

11. Establish and maintain adequate serological, bacteriological, parasitological, entomological and chemical laboratories with qualified assistants and facilities necessary for routine examinations and analyses and for investigations and research in matters affecting public health.
12. Supervise, inspect and enforce the rules concerning the operation of public bathing places and public and semipublic swimming pools adopted pursuant to section 36-136, subsection I, paragraph 10.
13. Take all actions necessary or appropriate to ensure that bottled water sold to the public and water used to process, store, handle, serve and transport food and drink are free from filth, disease-causing substances and organisms and unwholesome, poisonous, deleterious or other foreign substances. All state agencies and local health agencies involved with water quality shall provide to the department any assistance requested by the director to ensure that this paragraph is effectuated.
14. Enforce the state food, caustic alkali and acid laws in accordance with chapter 2, article 2 of this title, chapter 8, article 1 of this title and chapter 9, article 4 of this title, and collaborate in the enforcement of the federal food, drug, and cosmetic act (52 Stat. 1040; 21 United States Code sections 1 through 905).
15. Recruit and train personnel for state, local and district health departments.
16. Conduct continuing evaluations of state, local and district public health programs, study and appraise state health problems and develop broad plans for use by the department and for recommendation to other agencies, professions and local health departments for the best solution of these problems.
17. License and regulate health care institutions according to chapter 4 of this title.
18. Issue or direct the issuance of licenses and permits required by law.
19. Participate in the state civil defense program and develop the necessary organization and facilities to meet wartime or other disasters.
20. Subject to the availability of monies, develop and administer programs in perinatal health care, including:
  - (a) Screening in early pregnancy for detecting high-risk conditions.
  - (b) Comprehensive prenatal health care.
  - (c) Maternity, delivery and postpartum care.
  - (d) Perinatal consultation, including transportation of the pregnant woman to a perinatal care center when medically indicated.
  - (e) Perinatal education oriented toward professionals and consumers, focusing on early detection and adequate intervention to avert premature labor and delivery.
21. License and regulate the health and safety of group homes for persons with developmental disabilities. The department shall issue a license to an accredited facility for a period of the accreditation, except that no licensing period shall be longer than three years. The department is authorized to conduct an inspection of an accredited facility to ensure that the facility meets health and safety licensure standards. The results of the accreditation survey shall be public information. A copy of the final accreditation report shall be filed with the

department of health services. For the purposes of this paragraph, "accredited" means accredited by a nationally recognized accreditation organization.

B. The department may accept from the state or federal government, or any agency of the state or federal government, and from private donors, trusts, foundations or eleemosynary corporations or organizations grants or donations for or in aid of the construction or maintenance of any program, project, research or facility authorized by this title, or in aid of the extension or enforcement of any program, project or facility authorized, regulated or prohibited by this title, and enter into contracts with the federal government, or an agency of the federal government, and with private donors, trusts, foundations or eleemosynary corporations or organizations, to carry out such purposes. All monies made available under this section are special project grants. The department may also expend these monies to further applicable scientific research within this state.

C. The department, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.

D. The department may enter into contracts with organizations that perform nonrenal organ transplant operations and organizations that primarily assist in the management of end-stage renal disease and related problems to provide, as payors of last resort, prescription medications necessary to supplement treatment and transportation to and from treatment facilities. The contracts may provide for department payment of administrative costs it specifically authorizes.

36-136. Powers and duties of director; compensation of personnel; rules; definitions

A. The director shall:

1. Be the executive officer of the department of health services and the state registrar of vital statistics but shall not receive compensation for services as registrar.
2. Perform all duties necessary to carry out the functions and responsibilities of the department.
3. Prescribe the organization of the department. The director shall appoint or remove personnel as necessary for the efficient work of the department and shall prescribe the duties of all personnel. The director may abolish any office or position in the department that the director believes is unnecessary.
4. Administer and enforce the laws relating to health and sanitation and the rules of the department.
5. Provide for the examination of any premises if the director has reasonable cause to believe that on the premises there exists a violation of any health law or rule of this state.
6. Exercise general supervision over all matters relating to sanitation and health throughout this state. When in the opinion of the director it is necessary or advisable, a sanitary survey of the whole or of any part of this state shall be made. The director may enter, examine and survey any source and means of water supply, sewage disposal plant, sewerage system, prison, public or private place of detention, asylum, hospital, school, public building, private institution, factory, workshop, tenement, public washroom, public restroom, public toilet and toilet facility, public eating room and restaurant, dairy, milk plant or food manufacturing or processing plant, and any premises in which the director has reason to believe there exists a violation of any health law or rule of this state that the director has the duty to administer.
7. Prepare sanitary and public health rules.

8. Perform other duties prescribed by law.

B. If the director has reasonable cause to believe that there exists a violation of any health law or rule of this state, the director may inspect any person or property in transportation through this state, and any car, boat, train, trailer, airplane or other vehicle in which that person or property is transported, and may enforce detention or disinfection as reasonably necessary for the public health if there exists a violation of any health law or rule.

C. The director, after consultation with the department of administration, may take all necessary steps to enhance the highest and best use of the state hospital property, including contracting with third parties to provide services, entering into short-term lease agreements with third parties to occupy or renovate existing buildings and entering into long-term lease agreements to develop the land and buildings. The director shall deposit any monies collected from contracts and lease agreements entered into pursuant to this subsection in the Arizona state hospital charitable trust fund established by section 36-218. At least thirty days before issuing a request for proposals pursuant to this subsection, the department of health services shall hold a public hearing to receive community and provider input regarding the highest and best use of the state hospital property related to the request for proposals. The department shall report to the joint committee on capital review on the terms, conditions and purpose of any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, and the fiscal impact on the department and any revenues generated by the agreement. Any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, must be reviewed by the joint committee on capital review.

D. The director may deputize, in writing, any qualified officer or employee in the department to do or perform on the director's behalf any act the director is by law empowered to do or charged with the responsibility of doing.

E. The director may delegate to a local health department, county environmental department or public health services district any functions, powers or duties that the director believes can be competently, efficiently and properly performed by the local health department, county environmental department or public health services district if:

1. The director or superintendent of the local health agency, environmental agency or public health services district is willing to accept the delegation and agrees to perform or exercise the functions, powers and duties conferred in accordance with the standards of performance established by the director of the department of health services.

2. Monies appropriated or otherwise made available to the department for distribution to or division among counties or public health services districts for local health work may be allocated or reallocated in a manner designed to ensure the accomplishment of recognized local public health activities and delegated functions, powers and duties in accordance with applicable standards of performance. If in the director's opinion there is cause, the director may terminate all or a part of any delegation and may reallocate all or a part of any funds that may have been conditioned on the further performance of the functions, powers or duties conferred.

F. The compensation of all personnel shall be as determined pursuant to section 38-611.

G. The director may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.

H. Notwithstanding subsection I, paragraph 1 of this section, the director may define and prescribe emergency measures for detecting, reporting, preventing and controlling communicable or infectious diseases or conditions if the director has reasonable cause to believe that a serious threat to public health and welfare exists. Emergency measures are effective for not longer than eighteen months.

I. The director, by rule, shall:

1. Define and prescribe reasonably necessary measures for detecting, reporting, preventing and controlling communicable and preventable diseases. The rules shall declare certain diseases reportable. The rules shall prescribe measures, including isolation or quarantine, that are reasonably required to prevent the occurrence of, or to seek early detection and alleviation of, disability, insofar as possible, from communicable or preventable diseases. The rules shall include reasonably necessary measures to control animal diseases transmittable to humans.

2. Define and prescribe reasonably necessary measures, in addition to those prescribed by law, regarding the preparation, embalming, cremation, interment, disinterment and transportation of dead human bodies and the conduct of funerals, relating to and restricted to communicable diseases and regarding the removal, transportation, cremation, interment or disinterment of any dead human body.

3. Define and prescribe reasonably necessary procedures that are not inconsistent with law in regard to the use and accessibility of vital records, delayed birth registration and the completion, change and amendment of vital records.

4. Except as relating to the beneficial use of wildlife meat by public institutions and charitable organizations pursuant to title 17, prescribe reasonably necessary measures to ensure that all food or drink, including meat and meat products and milk and milk products sold at the retail level, provided for human consumption is free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe reasonably necessary measures governing the production, processing, labeling, storing, handling, serving and transportation of these products. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained in any warehouse, restaurant or other premises, except a meat packing plant, slaughterhouse, wholesale meat processing plant, dairy product manufacturing plant or trade product manufacturing plant. The rules shall prescribe minimum standards for any truck or other vehicle in which food or drink is produced, processed, stored, handled, served or transported. The rules shall provide for the inspection and licensing of premises and vehicles so used, and for abatement as public nuisances of any premises or vehicles that do not comply with the rules and minimum standards. The rules shall provide an exemption relating to food or drink that is:

(a) Served at a noncommercial social event such as a potluck.

(b) Prepared at a cooking school that is conducted in an owner-occupied home.

(c) Not potentially hazardous and prepared in a kitchen of a private home for occasional sale or distribution for noncommercial purposes.

(d) Prepared or served at an employee-conducted function that lasts less than four hours and is not regularly scheduled, such as an employee recognition, an employee fundraising or an employee social event.

(e) Offered at a child care facility and limited to commercially prepackaged food that is not potentially hazardous and whole fruits and vegetables that are washed and cut on-site for immediate consumption.

(f) Offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous.

(g) A cottage food product that is not potentially hazardous or a time or temperature control for safety food and that is prepared in a kitchen of a private home for commercial purposes, including fruit jams and jellies, dry mixes made with ingredients from approved sources, honey, dry pasta and roasted nuts. Cottage food products must be packaged at home with an attached label that clearly states the name and registration number of the food preparer, lists all the ingredients in the product and the product's production date and includes the following statement: "This product was produced in a home kitchen that may process common food allergens and is not subject to public health inspection." If the product was made in a facility for individuals with developmental disabilities, the label must also disclose that fact. The person preparing the food or supervising the food preparation must complete a food handler training course from an accredited program and maintain active certification. The food preparer must register with an online registry established by the department pursuant to paragraph 13 of this subsection. The food preparer must display the preparer's certificate of registration when operating as a temporary food establishment. For the purposes of this subdivision, "not potentially hazardous" means cottage food products that meet the requirements of the food code published by the United States food and drug administration, as modified and incorporated by reference by the department by rule.

(h) A whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption.

(i) Produce in a packing or holding facility that is subject to the United States food and drug administration produce safety rule (21 Code of Federal Regulations part 112) as administered by the Arizona department of agriculture pursuant to title 3, chapter 3, article 4.1. For the purposes of this subdivision, "holding", "packing" and "produce" have the same meanings prescribed in section 3-525.

(j) Spirituous liquor produced on the premises licensed by the department of liquor licenses and control. This exemption includes both of the following:

(i) The area in which production and manufacturing of spirituous liquor occurs, as defined in an active basic permit on file with the United States alcohol and tobacco tax and trade bureau.

(ii) The area licensed by the department of liquor licenses and control as a microbrewery, farm winery or craft distiller that is open to the public and serves spirituous liquor and commercially prepackaged food, crackers or pretzels for consumption on the premises. A producer of spirituous liquor may not provide, allow or expose for common use any cup, glass or other receptacle used for drinking purposes. For the purposes of this item, "common use" means the use of a drinking receptacle for drinking purposes by or for more than one person without the receptacle being thoroughly cleansed and sanitized between consecutive uses by methods prescribed by or acceptable to the department.

5. Prescribe reasonably necessary measures to ensure that all meat and meat products for human consumption handled at the retail level are delivered in a manner and from sources approved by the Arizona department of agriculture and are free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe standards for sanitary facilities to be used in identity, storage, handling and sale of all meat and meat products sold at the retail level.

6. Prescribe reasonably necessary measures regarding production, processing, labeling, handling, serving and transportation of bottled water to ensure that all bottled drinking water distributed for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained at any source of water, bottling plant and truck or vehicle in which bottled water is produced, processed, stored or transported and shall provide for inspection and certification of bottled drinking water sources, plants, processes and transportation and for abatement as a public nuisance of any water supply, label,

premises, equipment, process or vehicle that does not comply with the minimum standards. The rules shall prescribe minimum standards for bacteriological, physical and chemical quality for bottled water and for the submission of samples at intervals prescribed in the standards.

7. Define and prescribe reasonably necessary measures governing ice production, handling, storing and distribution to ensure that all ice sold or distributed for human consumption or for preserving or storing food for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions and the quality of ice that shall be maintained at any ice plant, storage and truck or vehicle in which ice is produced, stored, handled or transported and shall provide for inspection and licensing of the premises and vehicles, and for abatement as public nuisances of ice, premises, equipment, processes or vehicles that do not comply with the minimum standards.

8. Define and prescribe reasonably necessary measures concerning sewage and excreta disposal, garbage and trash collection, storage and disposal, and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels. The rules shall prescribe minimum standards for preparing food in community kitchens, adequacy of excreta disposal, garbage and trash collection, storage and disposal and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels and shall provide for inspection of these premises and for abatement as public nuisances of any premises or facilities that do not comply with the rules. Primitive camp and picnic grounds offered by this state or a political subdivision of this state are exempt from rules adopted pursuant to this paragraph but are subject to approval by a county health department under sanitary regulations adopted pursuant to section 36-183.02. Rules adopted pursuant to this paragraph do not apply to two or fewer recreational vehicles as defined in section 33-2102 that are not park models or park trailers, that are parked on owner-occupied residential property for less than sixty days and for which no rent or other compensation is paid. For the purposes of this paragraph, "primitive camp and picnic grounds" means camp and picnic grounds that are remote in nature and without accessibility to public infrastructure such as water, electricity and sewer.

9. Define and prescribe reasonably necessary measures concerning the sewage and excreta disposal, garbage and trash collection, storage and disposal, water supply and food preparation of all public schools. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained in any public school and shall provide for inspection of these premises and facilities and for abatement as public nuisances of any premises that do not comply with the minimum standards.

10. Prescribe reasonably necessary measures to prevent pollution of water used in public or semipublic swimming pools and bathing places and to prevent deleterious health conditions at these places. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained at any public or semipublic swimming pool or bathing place and shall provide for inspection of these premises and for abatement as public nuisances of any premises and facilities that do not comply with the minimum standards. The rules shall be developed in cooperation with the director of the department of environmental quality and shall be consistent with the rules adopted by the director of the department of environmental quality pursuant to section 49-104, subsection B, paragraph 12.

11. Prescribe reasonably necessary measures to keep confidential information relating to diagnostic findings and treatment of patients, as well as information relating to contacts, suspects and associates of communicable disease patients. In no event shall confidential information be made available for political or commercial purposes.

12. Prescribe reasonably necessary measures regarding human immunodeficiency virus testing as a means to control the transmission of that virus, including the designation of anonymous test sites as dictated by current epidemiologic and scientific evidence.

13. Establish an online registry of food preparers that are authorized to prepare cottage food products for commercial purposes pursuant to paragraph 4 of this subsection. A registered food preparer shall renew the registration every three years and shall provide to the department updated registration information within thirty days after any change.

14. Prescribe an exclusion for fetal demise cases from the standardized survey known as "the hospital consumer assessment of healthcare providers and systems".

J. The rules adopted under the authority conferred by this section shall be observed throughout the state and shall be enforced by each local board of health or public health services district, but this section does not limit the right of any local board of health or county board of supervisors to adopt ordinances and rules as authorized by law within its jurisdiction, provided that the ordinances and rules do not conflict with state law and are equal to or more restrictive than the rules of the director.

K. The powers and duties prescribed by this section do not apply in instances in which regulatory powers and duties relating to public health are vested by the legislature in any other state board, commission, agency or instrumentality, except that with regard to the regulation of meat and meat products, the department of health services and the Arizona department of agriculture within the area delegated to each shall adopt rules that are not in conflict.

L. The director, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.

M. After consultation with the state superintendent of public instruction, the director shall prescribe the criteria the department shall use in deciding whether or not to notify a local school district that a pupil in the district has tested positive for the human immunodeficiency virus antibody. The director shall prescribe the procedure by which the department shall notify a school district if, pursuant to these criteria, the department determines that notification is warranted in a particular situation. This procedure shall include a requirement that before notification the department shall determine to its satisfaction that the district has an appropriate policy relating to nondiscrimination of the infected pupil and confidentiality of test results and that proper educational counseling has been or will be provided to staff and pupils.

N. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (f) of this section, food and drink are exempt from the rules prescribed in subsection I of this section if offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous, without a limitation on its display area.

O. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (h) of this section, a whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption is exempt from the rules prescribed in subsection I of this section.

P. Until the department adopts an exclusion by rule as required by subsection I, paragraph 14 of this section, the standardized survey known as "the hospital consumer assessment of healthcare providers and systems" may not include patients who experience a fetal demise.

Q. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (j) of this section, spirituous liquor and commercially prepackaged food, crackers or pretzels that meet the requirements of subsection I, paragraph 4, subdivision (j) of this section are exempt from the rules prescribed in subsection I of this section.

R. For the purposes of this section:

1. "Cottage food product":

(a) Means a food that is not potentially hazardous or a time or temperature control for safety food as defined by the department in rule and that is prepared in a home kitchen by an individual who is registered with the department.

(b) Does not include foods that require refrigeration, perishable baked goods, salsas, sauces, fermented and pickled foods, meat, fish and shellfish products, beverages, acidified food products, nut butters or other reduced-oxygen packaged products.

2. "Fetal demise" means a fetal death that occurs or is confirmed in a licensed hospital. Fetal demise does not include an abortion as defined in section 36-2151.

[13-1210. Assaults on hospital employees, public safety employees or volunteers and state hospital employees; disease testing; petition; hearing; notice; definitions](#)

A. A hospital employee, a public safety employee or volunteer or the employing agency, officer or entity may petition the court for an order authorizing testing of another person for the human immunodeficiency virus, common blood borne diseases or other diseases specified in the petition if there are reasonable grounds to believe an exposure occurred and one of the following applies:

1. The person is charged in any criminal complaint and the complaint alleges that the person interfered with the official duties of the hospital employee or the public safety employee or volunteer by biting, scratching, spitting or transferring blood or other bodily fluids on or through the skin or membranes of the hospital employee or the public safety employee or volunteer.

2. There is probable cause to believe that the person interfered with the official duties of the hospital employee or the public safety employee or volunteer by biting, scratching, spitting or transferring blood or other bodily fluids on or through the skin or membranes of the hospital employee or public safety employee or volunteer and that the person is deceased.

3. There is probable cause to believe that the person bit, scratched, spat or transferred blood or other bodily fluid on or through the skin or membranes of a hospital employee or a public safety employee or volunteer who was performing an official duty.

4. The person is arrested, charged or in custody and the hospital employee or the public safety employee or volunteer alleges, by affidavit, that the person interfered with the official duties of the hospital employee or the public safety employee or volunteer by biting, scratching, spitting or transferring blood or other bodily fluids on or through the skin or membranes of the hospital employee or the public safety employee or volunteer.

5. The public safety employee or volunteer, as part of the employee's or volunteer's official duties, was rendering aid to the person as a result of a medical emergency and was exposed to blood or other bodily fluids on or through the skin or membranes.

6. The public safety employee or volunteer, as part of the employee's or volunteer's official duties, was rendering aid to the person as a result of a medical emergency and was exposed to blood or other bodily fluids on or through the skin or membranes, and the person is deceased.

B. An employee of the Arizona state hospital or the employing agency may petition the court for an order authorizing testing of another person for the human immunodeficiency virus, common blood borne diseases or other diseases specified in the petition if there are reasonable grounds to believe an exposure occurred and the person is a patient who is confined to the Arizona state hospital and who is alleged to have interfered with the official duties of the Arizona state hospital employee by biting, scratching, spitting or transferring blood or other bodily fluids on or through the skin or membranes of the Arizona state hospital employee.

C. The court shall hear the petition promptly. If the court finds that probable cause exists to believe that a possible transfer of blood or other bodily fluids occurred between the person and the hospital employee, the public safety employee or volunteer or the Arizona state hospital employee, the court shall order that either:

1. The person provide two specimens of blood for testing.
2. If the person is deceased, the medical examiner draw two specimens of blood for testing.

D. Notwithstanding subsection C, paragraph 2 of this section, on written notice from the agency, officer or entity employing the hospital employee or the public safety employee or volunteer, the medical examiner is authorized to draw two specimens of blood for testing during the autopsy or other examination of the deceased person's body. The medical examiner shall release the specimen to the employing agency, officer or entity for testing only after the court issues its order pursuant to subsection C, paragraph 2 of this section. If the court does not issue an order within thirty days after the medical examiner collects the specimen, the medical examiner shall destroy the specimen.

E. Notice of the test results shall be provided as prescribed by the department of health services to the person tested, to the hospital employee, the public safety employee or volunteer or the Arizona state hospital employee named in the petition and to the employee's or volunteer's employing agency, officer or entity and, if the person tested is incarcerated or detained, to the officer in charge and the chief medical officer of the facility in which the person is incarcerated or detained.

F. Section 36-665 does not apply to this section.

G. For the purposes of this section:

1. "Arizona state hospital" includes the Arizona community protection and treatment center.
2. "Arizona state hospital employee" means an employee of the Arizona state hospital who has direct patient contact.
3. "Hospital employee" means a private hospital employee or volunteer or a person who is authorized to perform official duties at a private hospital while performing those authorized duties.
4. "Private hospital" means a hospital that is not maintained and operated by this state or any political subdivision of this state.
5. "Private prison security officer" means a security officer who is employed by a private contractor that contracts with a governmental entity to provide detention or incarceration facility services for offenders.
6. "Public safety employee or volunteer" means a law enforcement officer, any employee, contractor or volunteer of a state or local law enforcement agency or correctional facility, a probation officer, a surveillance officer, an adult or juvenile correctional service officer, a detention officer, a private prison security officer, a

firefighter, an emergency medical technician or any other person who is authorized to perform official duties or be present within a correctional facility.

**NATUROPATHIC PHYSICIANS MEDICAL BOARD**

Title 4, Chapter 18, Article 1,2,4,5,7,8



# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

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**MEETING DATE:** Mar 7, 2023

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** Feb 6, 2023

**SUBJECT:** ARIZONA NATUROPATHIC PHYSICIANS MEDICAL BOARD  
Title 4, Chapter 18 Articles 1,2,4,5,7,8

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### Summary

This Five Year Review Report (5YRR) from the Arizona Naturopathic Physicians Medical Board relates to rules in Title 4, Chapter 18 Articles 1 (General Provisions), 2 (Licenses), 4 (Approval of Schools of Naturopathic Medicine), 5 (Naturopathic clinical Training and Preceptorship Training Requirements), 7 (Time-Frames for Board Decisions), and 8 (Experimental Medicine). Article 1 relates to definitions, Board members, and duties of the Board. Article 2 relates to licenses, renewal of licenses, and continuing education. Article 4 relates to approval and renewal of a School of Naturopathic Medicine. Article 5 relates to application and renewal of engaging in or conducting a clinical or preceptorship training. Article 7 relates to time frames for board decisions and Article 8 relates to consent and experimental medicine.

### Proposed Action

In the previous 5YRR, approved by Council March 2018, the Board planned on completing a rulemaking by December of 2018, however, this rulemaking did not occur. The Board received an exemption from the moratorium and plans on conducting a rulemaking early 2023 to remove R4-18-101(6) and (13); to update definitions; to update rules to comply with statute; remove R4-18-402, amend and remove rules that are in conflict with each other, remove burdensome rules, and redraft language in R4-18-401.

**1. Has the agency analyzed whether the rules are authorized by statute?**

The Board cites both general and specific statutory authority for these rules.

**2. Summary of the agency's economic impact comparison and identification of stakeholders:**

The Naturopathic Physicians Medical Board is vested to issue licenses and certificates to applicants that are qualified, according to A.R.S. § 32-1501 *et seq.* The Board indicates there is no economic impact statement to analyze in that their analysis is limited to consideration of materials submitted to the agency by another person. Stakeholders include the Board and individuals who are qualified to apply for and be issued licenses or certificates to practice Naturopathic Medicine.

**3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

Council staff reached out to OEO regarding their response to this question and confirmed that the following should be presented to the Council: The Board states that the rule does not appear to be more stringent than federal law.

**4. Has the agency received any written criticisms of the rules over the last five years?**

The Board indicates that they have not received any written criticisms of the rules in the last five years.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability?**

The Board indicates the rules are generally clear, concise and understandable with the following exceptions:

R4-18-101 (6) and R4-18-101(13) are already defined in statute. R4-18-101(6) "Device", is defined in A.R.S. § 32-1581(H)(1) and R4-18-101(13) "Medical student", is defined in A.R.S. § 32-1501(24).

R4-18-202(g), R4-18-203(g), and R4-18-207(g), all include the term "naturopathic college" which is not defined in statute. A.R.S. 32-1507 (8) defines "Approved School of Naturopathic medicine" or "school of naturopathic medicine.

R4-18-203(9) uses outdated language.

R4-18-207 (C) is in direct conflict with R4-18-207(D).

R4-18-202(5), R4-18-203(3),(7), R4-18-207(3), and R4-8-209(3) are burdensome and the Board is proposing striking them as they serve no purpose.

The rules in article 4 conflict with A.R.S. 32-1501(8).

**6. Has the agency analyzed the rules' consistency with other rules and statutes?**

The Board indicates the rules are generally consistent with other rules and statutes with the following exceptions:

The rules in Article 4 are inconsistent with statute as a school of naturopathic medicine is automatically approved by the Board by meeting requirements outlined in A.R.S. 32-1501(8). An accredited school of naturopathic medicine is reviewed and approved yearly by the accrediting agencies for the purpose of accreditation continuation which is inconsistent with Article 4.

**7. Has the agency analyzed the rules' effectiveness in achieving its objectives?**

The Board states the rules are effective in achieving their objective.

**8. Has the agency analyzed the current enforcement status of the rules?**

The Board states that the rules are enforced as written.

**9. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Board indicates the following rules are more stringent than a corresponding federal law:

R4-18-402 requires the board to consider and reapprove schools each year that already meet the approval requirement.

**10. For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

The Board indicates that the rules comply with A.R.S. § 41-1037.

**11. Conclusion**

As mentioned above, the Board indicates that the rules are generally clear, concise, and understandable; effective in achieving their objective; consistent with other rules and statutes; and enforced as they are written.

The Board is ready to initiate a rulemaking to implement the changes identified above as well as the changes from the 5YRR from March 2018 and will conduct a rulemaking in early 2023.

For these reasons, Council staff believe the Board has submitted an adequate report and recommends approval.





**State Of Arizona**  
**Naturopathic Physicians Medical Board**  
"Protecting the Public's Health"  
1740 W. Adams, Ste. 3002 Phoenix, AZ 85007  
Phone: 602-542-8242, Email: [info@nd.az.gov](mailto:info@nd.az.gov) Website: [nd.az.gov](http://nd.az.gov)  
**Douglas A. Ducey - Governor**

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12/28/2022

VIA EMAIL: [grrc@azdoa.gov](mailto:grrc@azdoa.gov)  
Nicole Sornsin, GRRC Chair  
Governor's Regulatory Review Council  
100 North 15<sup>th</sup> Avenue, Suite 305  
Phoenix, AZ 85007

RE: State of Arizona Naturopathic Physicians Medical Board, 5 YEAR REVIEW REPORT, TITLE 4, CHAPTER 18,  
ARTICALS 1, 2, 4, 5, 7, & 8

Dear Ms. Sornsin,

Please find enclosed the Five Year Review Report of the State of Arizona Naturopathic Physicians Medical Board, for TITLE 4, CHAPTER 18, ARTICALS 1, 2, 4, 5, 7, & 8, which is due on December 29, 2022.

The State of Arizona Naturopathic Physicians Medical Board hereby certifies compliance with A.R.S. 41-1091.

For questions about this report, please contact Gail Anthony at 602 542-8242 or [gail.anthony@nd.az.gov](mailto:gail.anthony@nd.az.gov).

Sincerely,

*Gail Anthony*

Gail Anthony, Executive Director  
State of Arizona  
Naturopathic Physicians Medical Board

**STATE OF ARIZONA**  
**NATUROPATHIC PHYSICIANS MEDICAL BOARD**

**5 YEAR REVIEW REPORT**

**TITLE 4, CHAPTER 18, ARTICLES 1, 2, 4, 5, 7, & 8**

**December 28, 2022**

**1. Authorization of the rule by existing statutes**

The Naturopathic Physicians Medical Board (Board) is statutorily vested to issue licenses and certificates to applicants who are qualified, according to A.R.S. § 32-1501 *et seq.* Pursuant to the Board’s Mission Statement “The Primary Duty of the Board is to Protect the Public through Regulation of the Practice of Naturopathic Medicine”. The Board’s statutes contain provisions authorizing the Board to write rules to implement the statutes. A.R.S. § 32-1504(A)(1) requires the Board to “adopt rules that are necessary or proper for the administration this chapter.”

**2. The objective of each rule:**

**Article 1 General Provisions**

Rule	Objective
R4-18-101 Definitions General Authorizing Statute A.R.S. § 32-1504(A)(1)	Defines terms in order to make the rules understandable to the reader, afford consistent interpretation and achieve clarity without needless repetition.
R4-18-102 Board Meetings; Elections; Officers Authorizing Statute A.R.S. § 32-1502 and A.R.S. § 32-1503.	Outlines when regular Board meetings are to be held, requires Board members to attend meetings, designates at which board meeting officers are to be elected, and defines the action to be taken by the Board, in the event an Officer’s position becomes vacant. The rule also allows for recommendation to be made to the Governor for removal of a Board member, in the event the member misses three consecutive meetings.
R4-18-103 Duties of Board Committees A.R.S. § 32- 1503(E).	Outlines the duties of Board appointed committees.
R4-18-106 Rehearing or Review of Decision Authorizing Statute A.R.S. § 32-1504(A)(1)	Outlines the procedure for requesting a rehearing or review, and the Board’s process for denying or granting such a request.

R4-18-107 Fees Authorizing Statute A.R.S. § 32-1527.	Establishes a specific set of fees the Board may charge, taking into consideration the maximum fee allowable pursuant to statute.
R4-18-108 Titles, Uses of Abbreviations Authorizing Statute A.R.S. § 32-1504(A)(1)	Identifies the recognized and appropriate designations use by licensed naturopathic physicians. Also identifies the designation of a preceptees or intern and, the requirement to disclose the designation when providing patient care.
R4-18-110 Display of Licenses and Certificates; Notice of Change in Status. Student Identification. Authorizing Statute A.R.S. § 32-1504(A)(1)	Requires a licensee or certificate holder to display credentials in a manner that affords easy viewing by the public, and requires a person under the jurisdiction of the board to notify the board within 30 days of any change to information provided in the initial application including name, address or place of practice. Also requires a 30 day notice to the board of any action taken against the licensee for any reason, in any court or by any governmental regulatory body.
R4-18-111 Notice of Civil and Criminal Actions. Authorizing Statute A.R.S. § 32-3208	Requires a person under the jurisdiction of the board to notify the board within 10 days of possible criminal action.

3. **Are the rules effective in achieving their objectives?**

Yes.

4. **Are the rules consistent with other rules and statutes?**

Yes.

5. **Are the rules enforced as written?**

Yes

6. **Are the rules clear, concise, and understandable?**

Yes.

R4-18-101 (6) and R4-18-101(13) are clear, concise, and understandable however, they include needless repetition. R4-18-101(6) defines Device, which is defined in A.R.S. § 32-1581(H)(1). R4-18-101(13) defines Medical student, which is defined in A.R.S. § 32-1501(24).

- The proposed course of action is to strike R4-18-101(6.), and R4-18-101(13.)

7. **Has the agency received written criticisms of the rules within the last five years?**

No. The Board has not received written criticism of the rules within the last five years. However, this does not take into account any comments which may have been received by the Governor's Office as part of the

"Regulation Rollback Initiative". The Board has not been made aware of any results of the initiative specific to this Board's rules.

**8. Economic, small business, and consumer impact comparison:**

None. This analysis is limited to consideration of materials submitted to the agency by another person. At this time, no such analysis has been submitted to the agency.

**9. Has the agency received any business competitiveness analyses of the rules?**

No. This analysis is limited to consideration of materials submitted to the agency by another person. At this time, no such analysis has ever been submitted to the agency.

**10. Has the agency completed the course of action indicated in the agency's previous five-year-review report?**

No. R4-18-101(6) and (13) are listed in the last report. The Board did not move forward with a request for exemption of the rules moratorium at that time, but has now received approval for the exemption. A rules package is planned for January of 2023.

Although listed in the last report, upon further review, it was determined a better course of action was to leave R4-18-101(11) in the rule as it further defines the type of training provided in an internship program. After obtaining legal opinion, it was determined the best course of action was to leave R4-18-102 as is. R4-18-108 is being left in because it does not conflict with statute or another rule, and does provide additional information to the reader relating unacceptable tile use. R4-18-110(C), is being left for now because the board has submitted a Legislative Proposal to remove the requirement for a certificate to engage in clinical training. In the event that legislation does pass, the Board will be reviewing and removing rules related to the clinical training certificate at that time. R4-18-110 (A) was mentioned in the last report, however upon further review, it was determined a better course of action was to leave the rule because it does provide additional clarity as to what constitutes ongoing activity as stated in statute.

**11. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective: Are the rules more stringent than corresponding federal laws?**

No. The rule does not appear to be more stringent than federal law.

**12. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

Rules adopted by the Board after July 29, 2010 comply with section 41-1037.

**13. Proposed course of action**

During a recent Auditor General's Sunset Audit, a recommendation for consideration of rulemaking was made. Specifically, rules relating to medical assistant training requirements and, labeling, recordkeeping, storage, and packaging of natural substances. Based on the audit recommendation, an exemption to the rules moratorium was requested from the Governor's Office, and approved. The Board plans to run the rules package in January of 2023. The recommendation relating to the removal of R4-18-101(6) and (13) was outlined in the request and will be included in the January 2023 rules package.

**1. Authorization of the rule by existing statutes**

The Naturopathic Physicians Medical Board (Board) is statutorily vested to issue licenses and certificates to applicants who are qualified, according to A.R.S. § 32-1501 *et seq.* Pursuant to the Board’s Mission Statement “The Primary Duty of the Board is to Protect the Public through Regulation of the Practice of Naturopathic Medicine”. The Board’s statutes contain provisions authorizing the Board to write rules to implement the statutes. A.R.S. § 32-1504(A)(1) requires the Board to “adopt rules that are necessary or proper for the administration this chapter.”

**2. The objective of each rule:**

**Article 2. Licenses; Specialist Certificates; Continuing Medical Education; Renewal**

Rule	Objective
R4-18-201 Jurisprudence Examination. Authorizing Statute A.R.S. § 32-1504(B)(6), and A.R.S. § 32- 1525(E).	Requires applicants demonstrate knowledge of the statutes and rules relating to naturopathic medicine in this state by passing an examination.
R4-18-202 License by Examination. Authorizing Statute A.R.S. § 32-1504(A)(1), A.R.S. § 32-1525, and A.R.S. § 32- 1522.	Outlines the requirements for obtaining licensure by examination and information required on the application.
R4-18-203 License by Endorsement. Authorizing Statute A.R.S. § 32-1504(A)(1), A.R.S. § 32-1525, and A.R.S. § 32- 1523.	Outlines the requirements for obtaining licensure by endorsement and information required on the application.
R4-18-204 Specialists Certificate. Authorizing Statute A.R.S. § 32-1504(B)(3) and A.R.S. § 32-1529.	Outlines the requirements for obtaining a specialists certificate and information required on the application.
R4-18-205 Continuing	Outlines the yearly continuing medical education requirements and specifies under what circumstances the Board has the ability to grant an extension.

Medical Education Requirements. Authorizing Statute A.R.S. §§ 32-1504(A)(5), 32-1504(A)(6), and 32-1504(B)(1).	
R4-18-206 Renewal of License. Authorizing Statute A.R.S. §§ 32-1526(B) and 32-1526(C).	Outlines the requirements for renewal of naturopathic medical license and what information is required on the application.
R4-18-207 Reinstatement of an Expired License or Certificate. Authorizing Statute A.R.S. § 32-1526 (H).	Outlines the requirements for reinstatement of an expired license and certificate and the information required on the application.
R4-18-208 Reinstatement of a Retired License. Authorizing Statute A.R.S. § 32-1528.	Outlines the requirements for reinstatement of a retired license and what information is required on the application.
R4-18-209 Reinstatement of a Suspended, or Revoked License or Certificate. Authorizing Statute A.R.S. § 32-1551.	Outlines the requirements for reinstatement of a Suspended or Revoked license or certificate and what information is required on the application.

3. **Are the rules effective in achieving their objectives?**

Yes.

4. **Are the rules consistent with other rules and statutes?**

Yes.

5. **Are the rules enforced as written?**

Yes.

**6. Are the rules clear, concise, and understandable?**

Yes.

However R4-18-202(g), R4-18-203(g), and R4-18-207(g), includes inconsistent language. A.R.S. 32-1507 (8) defines “Approved School of Naturopathic medicine” or “school of naturopathic medicine. R4-18-202(g), R4-18-203(g), and R4-18-207(g), all include the language “naturopathic college” which is not defined in statute.

- For consistency purpose, the Board proposes striking “naturopathic college” and inserting “School of Naturopathic Medicine” in all three rules mentioned above.

R4-18-203(9) informs the reader of the pharmacology education requirement needed for application for licensure under endorsement, if an applicant gained original licensure as a Naturopathic Physician prior to January 1, 2005. However, the required 60 hours of continuing medical education including an examination, is no longer available through appropriate continuing medical education avenues. The Board would like to utilize passing of the additional pharmacology examination offered by the National Board’s (NABNE) as proof of meeting the pharmacology requirement. Or, as an alternative, in the event the applicant can provide evidence that the state or Canadian province where the applicant is currently licensed, has enacted a pharmacology scope greater than or equal to that enacted in the State of Arizona for Naturopathic Physicians.

- Because the rule is outdated, the Board proposes the following language change to the rule.

“Applicants who were licensed in another state of a Canadian province before January 1, 2005, shall either cause to have submitted directly to the Board evidence of passing the NPLEX add on examination in the subject of pharmacology or provide evidence that the state or Canadian province where the Applicant is currently licensed has enacted a pharmacology scope greater than or equal to that enacted in A.R.S. Title 32, Chapter 14.

R4-18-207 (C) is in direct conflict with R4-18-207(D), which outlines the requirements and appropriate application form to use when applying for reinstatement of a certificate to dispense.

Because the rule is conflicting, the Board proposes striking R4-18-207(C).

R4-18-202(5), R4-18-203(3),(7), R4-18-207(3), and R4-8-209(3), all require an applicant to provide a passport size photo taken within 60 days of the applicant submission and signed on the back. These rules are burdensome and serve no purpose. Documentation that includes a picture is already required for proof of ability to receive benefits. The Board proposes striking all three rules mentioned above.

**7. Has the agency received written criticisms of the rules within the last five years?**

No. The Board has not received written criticism of the rules within the last five years. However, this does not take into account any comments which may have been received by the Governor's Office as part of the "Regulation Rollback Initiative". The Board has not been made aware of any results of the initiative specific to this Board's rules.

**8. Economic, small business, and consumer impact comparison:**

None. This analysis is limited to consideration of materials submitted to the agency by another person. At this time, no such analysis has been submitted to the agency.

**9. Has the agency received any business competitiveness analyses of the rules?**

No.

**10. Has the agency completed the course of action indicated in the agency’s previous five -year-review report?**

No.

**11. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective: Are the rules more stringent than corresponding federal laws?**

No. The rules do not appear to be more stringent than federal law.

**12. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

Rules adopted by the Board after July 29, 2010 comply with section 41-1037.

**13. Proposed course of action:**

R4-18-207(C), R4-18-202(5), R4-18-203(3)(7), R4-18-207(3), and R4-8-209(3) were incorporated into the recent rules moratorium exemption and approved. They will be included in the January 2023 rules package.

Pursuant to Executive Order 2022-01, the Board must obtain prior written approval of the Office of the Governor. In seeking prior written approval, the Board will attempt to justify the proposed course of action outlined for R4-18-202(g), R4-18-203(g), and R4-18-207(g) and, R4-18-203(9).

**1. Authorization of the rule by existing statutes**

The Naturopathic Physicians Medical Board (Board) is statutorily vested to issue licenses and certificates to applicants who are qualified, according to A.R.S. § 32-1501 *et seq.* Pursuant to the Board’s Mission Statement “The Primary Duty of the Board is to Protect the Public through Regulation of the Practice of Naturopathic Medicine”. The Board’s statutes contain provisions authorizing the Board to write rules to implement the statutes. A.R.S. § 32-1504(A)(1) requires the Board to “adopt rules that are necessary or proper for the administration this chapter.”

**2. The objective of each rule:**

**Article 4. Approval of Schools of Naturopathic Medicine**

Rule	Objective
R4-18-401 Approval of Schools of Naturopathic Medicine. Authorizing Statute A.R.S. § 32-1501(8), and A.R.S. § 32-1504(4).	Requires the Board to approve schools of naturopathic medicine that meet certain accreditation requirements.
R4-18-402 Annual Renewal of an Approved School of Naturopathic Medicine. Authorizing Statute A.R.S. § 32-1504(A)(1)	Requires the board to annually approve schools of naturopathic medicine.

**3. Are the rules effective in achieving their objectives?**

Yes.

**4. Are the rules consistent with other rules and statutes?**

No.

A school of naturopathic medicine is automatically approved by the Board by meeting requirements outline in A.R.S. 32-1501(8). An accredited school of naturopathic medicine is reviewed and approved yearly by the accrediting agencies for the purpose of accreditation continuation.

**5. Are the rules enforced as written?**

Yes.

**6. Are the rules clear, concise, and understandable?**

No.

They conflict with A.R.S. 32-1501(8). There is no need for the Board to formally approve a school of naturopathic medicine or renew approval of a school of naturopathic medicine. The Board does not have the ability to deny approval of a school of naturopathic medicine if it meets the criteria outlined in statute.

• The Board proposes striking R4-18-402, and rewriting R4-18-401 to include language indicating the schools are incorporated by reference. Exact language has not been decided on.

7. **Has the agency received written criticisms of the rules within the last five years?**

No. The Board has not received written criticism of the rules within the last five years. However, this does not take into account any comments which may have been received by the Governor's Office as part of the "Regulation Rollback Initiative". The Board has not been made aware of any results of the initiative specific to this Board's rules.

8. **Economic, small business, and consumer impact comparison:**

None. This analysis is limited to consideration of materials submitted to the agency by another person. At this time, no such analysis has been submitted to the agency.

9. **Has the agency received any business competitiveness analyses of the rules?**

No. This analysis is limited to consideration of materials submitted to the agency by another person. At this time, no such analysis has been submitted to the agency.

10. **Has the agency completed the course of action indicated in the agency's previous five-year-review report?**

N/A

11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective: Are the rules more stringent than corresponding federal laws?**

Yes. R4-18-402 requires the board to consider and reapprove schools each year that already meet the approval requirement.

12. **For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

Rules adopted by the Board after July 29, 2010 comply with section 41-1037.

13. **Proposed course of action**

Pursuant to Executive Order 2022-01, the Board must obtain prior written approval of the Office of the Governor. In seeking prior written approval, the Board will attempt to justify the proposed course of action outlined in 4, 6, and 11, under Executive Order A. (a-j). In the event prior written approval from the Office of the Governor is obtained, the Board will pursue removal of R4-18-402, and redraft language in R4-18-401.

**1. Authorization of the rule by existing Statute**

The Naturopathic Physicians Medical Board (Board) is statutorily vested to issue licenses and certificates to applicants who are qualified, according to A.R.S. § 32-1501 et seq. Pursuant to the Board’s Mission Statement “The Primary Duty of the Board is to Protect the Public through Regulation of the Practice of Naturopathic Medicine”. The Board’s statutes contain provisions authorizing the Board to write rules to implement the statutes. A.R.S. § 32-1504(A)(1) requires the Board to “adopt rules that are necessary or proper for the administration this chapter.”

**2. The objective of each rule:**

Rule	Objective
R4-18-501 Certificate to Engage in Clinical or Preceptorship Training. Authorizing statute A.R.S. §§ 32-1526.	Outlines the requirements to obtain a certificate for clinical training or preceptorship training and the information required on the application.
R4-18-502 Annual Renewal of a Certificate to Engage in Clinical or Preceptorship Training. Authorizing Statute A.R.S. 32-1526.	Outlines the requirements for renewal of a certificate for clinical training or preceptorship training, and the information required on the application.
R4-18-503 Application for Certificate to Conduct a Clinical or Preceptorship Training Program. Authorizing Statute A.R.S. § 32-1504(A)(1).	Outlines the requirements for obtaining a certificate to conduct a clinical or preceptorship training and the information required on the application.
R4-18-504 Annual Renewal of Certificate to Conduct a Clinical or Preceptorship Training Program. Authorizing statute A.R.S. 32-1526.	Outlines the requirements for renewing a certificate to conduct a clinical or preceptorship training certificate and the information required on the application.

3. **Are the rules effective in achieving their objectives?**  
Yes.
4. **Are the rules consistent with other rules and statutes?**  
Yes,
5. **Are the rules enforced as written?**  
Yes Where the rules conflict with statute, the Board enforces according to its statutes.
6. **Are the rules clear, concise, and understandable?**  
Yes
7. **Has the agency received written criticisms of the rules within the last five years?**  
No. The Board has not received written criticism of the rules within the last five years. However, this does not take into account any comments which may have been received by the Governor's Office as part of the "Regulation Rollback Initiative". The Board has not been made aware of any results of the initiative specific to this Board's rules.
8. **Economic, small business, and consumer impact comparison:**  
None This analysis is limited to consideration of materials submitted to the agency by another person. At this time, no such analysis has been submitted to the agency.
9. **Has the agency received any business competitiveness analyses of the rules?**  
No This analysis is limited to consideration of materials submitted to the agency by another person. At this time, no such analysis has been submitted to the agency.
10. **Has the agency completed the course of action indicated in the agency's previous five-year-review report?**  
N/A
11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective: Are the rules more stringent than corresponding federal laws?**  
No The rule does not appear to be more stringent than federal law.
12. **For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**  
Rules adopted by the Board after July 29, 2010 comply with section 41-1037.
13. **Proposed course of action**  
None at this time.

**1. Authorization of the Rule by Existing Statutes**

The Naturopathic Physicians Medical Board (Board) is statutorily vested to issue licenses and certificates to applicants who are qualified, according to A.R.S. § 32-1501 et seq. Pursuant to the Board’s Mission Statement “The Primary Duty of the Board is to Protect the Public through Regulation of the Practice of Naturopathic Medicine”. The Board’s statutes contain provisions authorizing the Board to write rules to implement the statutes. A.R.S. § 32-1504(A)(1) requires the Board to “adopt rules that are necessary or proper for the administration this chapter.”

**2. The objective of each rule :**

**Article 7 Time-Frame for Board Decisions**

Rule	Objective
R4-18-701 Time-frame for Board Decisions. Authorizing Statute A.R.S. § 32-1522. 32-1524 and 41-1072 <i>et seq.</i>	Outlines defined steps required for the administrative completeness review, substantive review, and overall time frame, including the maximum number of days the Board may take to complete review of each.

**3. Are the rules effective in achieving their objectives?**

Yes.

**4. Are the rules consistent with other rules and statutes?**

Yes.

**5. Are the rules enforced as written?**

Yes Where the rules conflict with statute, the Board enforces according to its statutes.

**6. Are the rules clear, concise, and understandable?**

Yes

**7. Has the agency received written criticisms of the rules within the last five years?**

No. The Board has not received written criticism of the rules within the last five years. However, this does not take into account any comments which may have been received by the Governor’s Office as part of the "Regulation Rollback Initiative". The Board has not been made aware of any results of the initiative specific to this Board’s rules.

**8. Economic, small business, and consumer impact comparison:**

None. This analysis is limited to consideration of materials submitted to the agency by another person. At this time, no such analysis has been submitted to the agency.

**9. Has the agency received any business competitiveness analyses of the rules?**

No. This analysis is limited to consideration of materials submitted to the agency by another person. At this time, no such analysis has been submitted to the agency.

10. **Has the agency completed the course of action indicated in the agency's previous five-year-review report?**  
N/A
11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective: Are the rules more stringent than corresponding federal laws?**  
No. The rule does not appear to be more stringent than federal law.
12. **For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**  
Rules adopted by the Board after July 29, 2010 comply with section 41-1037.
13. **Proposed course of action**  
None at this time.

**1. Authorization by Existing Statute**

The Naturopathic Physicians Medical Board (Board) is statutorily vested to issue licenses and certificates to applicants who are qualified, according to A.R.S. § 32-1501 et seq. Pursuant to the Board’s Mission Statement “The Primary Duty of the Board is to Protect the Public through Regulation of the Practice of Naturopathic Medicine”. The Board’s statutes contain provisions authorizing the Board to write rules to implement the statutes. A.R.S. § 32-1504(A)(1) requires the Board to “adopt rules that are necessary or proper for the administration this chapter.”

**2. The objective of each rule:**

**Article 8. Experimental Medicine**

Rule	Objective
R4-18-801 Experimental Medicine. Authorizing Statute A.R.S. § 32-1504(31)(dd).	Defines experimental medicine.
R4-18-802 Informed Consent and Duty to Follow Protocols. Authorizing Statute A.R.S. § 32-1504(A)(1)	Outlines when informed consent is required and the duty to follow protocols.

**3. Are the rules effective in achieving their objectives?**

Yes.

**4. Are the rules consistent with other rules and statutes?**

Yes.

**5. Are the rules enforced as written?**

Yes Where the rules conflict with statute, the Board enforces according to its statutes.

**6. Are the rules clear, concise, and understandable?**

Yes.

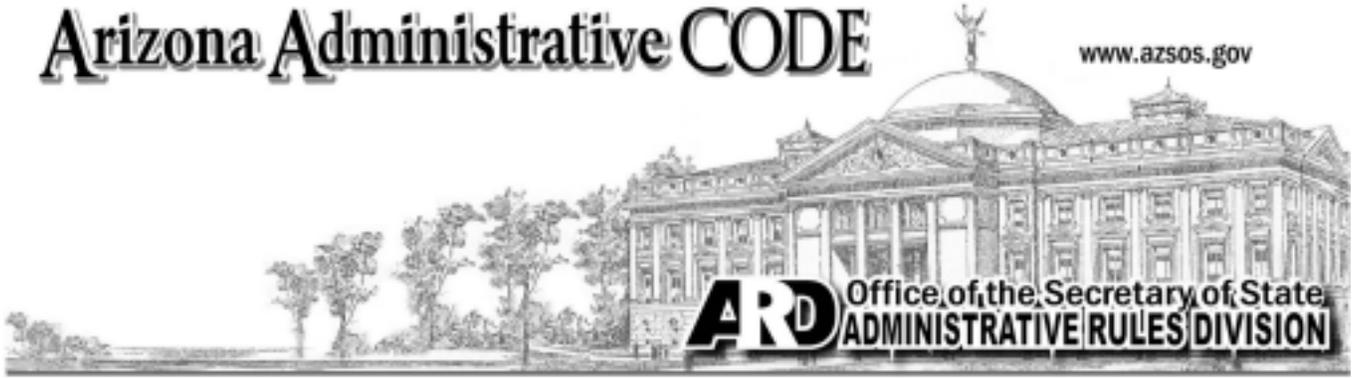
**7. Has the agency received written criticisms of the rules within the last five years?**

No. The Board has not received written criticism of the rules within the last five years. However, this does not take into account any comments which may have been received by the Governor's Office as part of the "Regulation Rollback Initiative". The Board has not been made aware of any results of the initiative specific to this Board's rules.

**8. Economic, small business, and consumer impact comparison:**

None This analysis is limited to consideration of materials submitted to the agency by another person. At this time, no such analysis has been submitted to the agency.

9. **Has the agency received any business competitiveness analyses of the rules?**  
No This analysis is limited to consideration of materials submitted to the agency by another person. At this time, no such analysis has been submitted to the agency.
10. **Has the agency completed the course of action indicated in the agency's previous five-year-review report?**  
N/A
11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective: Are the rules more stringent than corresponding federal laws?**  
No The rule does not appear to be more stringent than federal law.
12. **For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**  
Rules adopted by the Board after July 29, 2010 comply with section 41-1037.
13. **Proposed course of action**  
None at this time.



## 4 A.A.C. 18 Supp. 22-3

### TITLE 4. PROFESSIONS AND OCCUPATIONS CHAPTER 18. NATUROPATHIC PHYSICIANS MEDICAL BOARD

The table of contents on page one contains links to the referenced page numbers in this Chapter.

Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*. This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of July 1, 2022 through September 30, 2022

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<p><b>Questions about these rules? Contact:</b>  Board: Naturopathic Physicians Medical Board Address:  1740 W. Adams, Suite 3002  Phoenix, AZ 85007  Website: <a href="https://nd.az.gov/">https://nd.az.gov/</a>  Name: Gail Anthony, Executive Director  Telephone: (602) 542-8242  Email: <a href="mailto:gail.anthony@nd.az.gov">gail.anthony@nd.az.gov</a></p>
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### The release of this Chapter in Supp. 22-3 replaces Supp. 15-3, 1-16 pages.

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

i  
**PREFACE**

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “Rule” means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

- First Quarter: January 1 - March 31
- Second Quarter: April 1 - June 30
- Third Quarter: July 1 - September 30
- Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is

cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

**RULE HISTORY**

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

**AUTHENTICATION OF PDF CODE CHAPTERS** The Office began to authenticate Chapters of the *Code* in Supp. 18- 1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

**HOW TO USE THE CODE**

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

**ARIZONA REVISED STATUTE REFERENCES** The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

**SESSION LAW REFERENCES**

Arizona Session Law references in a Chapter can be found at the

Secretary of State’s website, [www.azsos.gov](http://www.azsos.gov) under Services-> Legislative Filings.

**EXEMPTIONS FROM THE APA**

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

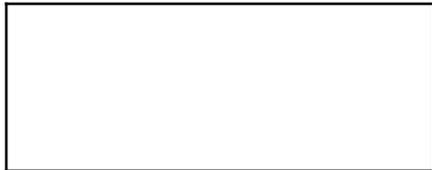
The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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**Arizona Administrative Code 4 A.A.C. 18**

Administrative Rules Division

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**TITLE 4. PROFESSIONS AND OCCUPATIONS**

**CHAPTER 18. NATUROPATHIC PHYSICIANS MEDICAL BOARD**

Authority: A.R.S. § 32-1501 et seq.

*Editor's Note: Laws 2008, 2nd Regular Session, Ch. 16 provided for a name change of the Naturopathic Physicians Board of Medical Examiners to Naturopathic Physicians Medical Board (Supp. 12-2).*

*Editor's Note: The Office of the Secretary of State publishes all Code Chapters on white paper (Supp. 02-3).*

*Editor's Note: This Chapter contains rules which were adopted under exemptions from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(25). Exemption from A.R.S. Title 41, Chapter 6 means that the Naturopathic Physicians Board of Medical Examiners did not submit these rules to the Governor's Regulatory Review Council for review; the Board did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Board 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.*

*Editor's Note: This Chapter has been reprinted due to an error in publishing text that was thought to be adopted and certified but in fact was rejected by the Attorney General on December 29, 1995 (Supp. 95-4). Text removed includes amendments made to R4-18-101 and adoption of Article 2, consisting of Sections R4-18-201 through R4-18-205. Removal of this text reflects the latest effective rules on file with the Office of the Secretary of State last modified Supp. 88-4 (reprinted Supp. 96-4).*

*Laws 1982, 6th S.S., Chs. 1 and 4 provided for a name change of the Naturopathic Board of Examiners to Naturopathic Physicians Board of Examiners.*

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*Article 2 consisting of Sections R4-18-201 through R4-18-205 has been deleted due to an error in publishing text that was*

*thought to be adopted and certified but in fact was rejected by the Attorney General on December 29, 1995 (Supp. 95-4). Removal of this text reflects the latest effective rules on file with the Office of the Secretary of State last modified Supp. 88-4 (reprinted Supp. 96-4).*

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**CHAPTER 18. NATUROPATHIC PHYSICIANS MEDICAL BOARD**

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**ARTICLE 1. GENERAL PROVISIONS**

**R4-18-101. Definitions**

In addition to the definitions in A.R.S. §§ 32-1501 through 32-1581, the following definitions apply to this Chapter unless otherwise specified:

- 1. "Administrative completeness review" means the Board's

- process for determining that an applicant has provided, or caused to be provided, all of the application packet information and documentation required by statute or rule for an application for a license or a certificate.
2. "Applicant" means a person requesting from the Board an initial, temporary, or renewal license or certificate.
  3. "Approved Specialty College or Program" means a post doctoral training program that awards a medical specialist certificate, and is certified by a Specialty Board of Examiners, The American Association of Naturopathic Physicians ("AANP") or another professional association or, another state's licensing agency, and which is recognized by the Board.
  4. "Chief medical officer" means a physician who is responsible for a clinical, preceptorship, internship, or postdoctoral training program's compliance with state and federal laws, rules, and regulations.
  5. "Continuing medical education" or "CME" means courses, seminars, lectures, programs, conferences, and workshops related to subjects listed in A.R.S. § 32-1525(B), that are offered or sanctioned by one of the organizations referenced in R4-18-205(B).
  6. "Device" means the same as in A.R.S. § 32-1581(H)(1). 7. "Endorsement" means the procedure for granting a license in this state to an applicant who is currently licensed to practice naturopathic medicine by another state, district, or territory of the United States or by a foreign country that requires a written examination substantially equivalent to the written examination provided for in A.R.S. § 32-1525.
  8. "Facility" means a health care institution as defined in A.R.S. § 36-401, office or clinic maintained by a health care institution or by an individual licensed under A.R.S. Title 32, Chapter 13, 14, 17, or 29, office or public health clinic maintained by a state or county, office or clinic operated by a qualifying community health center under A.R.S. § 36-2907.06, or an office or clinic operated by a corporation, association, partnership, or company authorized to do business in Arizona under A.R.S. Title 10.
  9. "Informed consent" means a document, signed by a patient or the patient's legal guardian, which contains the information in R4-18-802(A)(1), (A)(2), and (A)(3).
  10. "Institutional review board" means a group of persons that is approved according to guidelines of the United States Department of Health and Human Services, Office for Human Research Protection, which reviews investigational or experimental protocols and approves their use on animals or humans for the purposes of protecting the subjects of the investigational or experimental protocol from undue harm and assures that the research and its review is carried out according to guidelines of the United States Department of Health and Human Services, Office for Human Research Protection.
  11. "Internship" means clinical and didactic training by a doctor of naturopathic medicine certified by the Board according to A.R.S. § 32-1561.
  12. "License" means a document issued by the Board that authorizes the individual to whom it is issued to practice naturopathic medicine.
  13. "Medical student" means naturopathic medical student defined in A.R.S. § 32-1501(24).
  14. "Medication" means the same as drug defined in A.R.S. § 32-1501(15) or natural substance defined in A.R.S. § 32-1501(23).
  15. "National board" means any of the following:
    - a. The Federation of State Medical Licensing Boards,
    - b. The National Board of Chiropractic Examiners, c. The National Board of Medical Examiners,
    - d. The National Board of Osteopathic Examiners, or e. The North American Board of Naturopathic Examiners.
  16. "Procedure" means an activity directed at or performed on an individual for improving health, treating disease or injury, or making a diagnosis.
  17. "Protocol" means an explicit detailed plan of an experimental medical procedure or test that is approved by an institutional review board.
  18. "Resident physician in training" means a person who holds a degree of doctor of naturopathic medicine and is certified by the Board to diagnose and treat patients under supervision in an internship, preceptorship, or a post doctoral training program.
  19. "Substantive review" means the Board's process for determining whether an applicant for licensure, certification, or approval meets the requirements of A.R.S. Title 32, Chapter 14 and this Chapter.
  20. "Verified" means a notarized form dated, and signed by the applicant, affirming the information provided in the application, including any accompanying documents submitted by or on behalf of the applicant, is true and complete.

#### Historical Note

Adopted effective December 31, 1984 (Supp. 84-6).  
 Amended effective December 29, 1995 (Supp. 95-4).  
 Amended Section corrected Supp. 96-4 to reflect adopted Section on file with the Office of the Secretary of State effective December 31, 1984 (Supp. 84-6). Amended by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking at 19 A.A.R. 1302, effective July 6, 2013 (Supp. 13-2).  
 Amended by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3).

**R4-18-102. Board Meetings; Elections; Officers A.** The Board shall hold a regular meeting in January and July of each year. The officers shall be elected at the January meeting of the Board by majority vote of the Board members present at that meeting. The Board chairman shall preside at all Board meetings. If the chairman is disqualified or unable to attend, the Board vice-chairman shall preside at the meeting. If the Board vice-chairman is disqualified or unable to attend, the Board secretary-treasurer shall preside at the meeting. **B.** If an officer's position becomes vacant, the Board shall elect a member of the Board to complete the term of office that is vacant.  
**C.** A Board member shall attend meetings scheduled by the Board. The Board may recommend to the Governor that a Board member who fails to attend three consecutive Board meetings be removed from the Board.

#### Historical Note

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effective August 9, 2002 (Supp. 02-3).

Adopted effective December 31, 1984 (Supp. 84-6).  
 Amended by final rulemaking at 8 A.A.R. 3702,

#### R4-18-103. Duties of Board Committees

A committee appointed by the Board chairman shall make a report

to the Board based on the findings or investigations of the committee and may make recommendations for further action by the Board.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**R4-18-104. Repealed**

**Historical Note**

Adopted effective December 31, 1984 (Supp. 84-6). Amended by adding a new subsection (H) effective June 18, 1987 (Supp. 87-2). Section repealed by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**R4-18-105. Reserved**

**R4-18-106. Rehearing or Review of Decision**

- A. Except as provided in subsection (G), any party who is aggrieved by a decision issued by the Board may file with the Board not later than 30 days after service of the decision, a written motion for rehearing or review of the decision specifying the particular grounds for the rehearing or review. For purposes of this Section, a decision is considered served when personally delivered or five days after mailing by certified mail to the party at the party's last known residence or place of business.
- B. A motion for rehearing or review under this Section may be amended at any time before it is ruled upon by the Board. A response may be filed within 15 days after service of the motion or amended motion by any other party. The Board may require the filing of written briefs upon the issue raised in the motion and may provide for oral argument.
- C. A rehearing or review of a decision may be granted by the Board for any of the following reasons materially affecting the party's rights:
  - 1. Irregularity in the proceedings of the Board, administrative law judge, or any abuse of discretion that deprives the moving party of a fair hearing;
  - 2. Misconduct of the Board or an administrative law judge;
  - 3. Accident or surprise that could not have been prevented by ordinary prudence;
  - 4. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the hearing;
  - 5. Excessive or insufficient penalties;
  - 6. Error in the admission or rejection of evidence or other errors of law occurring at the hearing; or
  - 7. That the findings of fact or decision is not justified by the evidence, or is contrary to law.
- D. The Board may affirm or modify its decision or grant a rehearing or review, to all or any of the parties on all or part of the issues for the reasons specified in subsection (C). An order modifying a decision or granting a rehearing or review shall specify with particularity the grounds on which the rehearing or review is granted, and the rehearing or review shall cover only those matters specified.
- E. Not later than 35 days after the date a decision is rendered, the Board may, on its own initiative order a rehearing or review of its decision for any reason for which it might have granted a rehearing or review on motion of a party. After giving the parties or their counsel notice and an opportunity to be heard on the matter, the Board may grant a motion for rehearing or

review, timely served, for a reason not stated in the motion. In either case, the order shall specify the grounds for rehearing and review.

- F. When a motion for rehearing is based upon affidavits, they shall be served with the motion. An opposing party may, within 15 days after service, serve opposing affidavits. The Board may extend this period for good cause.
- G. If the Board makes specific findings that the immediate effectiveness of the decision is necessary for the preservation of the public health and safety and determines that a rehearing or review of the decision is impracticable, unnecessary, or contrary to the public interest, the decision may be issued as a final decision without an opportunity for a rehearing or review. If a decision is issued as a final decision without an opportunity for rehearing or review, any application for judicial review of the decision shall be made within the time limits permitted for applications for judicial review of the Board's final decisions under A.R.S. Title 12, Chapter 7, Article 6.

**Historical Note**

Adopted effective December 31, 1984 (Supp. 84-6). Section repealed; new Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

*Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 41-1005(25). Exemption from A.R.S. Title 41, Chapter 6 means the Board did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Board did not submit the rules to the Governor's Regulatory Review Council for review; and the Board was not required to hold public hearings on this Section (Supp. 99-3).*

**R4-18-107. Fees**

- A. Application fees are as follows:
  - 1. Medical license, \$225
  - 2. Certificate to dispense, \$225
  - 3. Medical assistant certificate, \$100
  - 4. Clinical training certificate, \$0.00
  - 5. Preceptorship certificate, \$100
  - 6. Specialty certificate, \$225
- B. Arizona naturopathic jurisprudence examination, \$30
- C. Annual renewal fees are as follows:
  - 1. Medical license, \$165
  - 2. Certificate to Dispense, \$225
  - 3. Medical assistant certificate, \$150
  - 4. Clinical training certificate, \$0.00
  - 5. Preceptorship certificate, \$225
  - 6. Renewal of Specialty certificate, \$225
- D. Late renewal fees are as follows:
  - 1. Medical license \$83
  - 2. Certificate to dispense, \$113
  - 3. Medical assistant certificate, \$75
  - 4. Clinical training certificate, \$0.00
  - 5. Preceptorship certificate, \$113
  - 6. Specialty certificate, \$113
- E. Other fees are as follows:
  - 1. For a duplicate license or certificate, \$20
  - 2. For photocopying Board records, documents, letters, applications, or files, \$5 or \$0.25 per page, whichever is greater.

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3. For each audio tape or computer disk containing information requested, \$25
4. For written verification of a license or certificate, \$5
5. For the costs in locating a person who is licensed or certified, Actual cost incurred by the Board.
6. For each insufficient fund check, \$25.

### Historical Note

Adopted effective December 31, 1984 (Supp. 84-6). Amended as an emergency effective December 31, 1986, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 86-6). Emergency expired. Amended and adopted as a permanent rule effective June 18, 1987 (Supp. 87-2). Amended paragraph (3) effective November 10, 1988 (Supp. 88-4). Section repealed; new Section adopted by exempt rulemaking at 5 A.A.R. 2874, effective July 28, 1999 (Supp. 99-3). Amended by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by exempt rulemaking at 18 A.A.R. 1499, effective June 6, 2012 (Supp. 12-2). Amended by exempt rulemaking at 19 A.A.R. 1986, effective September 16, 2013 (Supp. 13-3). Amended by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3). Amended by exempt rulemaking at 28 A.A.R. 2643 (October 7, 2022), effective November 13, 2022 (Supp. 22-3).

### R4-18-108. Titles, Use of Abbreviations

- A. A physician issued a license by the Board may use any of the following titles or abbreviations:
  1. Doctor of Naturopathic Medicine,
  2. N.M.D.,
  3. Doctor of Naturopathy,
  4. N.D.,
  5. Naturopath,
  6. Naturopathic Physician, or
  7. Naturopathic Medical Doctor.
- B. A physician issued a license, or a graduate of a school approved by the Board, shall not use any of the following titles or abbreviations:
  1. Doctor of medicine (naturopathic),
  2. M.D.(N.), or
  3. M.D.(naturopathic).
- C. An unlicensed graduate of a Board approved school of naturopathic medicine who is certified by the Board to engage in preceptorship training shall use the designation “(Preceptee)” after any of the designations in subsection (A). The preceptee shall also ensure that any patient treated by the preceptee signs an informed consent treatment form stating clearly that the preceptee is undergoing training, is not licensed, and identifying the name of the supervising physician.
- D. An unlicensed graduate of a Board approved school of naturopathic medicine who is certified by the Board to engage in internship training shall use the designation “(Intern)” after any of the designations in subsection (A). The intern shall ensure that any patient treated by the intern signs an informed consent treatment form stating clearly that the intern is undergoing training, is not licensed and identifying the name of the supervising physician.
- E. A person who is permanently retired under A.R.S. § 32-1528 may use any of the designations listed in subsection (A) if that person also uses the designation “(Retired)” after each designation.

### Historical Note

Adopted effective December 31, 1984 (Supp. 84-6). Amended by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

### R4-18-109. Repealed

#### Historical Note

Adopted effective December 31, 1984 (Supp. 84-6). Section repealed by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

### R4-18-110. Display of Licenses and Certificates; Notice of Change of Status; Student Identification

- A. Each person licensed by the Board shall display that license, or a Board issued duplicate in a conspicuous place in each location in which the person conducts regular and ongoing patient care activity.
- B. A person, business, or institution regulated by the Board shall notify the Board of any change in the information provided to the Board concerning a license or certificate application or its renewal, including changes in name, address, place of practice, or actions taken against the licensee, for any reason, in any court or by any governmental regulatory body.
- C. Each person certified by the Board to engage in clinical training shall wear an identification card issued by the approved naturopathic medical school conducting the training that clearly identifies the person as a student, at all times that the person is involved in clinical training. An approved school may keep all certificates to engage in clinical training issued by the Board at a central location of the primary training facility, if it is easily available for public viewing.
- D. Each person, business, or institution that is issued a certificate by the Board shall display that certificate or a Board issued duplicate, in a conspicuous place at each location in which the person, business, or institution conducts regular and ongoing business activity.
- E. All notice requirements under this rule shall be in writing and made within 30 days of change of status.

#### Historical Note

Adopted effective December 31, 1984 (Supp. 84-6). Amended by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

- A. A person licensed or certified by the Board shall, within 10 days of receipt, notify the Board of any notice, subpoena, summons, or receipt of complaint, whether civil or criminal, arising directly or indirectly out of the person's conduct of the person's professional activities.
- B. To provide notice to the Board a person licensed or certified by the Board shall provide either a photocopy or facsimile copy of the notice or other service or a letter advising the Board of the nature of the cause of action allegations made, and the date, time, and place where appearance is required.

#### Historical Note

Adopted effective December 31, 1984 (Supp. 84-6). Amended by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

### R4-18-112. Reserved

### R4-18-113. Reserved

### R4-18-114. Reserved

### R4-18-115. Reserved

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**R4-18-116. Repealed**

**Historical Note**

Adopted effective December 31, 1984 (Supp. 84-6). Section repealed by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**R4-18-117. Repealed**

**Historical Note**

Adopted effective December 31, 1984 (Supp. 84-6). Section repealed by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**ARTICLE 2. LICENSES; SPECIALIST CERTIFICATES;  
CONTINUING MEDICAL EDUCATION; RENEWAL**

**R4-18-201. Jurisprudence Examination**

In addition to the requirements of R4-18-202 or R4-18-203, every applicant for licensure shall take and pass the Arizona Naturopathic Jurisprudence Examination, administered by the Board, with a minimum score of 75%. The examination shall consist of multiple choice and true-false questions. If an applicant passes the jurisprudence examination to obtain a clinical training certificate under R4-18-501 and is under the continuous regulation of the Board after obtaining the clinical training certificate, the applicant is not required to take the examination again.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**R4-18-202. License by Examination**

In addition to the requirements of R4-18-201, an applicant for licensure by examination shall meet the requirements of A.R.S. Title 32, Chapter 14 and provide the Board:

1. A completed application form, provided by the Board that is signed, dated, and verified; and shall include the following information:
  - a. Applicant's full name and any former names used by the applicant;
  - b. Applicant's place and date of birth;
  - c. Applicant's Social Security number;
  - d. Applicant's home, business, and e-mail addresses; e. Applicant's home, business, and cell phone numbers;
  - f. A completed Arizona Statement of Citizenship and Alien Status for State Public Benefits, and copy of evidence;
  - g. The name of the approved naturopathic college applicant graduated from, date of graduation, and date of clinical training completion;
  - h. The date applicant took and passed the required NPLEX examinations of Part I; Biomedical examination, Part II; Clinical Science examination, Part II; Core Clinical Science Examination, and the Clinical Elective examinations in acupuncture, and minor surgery. The date applicant took and passed the examination in Arizona naturopathic jurisprudence that is administered by the Board. Applicant must have taken and passed all the required examinations within a five-year period immediately preceding the date of application submission to the Board;
  - i. A list of all license or certificates issued or denied by any agency. Applicant must cause to have a document submitted directly to the Board from each

agency listed, containing the applicant's name, date of issuance or denial, current status, and whether or not any disciplinary actions are pending or have ever been taken;

- j. Whether applicant has ever been arrested, charged with, convicted of, or entered into a plea of no contest to a felony or a misdemeanor;
  - k. Whether applicant has ever had a naturopathic medical license or certification, or any other health profession license or certification denied, suspended, rejected or revoked by any agency;
  - l. Whether applicant has ever been disciplined by any agency for any act of unprofessional conduct as defined in A.R.S. § 32-1501;
  - m. Whether applicant, in lieu of disciplinary action, has entered into a consent agreement or stipulation with a licensing agency in any state, district or territory of the United States or another country;
  - n. Whether applicant currently has an open complaint or is involved in any open investigation in any agency or court of law, in any state, district or territory of the United States or another country;
  - o. Whether applicant has ever had the authority to prescribe, dispense, or administer a natural substance, drug, or device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency or court of law, in any state, district or territory of the United States or country;
  - p. Whether applicant has ever been found medically incompetent;
  - q. Whether applicant has ever been a defendant in any malpractice matter that resulted in a settlement or judgment;
  - r. Whether applicant has a medical condition that in any way impairs or limits applicant's ability to practice medicine, and;
  - s. A detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background;
2. A copy of the applicant's complete NPLEX examination record, to be sent directly to the Board by the North American Board of Naturopathic Examiners ("NABNE") or its successor;
  3. A complete transcript sent directly to the Board from the approved school of naturopathic medicine from which the applicant graduated. The transcript shall include the date of graduation and the date of completion of clinical training;
  4. A complete and legible fingerprint card, including the DPS processing fee as specified on the application form;
  5. A passport size photograph taken within 60 days prior to application submission that is signed on the back by the applicant, and;
  6. The fees specified in R4-18-107.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3).

**R4-18-203. License by Endorsement**

In addition to the requirements of R4-18-201, an applicant for licensure by endorsement shall meet the requirements of A.R.S. Title 32, Chapter 14, and provide the Board:

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1. A completed application form, provided by the Board that is signed, dated, and verified, which shall include the following information:
  - a. Applicant's full name and any former names used by the applicant;
  - b. Place and date of birth;
  - c. Social Security number;
  - d. Home, business, and e-mail addresses;
  - e. Home, business, and cell phone numbers;
  - f. A completed Arizona Statement of Citizenship and Alien Status for State Public Benefits, and copy of evidence;
  - g. The name of the approved naturopathic college applicant graduated from, date of graduation, and date of clinical training completion;
  - h. The date applicant took and passed the examination in Arizona naturopathic jurisprudence that is administered by the Board, and the required NPLEX examinations of Part I; Biomedical examination, Part II; Clinical Science examination, Part II; Core Clinical Science Examination, the Clinical Elective examination in acupuncture, and the Clinical Elective examination in minor surgery;
  - i. A list of all license or certificates issued or denied by any agency in any state, district or territory of the United States or another country. Applicant must cause to have a document submitted directly to the Board from each agency listed, containing the applicant's name, date of issuance or denial, current status, and whether or not any disciplinary actions are pending or have ever been taken;
  - j. Whether applicant has ever been arrested, charged with, convicted of, or entered into a plea of no contest to a felony or a misdemeanor;
  - k. Whether applicant has ever had a naturopathic medical license or certification, or any other profession license or certification denied, suspended, rejected or revoked by any agency in any state, district or territory of the United States or another country;
  - l. Whether applicant has ever been disciplined by any agency in any state, district or territory of the United States or another country, for any act of unprofessional conduct as defined in A.R.S. § 32-1501;
  - m. Whether applicant, in lieu of disciplinary action, has entered into a consent agreement or stipulation with a licensing agency in any state, district or territory of the United States or another country;
  - n. Whether applicant currently has an open complaint or is involved in any open investigation in any agency or court of law, in any state, district or territory of the United States or another country;
  - o. Whether applicant has ever had the authority to prescribe, dispense, or administer a natural substance, drug, or device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency or court of law; in any state, district or territory of the United States or another country;
  - p. Whether applicant has ever been found medically incompetent;
  - q. Whether applicant has ever been a defendant in any malpractice matter that resulted in a settlement or judgment;
  - r. Whether applicant has a medical condition that in any way impairs or limits applicant's ability to practice medicine, and;
  - s. A detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background;
2. A document submitted directly to the Board by the agency by whom the applicant is licensed as a naturopathic physician that is signed and dated by an official of the agency and that contains:
  - a. The applicant's name;
  - b. The date of issuance of the license;
  - c. The current status of the license;
  - d. A statement of whether the applicant has ever been denied a license by the agency, and;
  - e. A statement of whether any disciplinary action is pending or has ever been taken against the applicant;
3. A copy of the applicant's complete NPLEX examination record, to be sent directly to the Board by the North American Board of Naturopathic Examiners "NABNE" or its successor;
4. A complete transcript sent directly to the board from the approved school of naturopathic medicine from which the applicant graduated. The transcript shall include the date of graduation and the date of completion of clinical training.
5. Applicant must provide evidence of being actively engaged, for at least three years immediately preceding the application, in one or more of the following:
  - a. The active practice as a licensed doctor of naturopathic medicine;
  - b. Participation in an approved internship, preceptorship or clinical training program in naturopathic medicine, as defined in A.R.S. § 32-1501(4), (5), (7);
  - c. Participation in an approved postdoctoral training program in naturopathic medicine, as defined in A.R.S. § 32-1501(6);
  - d. Active in the resident study of naturopathic medicine at an approved school of naturopathic medicine, as defined in A.R.S. § 32-1501(8)(a) and (b);
6. A complete and legible fingerprint card, including the DPS processing fee, as specified on the application form;
7. A passport size photograph taken within 60 days prior to application submission, that is signed on the back by the applicant;
8. The fees specified in R4-18-107;
9. Applicants who were licensed in another state or a Canadian province before January 1, 2005, shall include evidence of completion of additional 60 hours of continuing medical education ("CME") in the subject of pharmacotherapeutics. The CME must be offered, sanctioned, or accredited by one of the organizations referenced in R4-18-205(B)(1), (2)(a), (b), (c) or (4)(a), (b), (c), and include an examination. In the event the applicant cannot provide satisfactory evidence of completion of the required pharmacotherapeutics, or the required examinations, pursuant to A.R.S. § 32-1524(E), and (G)(3), the applicant will have an additional 365 days from the date the board notifies the applicant of the deficiency, to supply satisfactory evidence of completion.

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rulemaking at 21 A.A.R. 2009, effective September 1,  
2015 (Supp. 15-3). Duplicate word "has" removed under  
subsection (1)(m) (Supp. 22-3).

**R4-18-204. Specialists Certificate**

To obtain a specialist certificate, a physician shall meet the require  
ments of A.R.S. Title 32, Chapter 14 and provide the Board: 1. A  
completed application form, provided by the Board that is signed,  
dated, and verified, which shall include the following information;

- a. Applicant's full name;
  - b. Current State of Arizona Naturopathic Physicians  
Medical License number;
  - c. Email address, phone number, and mailing address;
  - d. Name and address of the approved specialty college or  
program from which applicant completed post doctoral  
specialty training;
  - e. The specialty applicant received training in, and a  
copy of the certificate of completion received in the  
specialty;
  - f. Who the specialty program was approved by;
  - g. Whether applicant has a medical condition that in any  
way impairs or limits applicant's ability to practice  
medicine;
  - h. Whether applicant has ever been disciplined by any  
agency in any state or territory of the United States,  
for any act of unprofessional conduct as defined in  
A.R.S. § 32-1501;
  - i. Whether applicant has ever had a naturopathic medi  
cal license or certification, or any other health pro  
fession license or certification denied, suspended,  
rejected or revoked by any agency in any state or  
territory of the United States, and;
  - j. A detailed explanation and supporting documenta  
tion for each affirmative answer to questions regard  
ing the applicant's background;
2. The fees specified in R4-18-107 and;
  3. A letter from the specialty board that conducted the spe  
cialty examination verifying that the licensee is certified  
as a specialists in the specialty for which application is  
made;
  4. A certificate issued to a physician pursuant to A.R.S. §  
32-1529(C.), shall be concurrently renewed, suspended  
or revoked, with that physician's license to practice natu  
ropathic medicine.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R.  
3702, effective August 9, 2002 (Supp. 02-3). Amended  
by final rulemaking at 21 A.A.R. 2009, effective  
September 1, 2015 (Supp. 15-3).

**R4-18-205. Continuing Medical Education Requirements A.**

Every calendar year, a physician shall complete 30 credit hours of  
approved continuing medical education activities. Ten credit hours  
shall be in pharmacology as it relates to the diag nosis, treatment,  
or prevention of disease. Eight credit hours shall be from programs  
approved by one or more of the organi zations listed in subsection  
(B)(2). One hour of credit is allowed for every 50 minutes of  
participation in an approved continuing medical education activity  
unless otherwise noted in R4-18-205(B).

**B.** The following are approved continuing medical education  
activities:

1. Education certified as Category I by an organization  
accredited by the Accreditation Council on Continuing  
Medical Education;
2. Continuing medical educational programs in the clinical  
application of naturopathic medical philosophy that are  
approved by;
  - a. The American Association of Naturopathic Physi  
cians or any of its constituent organizations,
  - b. The Arizona Naturopathic Medical Association, or c.  
Any naturopathic licensing authority in the United States  
or Canada.
3. One credit hour may be claimed for each eight hour day of  
training in an internship training program, a preceptor  
ship training program, or a postdoctoral training program  
approved by the Board. A maximum of eight hours per  
year may be claimed in this manner.
4. One credit hour, not to exceed eight credit hours, may be  
claimed for each eight hour day of research in subjects  
listed in A.R.S. § 32-1525(B), if the research is  
conducted by or sponsored by a school of naturopathic  
medicine that is accredited or a candidate for  
accreditation by:
  - a. The Council on Naturopathic Medical Education, b.  
The Council for Higher Education Accreditation, or c.  
An accrediting agency recognized by the United States  
Department of Education.
5. One credit hour may be claimed for each hour serving as an  
instructor of naturopathic medical students or other  
physicians in a program approved by one of the  
organizations listed in subsection (B)(2), or a school  
approved by the Board. A maximum of eight hours may  
be claimed in this manner.
6. A maximum of four credit hours may be claimed for pre  
paring or writing for presentation or publication, a medi  
cally related paper, report, or book that is presented or  
published addressing current developments, skills, proce  
dures, or treatment in the practice of naturopathic medi  
cine. Credit may be claimed only for materials presented  
or published. Credit may be claimed once as of the date  
of publication or presentation.
7. A maximum of eight credit hours may be earned for the  
following activities that provide necessary understanding  
of current developments, skills, procedures, or treatment  
related to the practice of naturopathic medicine if the  
physician maintains a record for at least three years that  
includes the name of the activity, the date of the activity,  
and the amount of time to complete the activity:
  - a. Self-instruction that utilizes videotapes, audiotapes,  
films, filmstrips, slides, radio broadcasts, or comput  
ers;
  - b. Independent reading of scientific journals and books;
  - c. Preparation for specialty board certification or re  
certification examinations; or
  - d. Participation on a staff committee or quality of care or  
utilization review committee in a facility or gov  
ernment agency.

**C.** The Board shall grant an extension of time to complete con

tinuing medical education required in subsection (A) upon written application by a licensee if the licensee fails to meet the requirements due to illness, military service, medical or religious missionary activity, residence in a foreign country, or other extenuating circumstance. An extension, other than

for military service, shall not exceed 90 days.

**D.** An applicant for renewal of a license shall certify on the application for renewal, under penalty of perjury, that the applicant

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has met or will meet, before January 1, the continuing medical education requirements for the calendar year.

**E.** Board staff shall annually select a minimum of ten percent of the active licensees for an audit of required continuing medical education. Failure to complete the required continuing medical education is considered unprofessional conduct.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**R4-18-206. Renewal of a License**

To renew a license to practice naturopathic medicine, on or before January 1 of each year, a licensee shall submit a complete license application renewal form, that allows the Board to determine whether the applicant continues to meet the requirements of A.R.S. Title 32, Chapter 14. If an applicant makes a timely and complete application for renewal of the applicant's license, the physician may continue to practice until the application is approved or denied by the Board.

1. A completed application form, provided by the Board that is signed, dated, and verified, which shall include the following information;
  - a. Applicant's full name;
  - b. Applicant's State of Arizona Naturopathic Physicians Medical License number and initial issuance date of the license;
  - c. Applicant's home, business, and choice of e-mail addresses, and choice of mailing address;
  - d. Applicant's home, business, and cell phone numbers;
  - e. Applicant's attestation of completion of the Continuing Medical Education credit hours required to renew the medical license;
  - f. A statement indicating whether, during the last 12 months, applicant was arrested, charged with, convicted of, or entered into a plea of no contest to any criminal act;
  - g. A statement indicating whether, during the last 12 months, applicant had any licensing agency or board, in any state, district or territory of the United States or another country, initiate or take any action against any license or certificate that is or was held;
  - h. A statement indicating whether, during the last 12 months, applicant entered into a consent agreement or stipulation with any agency in lieu of disciplinary action in any state, district or territory of the United States or another country;
  - i. A statement of whether during the last 12 months applicant was named in a malpractice suit;
  - j. A statement of whether applicant has a complaint currently pending before any agency, or court of law; in any state, district or territory of the United States or another country;
  - k. A detailed explanation and supporting documentation for each affirmative answer to questions regarding

2. The fee specified in R4-18-107.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3).

**R4-18-207. Reinstatement of an Expired License or Certificate**

- A.** In order to reinstate an expired license, an applicant must meet the requirements in A.R.S. § 32-1526, and pay a renewal and penalty fee for each year the license has been expired. In addition, the applicant must demonstrate completion of 30 hours of continuing medical education for each year the license has been expired. The CME must cover clinical application of naturopathic medical philosophy, pharmacology, and be accredited by the Accreditation Council on Continuing Medical Education or approved by any of the programs listed in R4-18-201(B)(2).
- B.** The applicant must provide the Board with:
1. A completed application form, provided by the Board that is signed, dated, and verified; which shall include the following information;
    - a. Applicant's full name and any former names used by the applicant;
    - b. Applicant's place and date of birth;
    - c. Applicant's Social Security number;
    - d. Applicant's home, business, and e-mail addresses; e. Applicant's home, business, and cell phone numbers;
    - f. A completed Arizona Statement of Citizenship and Alien Status for State Public Benefits, and copy of evidence;
    - g. The name of the approved naturopathic college applicant graduated from, date of graduation, and date of clinical training completion;
    - h. A list of all license or certificates issued or denied by any agency in any state, district or territory of the United States or another country. Applicant must cause to have a document submitted directly to the Board from each agency listed, containing the applicant's name, date of issuance or denial, current status and whether or not any disciplinary actions are pending or have ever been taken;
    - i. Whether applicant has ever been arrested, charged with, convicted of, or entered into a plea of no contest to a felony or a misdemeanor;
    - j. Whether applicant has ever had a naturopathic medical license or certification, or any other health profession license or certification denied, suspended, rejected or revoked by any agency in any state, district or territory of the United States or another country;
    - k. Whether applicant has ever been disciplined by any agency in any state, district or territory of the United States or another country for any act of

unprofessional conduct as defined in A.R.S. § 32-1501;

- l. Whether in lieu of disciplinary action, has applicant ever entered into a consent agreement or stipulation with a licensing agency in any state, district or territory of the United States or another country;
- m. Whether applicant currently has an open complaint or is involved in any open investigation in any agency

or court of law, in any state, district or territory of the United States or another country;

- n. Whether applicant has ever had the authority to prescribe, dispense, or administer a natural substance, drug, or device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency or court of law in any state, district or territory of the United States or another country;

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- o. Whether applicant has ever been found medically incompetent;
  - p. Whether applicant has ever been a defendant in any malpractice matter that resulted in a settlement or judgment;
  - q. Whether applicant has a medical condition that in any way impairs or limits applicant's ability to practice medicine, and;
  - r. A detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background;
2. A complete and legible fingerprint card, including the DPS processing fee as specified on the application form; 3. A passport size photograph taken within 60 days prior to application submission that is signed on the back by the applicant;
- C.** An applicant for reinstatement of an expired certificate to dispense must complete the renewal application form and pay the renewal and late fees for each year the certificate has been expired;
- D.** An applicant for reinstatement of a certificate to dispense must complete the initial application form for the certificate. Pursuant to A.R.S. § 32-1526(H), an applicant for reinstatement of an expired certificate shall pay all renewal and penalty fees;
- E.** A applicant who held a specialty certificate that expired with the license, may request reinstatement of the certificate on the application for reinstatement of the medical license.
- Historical Note**
- New Section made by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3).
- R4-18-208. Reinstatement of a Retired License A.** A person may apply to reinstate a retired license to active practice, upon payment of the renewal fee. As a condition of reinstatement of a retired license, pursuant to A.R.S. § 32-1528, each applicant shall provide proof of completion of 30 hours of continuing medical education, and provide the Board with:
- 1. A completed application form, provided by the Board that is signed, dated, and verified; which shall include the following information:
    - a. Applicant's full name and any former names used by the applicant;
    - b. Applicant's place and date of birth;
    - c. Applicant's Social Security number;
    - d. Applicant's home, business, and e-mail addresses; e. Applicant's home, business, and cell phone numbers;
    - f. A completed Arizona Statement of Citizenship and Alien Status for State Public Benefits, and copy of evidence;
  - g. The name of the approved naturopathic college applicant graduated from, date of graduation, and date of clinical training completion;
- h. The dates applicant retired the license;
  - i. A list of all licenses or certificates issued or denied by any agency in any state, district or territory of the United States or another country. Applicant must cause to have a document submitted directly to the Board from each agency listed, containing the applicant's name, date of issuance or denial, current status and whether or not any disciplinary actions are pending or have ever been taken;
  - j. Whether applicant has ever been arrested, charged with, convicted of, or entered into a plea of no contest to a felony or a misdemeanor;
  - k. Whether applicant has ever had a naturopathic medical license or certification, or any other health profession license or certification denied, suspended, rejected or revoked by any agency in any state, district or territory of the United States or another country;
  - l. Whether applicant has ever been disciplined by any agency in any state, district or territory of the United States or another country, for any act of unprofessional conduct as defined in A.R.S. § 32-1501;
  - m. Whether in lieu of disciplinary action, has applicant ever entered into a consent agreement or stipulation with a licensing agency in any state, district or territory of the United States or another country;
  - n. Whether applicant currently has an open complaint or is involved in any open investigation in any agency or court of law, in any state, district or territory of the United States or another country;
  - o. Whether applicant has ever had the authority to prescribe, dispense, or administer a natural substance, drug, or device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency or court of law in any state, district or territory of the United States or another country;
  - p. Whether applicant has ever been found medically incompetent;
  - q. Whether applicant has ever been a defendant in any malpractice matter that resulted in a settlement or judgment;
  - r. Whether applicant has a medical condition that in any way impairs or limits applicant's ability to practice medicine, and;
  - s. A detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background.
2. A complete and legible fingerprint card, including the DPS processing fee as specified on the form;
3. A passport size photograph taken within 60 days prior to application submission that is signed on the back by the

applicant;

4. The fees specified in R4-18-107; and
5. Provide proof of completion of 30 hours of CME taken, within the last 12 months prior to application submission. The CME is in addition to the 30 hours required each year for license renewal, must cover clinical application of naturopathic medical philosophy, pharmacology, and be accredited by the Accreditation Council on Continuing Education, or approved by any of the programs listed in R4-18-201(B)(2).

**B.** An applicant for reinstatement of a retired certificate to dis

pense must complete the renewal application form for the certificate, and pay the fee specified in R4-18-107.

**C.** An applicant who held a specialty certificate that retired with the license, may request reinstatement of the certificate on the application for reinstatement of the medical license.

#### **Historical Note**

New Section made by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3).

#### **R4-18-209. Reinstatement of a Suspended, Revoked, or Sur-**

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#### **rendered License or Certificate**

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p. Whether applicant has ever been found medically

**A.** A person may apply to the board for the termination of the suspension or reissuance of a revoked license. Pursuant to A.R.S. § 32-1551, the board shall make its determination on each application as it deems consistent with the public health, safety and just in the circumstances. The applicant must provide the Board with;

1. A completed application form, provided by the Board that is signed, dated, and verified; which shall include the following information;

a. Applicant's full name and any former names used by the applicant;

b. Applicant's place and date of birth;

c. Applicant's Social Security number;

d. Applicant's home, business, and e-mail addresses; e. Applicant's home, business, and cell phone numbers;

f. A completed Arizona Statement of Citizenship and Alien Status for State Public Benefits, and copy of evidence;

g. The name of the approved naturopathic college applicant graduated from, date of graduation, and date of clinical training completion;

h. Documentation showing that the basis for the suspension or revocation has been removed, and that suspension termination or reinstatement of the license or certificate, does not constitute a threat to the public health or safety;

i. A list of all license or certificates issued or denied by any agency in any state, district or territory of the United States or another country. Applicant must cause to have a document submitted directly to the Board from each agency listed, containing the applicant's name, date of issuance or denial, current status and whether or not any disciplinary actions are pending or have ever been taken;

j. Whether applicant has ever been arrested, charged with, convicted of, or entered into a plea of no contest to a felony or a misdemeanor;

k. Whether applicant has ever had a naturopathic medical license or certification, or any other health profession license or certification denied, suspended, rejected or revoked by any agency in any state, district or territory of the United States or another country;

l. Whether applicant has ever been disciplined by any agency in any state, district or territory of the United States or another country, for any act of unprofessional conduct as defined in A.R.S. § 32-1501;

m. Whether in lieu of disciplinary action, has applicant ever entered into a consent agreement or stipulation with a licensing agency in any state, district or territory of the United States or another country;

n. Whether applicant currently has an open complaint or is involved in any open investigation in any agency or court of law, in any state, district or territory of the United States or another country;

o. Whether applicant has ever had the authority to prescribe, dispense, or administer a natural substance, drug, or device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency or court of law in any state, district or territory of the United States or another country; incompetent;

q. Whether applicant has ever been a defendant in any malpractice matter that resulted in a settlement or judgment;

r. Whether applicant has a medical condition that in any way impairs or limits applicant's ability to practice medicine, and;

s. A detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background;

2. A complete and legible fingerprint card, including the DPS processing fee as specified on the application form; 3. A passport size photograph taken within 60 days prior to application submission that is signed on the back by the applicant, and;

4. The fees specified in R4-18-107;

5. Proof of completion of 30 hours of CME for each year the license has been suspended or revoked. The CME is in addition to the 30 hours required each year for license renewal, must cover clinical application of naturopathic medical philosophy and pharmacology, and, be accredited by the Accreditation Council on Continuing Education, or approved by any of the programs listed in R4-18-205(B)(2);

**B.** An applicant for reinstatement of a suspended or revoked certificate to dispense shall submit a complete renewal form, along with the fee specified in R4-18-107;

**C.** An applicant who held a specialty certificate that was sus

pending or revoked with the license, may request reinstatement of the certificate on the application for reinstatement of the medical license.

- D.** An applicant seeking licensure after the surrendered of a license or certificate must apply and meet the requirements as a new applicant.

#### **Historical Note**

New Section made by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3).

### **ARTICLE 3. RESERVED**

### **ARTICLE 4. APPROVAL OF SCHOOLS OF NATUROPATHIC MEDICINE**

**R4-18-401. Approval of a School of Naturopathic Medicine** The Board shall approve a school of naturopathic medicine if, in addition to the requirements of A.R.S. § 32-1501(8):

1. It is accredited or a candidate for accreditation by the Council on Naturopathic Medical Education, or its successor agency, and
2. It has complied with the requirements of the Arizona State Board of Private Post Secondary Education in A.R.S. Title 32, Chapter 30 and A.A.C. 4-39-101 through 4-39-603.

#### **Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

### **R4-18-402. Annual Renewal of an Approved School of Naturopathic Medicine**

An approved school of naturopathic medicine shall be renewed by submitting on or before January 1 of each year, the information required by the Board that allows the Board to determine if the

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applicant continues to meet the requirements of A.R.S. § 32-1501(8) and of R4-18-401.

#### **Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

### **ARTICLE 5. NATUROPATHIC CLINICAL TRAINING AND PRECEPTORSHIP TRAINING PROGRAM REQUIREMENTS**

#### **R4-18-501. Certificate to Engage in Clinical or Preceptorship Training**

- A.** To obtain a certificate to engage in clinical or preceptorship training, an applicant shall submit to the Board a complete application form provided by the Board, that allows the Board to determine if the applicant meets the requirements of A.R.S. § 32-1524. The application shall be verified, and include the fee listed in R4-18-107;
- B.** In addition to the requirements in subsection (A) a naturopathic medical student who applies for a certificate to engage in clinical training shall comply with the requirements of A.R.S. § 32-1560, and, be attending an approved naturopathic medical school. Applicant must arrange to have submitted directly to the Board, a letter from the chief medical officer of the medical school verifying that the applicant will be entering clinical training, and the anticipated starting and completion dates. The Board may deny an application for any reason set forth in A.R.S. § 32-1501(31) and A.R.S. § 32-1522(A)(3) through (6);
- C.** Applicant must take and pass the examination in Arizona naturopathic jurisprudence that is administered by the Board, with a minimum score of 75%, include with the application a passport size photograph taken within 60 days prior to application submission that is signed on the back by the applicant, provide a legible fingerprint card, including the DPS processing fee as specified on the application form;
- D.** The application form for clinical training entry shall include:
1. Applicant's full name and any former names used by applicant;
  2. Applicant's place and date of birth;
  3. Applicant's Social Security number;
  4. Applicant's home and email address;

5. Applicant's home and cell phone numbers;
6. The name and address of the approved naturopathic college applicant is attending; name and address of clinical training program, the date of clinical entry and the date of completion of clinical entry;
7. The name of the Supervising Physician and the name of the Chief Medical Officer of the Clinical Training program;
8. Whether applicant has ever been arrested, charged with, convicted of, or entered into a plea of no contest to a felony or a misdemeanor;
9. Whether applicant has ever had a naturopathic medical license or certification, or any other health profession license or certification denied, suspended, rejected or revoked by any agency in any state, district or territory of the United States or another country;
10. Whether applicant has ever been disciplined by any agency in any state, district or territory of the United States or another country, for any act of unprofessional conduct as defined in A.R.S. § 32-1501;
11. Whether applicant, in lieu of disciplinary action, has entered into a consent agreement or stipulation with a licensing agency in any state, district or territory of the United States or another country;
12. Whether applicant currently has an open complaint or is involved in any open investigation in any agency or court of law, in any state, district or territory of the United States or another country;
13. Whether applicant has ever had the authority to prescribe, dispense, or administer a natural substance, drug, or device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency or court of law, in any state, district or territory of the United States or another country;
14. Whether applicant has ever been found medically incompetent;
15. Whether applicant has ever been a defendant in any malpractice matter that resulted in a settlement or judgment;
16. Whether applicant has a medical condition, that in any way, impairs or limits applicant's ability to practice medicine;
17. A detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background, and;
18. A completed Arizona Statement of Citizenship and Alien

Status for State Public Benefits, and copy of evidence; **E.** In addition to the requirements in subsection (A), an applicant for a certificate to engage in a preceptorship training program shall comply with the requirements of A.R.S. § 32-1561 and arrange to have submitted directly to the Board, an official transcript from the approved naturopathic medical school from which the applicant graduated;

**F.** Applicant must take and pass the examination in Arizona naturopathic jurisprudence that is administered by the Board with a minimum score of 75%, include with the application, a passport size photograph taken within 60 days prior to application submission that is signed on the back by the applicant, provide a legible fingerprint card, including the DPS processing fee as specified on the application form;

**G.** The application form for preceptorship training shall include: 1. Applicant's full name and any former names used by applicant; 2. Applicant's place and date of birth; 3. Applicant's Social Security number; 4. Applicant's home and email address 5. Applicant's home and cell phone numbers;

6. The name, address, and medical license number of the Supervising Physician, designated Supervising Physician, if any, and Chief Medical Officer;
7. Attestation signed by the Supervising Physician declaring they have read and understand A.R.S. § 32-1561 and R4-18-108, and agree to be the Supervising physician of record;
8. Whether applicant has ever been arrested, charged with, convicted of, or entered into a plea of no contest to a felony or a misdemeanor;
9. Whether applicant has ever had a naturopathic medical license or certification, or any other health profession license or certification denied, suspended, rejected or revoked by any state, district or territory or the United States or another country;
10. Whether applicant has ever been disciplined by any agency in any state, district or territory of the United States or another country, for any act of unprofessional conduct as defined in A.R.S. § 32-1501;

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11. Whether applicant, in lieu of disciplinary action by any agency, in any state, district or territory of the United States or another country, has entered into a consent agreement or stipulation with a licensing agency;
12. Whether applicant currently has an open complaint or is involved in any open investigation in any agency or court of law, in any state, district or territory of the United States or another country;
13. Whether applicant has ever had the authority to prescribe, dispense, or administer a natural substance, drug, or device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency or court of law, in any state, district or territory of the United States, or another country;
14. Whether applicant has ever been found medically incompetent;
15. Whether applicant has ever been a defendant in any malpractice matter that resulted in a settlement or judgment;
16. Whether applicant has a medical condition, that in any way, impairs or limits applicant's ability to practice medicine;
17. A detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background; and
18. A completed Arizona Statement of Citizenship and Alien Status for State Public Benefits, and copy of evidence.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3).

**R4-18-502. Annual Renewal of a Certificate to Engage in Clinical or Preceptorship Training**

A holder of a certificate to engage in clinical training shall renew the certification by submitting before the expiration date of the certificate a completed clinical training renewal form. A holder of a certificate to engage in preceptorship training shall renew the certification on or before July 1, by submitting a completed preceptorship renewal form.

1. Applicant must submit a completed application form provided by the Board for renewal of certification that allows the Board to determine whether the holder of the certificate continues to meet the requirements of A.R.S. Title 32 Chapter 14. The form must be signed, dated, and shall include:
  - a. Applicant's full name and any former names used by applicant;
  - b. Applicant's certificate number, and original issue date;
2. The fees specified in R4-18-107.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3).

**R4-18-503. Application for a Certificate to Conduct a Clinical or Preceptorship Training Program**

A chief medical officer applying on behalf of a school of naturopathic medicine for a certificate to conduct clinical training, or on behalf of a preceptorship training program, shall submit to the Board the fee indicated in R4-18-107 and an application form provided by the Board, signed and dated by the chief medical officer, that contains:

1. The chief medical officer's name, mailing address, and telephone number;
2. The name and address of the training program and of each facility where training will be conducted;
3. The name, professional degree, license number, and licensing agency for each physician who will be providing supervision in the training program; and
4. A mission statement outlining the goals of the training program.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**R4-18-504. Annual Renewal of Certificate to Conduct a Clinical or Preceptorship Training Program**

A certificate to conduct clinical or preceptorship training shall be renewed before the anniversary date, by submitting the appropriate fee listed in R4-18-107 and a completed form.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**ARTICLE 6. NATUROPATHIC MEDICAL ASSISTANTS**

**R4-18-601. Definitions**

In addition to the definitions in A.R.S. § 32-1501 and R4-18-101, the following definitions apply to this Article:

1. "Approved medical assistant program" means a course of study for medical assistants that is provided:
  - a. At an institution that is accredited by:
    - i. The Commission on Accreditation of Allied Health Education Programs,
    - ii. The Commission for the Accrediting Bureau of Health Education Schools, or
    - iii. An accrediting agency recognized by the United States Department of Education or the Armed Forces of the United States, or

b. By an organization recognized by the American Association of Naturopathic Physicians.

2. "Employ" means to compensate by money or other consideration for work performed.
3. "Medical history" means an account of an individual's past and present physical and mental health including the individual's illness, injury, or disease.
4. "Medication" means a drug as defined in A.R.S. § 32-1501 or a natural substance as defined in A.R.S. § 32-1581.
5. "Naturopathic practice" means a place where the practice of naturopathic medicine as defined in A.R.S. § 32-1501 takes place.
6. "Training" means classroom and clinical instruction completed by an individual as part of an approved medical assistant program.
7. "Treatment" means any of the acts included in the practice of naturopathic medicine as defined in A.R.S. § 32-1501.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1547, effective June 4, 2005 (Supp. 05-2).

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**R4-18-602. Medical Assistant Qualification**

An individual shall complete an approved medical assistant program to qualify for certification as a medical assistant.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1547, effective June 4, 2005 (Supp. 05-2).

**R4-18-603. Application for Medical Assistant Certification** An applicant for a medical assistant certificate shall submit an application packet to the Board that contains the following:

1. An application form provided by the Board, signed and dated by the applicant that contains:
  - a. The applicant's name, mailing address, telephone number, and Social Security number;
  - b. The applicant's date and place of birth;
  - c. The applicant's height, weight, and eye and hair color;
  - d. The name, address, and telephone number of the applicant's employer, if applicable;
  - e. The name of the licensed physician who will supervise the applicant;
  - f. The name and address of the institution where the applicant completed an approved medical assistant program;
2. A copy of a certificate of completion from an approved medical assistant program or a letter of completion from an approved medical assistant program signed by the person in charge of the approved medical assistant program;
3. A completed and legible fingerprint card; and
4. The fees required by the Board under A.R.S. § 32-1527.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1547, effective June 4, 2005 (Supp. 05-2).

**R4-18-604. Renewal of Medical Assistant Certificate** An applicant for a renewal certificate shall submit to the Board: 1. A renewal form, provided by the Board, that is signed and dated by

the applicant and contains the applicant's:

- a. Name,
- b. Social Security number,
- c. Residence and naturopathic practice addresses, and
- d. Telephone number; and

2. The fee required by the Board under A.R.S. § 32-1527.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1547, effective June 4, 2005 (Supp. 05-2).

**R4-18-605. Authorized Procedures for Medical Assistants A.** A medical assistant may perform the following under the direct supervision of a physician:

1. Obtain a patient's medical history;
2. Obtain a patient's vital signs;
3. Assist a physician in performing a physical examination, surgical procedure, or treatment;
4. Perform a diagnostic test ordered by a physician including:
  - a. An electrocardiogram;
  - b. A peripheral vein puncture;
  - c. A capillary puncture;
  - d. Urine analysis;
  - e. A hematology test; or
  - f. Respiratory function testing;
5. Administer a medication:
  - a. By mouth; or
  - b. By subcutaneous or intra-muscular injection if the medical assistant received training on performing this type of administration from an approved medical assistant training program;
6. Monitor and remove an intravenous administration of a medication established by a supervising physician if the medical assistant received training on monitoring and removing an intravenous administration from an approved medical assistant training program.
7. Perform physiotherapy, which includes the following:
  - a. Whirlpool treatment,
  - b. Diathermy treatment,

- c. Electronic stimulation treatment,
- d. Ultrasound therapy,
- e. Massage therapy,
- f. Traction,
- g. Transcutaneous nerve stimulation,
- h. Colon hydrotherapy, or
- i. Hot and cold pack treatment.

**B. A medical assistant shall not:**

1. Diagnose a medical condition;
2. Design or modify a treatment program;
3. Prescribe a medication or natural substance;
4. Provide a patient with a prognosis;
5. Unless authorized by law, perform:
  - a. An ionizing radiographic procedure,
  - b. A surgical procedure,
  - c. A central venous catheterization,
  - d. An acupuncture needle insertion, or
  - e. Manipulative therapy;
6. Administer or establish an intravenous medication; 7. Perform any procedure that requires precise placement of a needle into a patient by single or multiple injections including:
  - a. Sclerotherapy,
  - b. Prolotherapy,
  - c. Mesotherapy, or
  - d. Neurotherapy; or
8. Employ the medical assistant's supervising physician or

have any financial interest in a naturopathic practice where the supervising physician is employed.

- C. While assisting a naturopathic physician or performing a procedure delegated to the medical assistant, the medical assistant shall wear a clearly visible tag that states the individual is a medical assistant.**

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1547, effective June 4, 2005 (Supp. 05-2).

**ARTICLE 7. TIME-FRAMES FOR BOARD DECISIONS**

**R4-18-701. Time-frames for Board Decisions**

- A.** The overall time-frame described in A.R.S. § 41-1072(2) for each type of license, certification, or approval granted by the Board is listed in Table 1. The applicant and the Executive Director of the Board may agree in writing to extend a substantive review and overall time-frame by no more than 25 percent of the overall time-frame listed in Table 1.
- B.** The administrative completeness review time-frame described in A.R.S. § 41-1072(1) for each type of license, certification, and approval granted by the Board is listed in Table 1. 1. The administrative completeness review time-frame begins on the day the Board receives the application form and the appropriate fee.

2. If the application packet is incomplete, the Board shall send to the applicant a written notice specifying the missing document or incomplete information.
  3. The administrative completeness review time-frame and the overall time-frame are suspended from the date on the Board's notice until the date the Board office receives all missing information.
- C.** The substantive review time-frame described in A.R.S. § 41-1072(3) for each type of license, certification, and approval granted by the Board is listed in Table 1.
1. The substantive review time-frame begins on the date of the Board's notice of administrative completeness.
  2. If the Board determines that additional information or documentation is required, the Board shall send to the applicant a written request for that additional information or documentation.
  3. The time-frame for the substantive review is suspended from the date the request for additional information or documentation is sent to the applicant, until the date on which all of the requested information is received.
  4. The Board shall notify the applicant of the dates of all Board meetings at which the application will be considered.

**Table 1. Time-frames**

5. The Board shall send a written notice of approval or denial to applicants within ten working days of the Board meeting at which the decision is made. An applicant may request a hearing on the decision within 30 days of the Board's action.
- D.** The Board shall consider an application withdrawn if within 360 days from the date of application the applicant fails to: 1. Supply the missing information requested under subsection (B)(2) or (C)(2); or
2. If applicable, take and obtain a minimum score of 75% on the Arizona Naturopathic Jurisprudence Examination.
- E.** During the administrative review period, an applicant may withdraw an application by requesting withdrawal in writing. During the substantive review period, the Board shall decide whether to grant a request to withdraw.
- F.** An applicant shall send written notice to the Board within 10 days from the date of any change of applicant's address.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

Type of Approval	Statutory Authority	Administrative Completeness Time-frame	Substantive Review Time-frame	Overall Time-frame
License by Examination (R4-18-202)	A.R.S. §§ 32-1504(A), 32- 1522, 32-1523, 32-1523.01, 32-1524	90 days	90 days	180 days

License by Endorsement (R4-18-203)	A.R.S. §§ 32-1504(A), 32- 1523	60 days	60 days	120 days
Specialist Certificate (R4-18-204)	A.R.S. §§ 32-1504(B)(3), 32-1529	60 days	60 days	120 days
Annual Renewal of License (R4-18-206)	A.R.S. §§ 32-1504(A), 32- 1526	30 days	60 days	90 days
Certificate to Dispense	A.R.S. §§ 32-1504(A), 32- 1581	30 days	60 days	90 days
Annual Renewal of Certificate to Dispense	A.R.S. §§ 32-1504(A), 32- 1581	30 days	60 days	90 days
Certificate to Engage in a Clinical, Preceptor ship, Internship, or Postdoctoral Training Pro gram (R4-18-501)	A.R.S. §§ 32-1504(A), 32- 1560, 32-1561	30 days	60 days	90 days
Annual Renewal of Certificate to Engage in a Clinical, Preceptorship, Internship, or Postdoc toral Training Program (R4-18-502)	A.R.S. §§ 32-1504(A), 32- 1560, 32-1561	30 days	60 days	90 days
Certificate to Conduct a Clinical, Preceptor ship, Internship, or Postdoctoral Training Pro gram (R4-18-503)	A.R.S. §§ 32-1501, 32- 1504(A)	30 days	60 days	90 days
Annual Renewal of Certificate to Conduct a Clinical, Preceptorship, Internship, or Postdoc toral Training Program (R4-18-504)	A.R.S. § 32-1504(A)	30 days	60 days	90 days
Medical Assistant Certificate	A.R.S. §§ 32-1504(A), 32- 1559	30 days	60 days	90 days
Annual Renewal of Medical Assistant Certifi cate	A.R.S. §§ 32-1504(A), 32- 1559	30 days	60 days	90 days

**Historical Note**

New Table made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

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**4 A.A.C. 18 Arizona Administrative Code** TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 18. NATUROPATHIC PHYSICIANS MEDICAL BOARD

**ARTICLE 8. EXPERIMENTAL MEDICINE**

**R4-18-801. Experimental Medicine**

A procedure, medication, or device is experimental if: 1. An Institutional review board exists for a particular procedure, medication, or device;  
2. The procedure, medication, or device is not generally

- considered to be within the accepted practice standards for the naturopathic profession; and
- The procedure, medication, or device is not part of the curriculum at an approved school of naturopathic medicine or approved postdoctoral training.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R.

3702, effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking at 19 A.A.R. 1302, effective July 6, 2013 (Supp. 13-2).

**R4-18-802. Informed Consent and Duty to Follow Protocols A.**

A physician, medical student engaged in an approved clinical training program, preceptee, or intern who conducts research involving an experimental procedure, medication, or device, shall ensure that all research subjects give informed consent to participate, which states:

1. Whether a physician, preceptee, or an intern is treating the patient;
2. That the patient or legal guardian of the patient under stands:
  - a. The type of treatment the patient is to receive; b. Each procedure that will be provided to the patient; c. The risks and benefits of each procedure, medication, or device to be provided;
  - d. That the patient can withdraw at any time; and e. That the patient is voluntarily participating; and
3. The physician, medical student engaged in the approved clinical training program, preceptee, or intern has established a protocol as required by subsection (B) that meets the requirements of the institutional review board that approved the protocol.

**B.** A physician, medical student engaged in an approved clinical training program, preceptee, or intern, who conducts research on humans involving an experimental procedure, medication, or device shall have a protocol for that research approved by an institutional review board.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking at 19 A.A.R. 1302, effective July 6, 2013 (Supp. 13-2).

**ARTICLE 9. CERTIFICATE TO DISPENSE**

**R4-18-901. Definitions**

The following definitions apply in this Article:

1. "Applicant" means:
  - a. An individual applying for a license and a certificate to dispense; or
  - b. A licensee requesting a certificate to dispense only.
2. "Auscultation" means the act of listening to sounds within the human body either directly or through the use of a stethoscope or other means.
3. "Certificate to dispense" means an approval granted by the Board to dispense a natural substance, drug, or device.
4. "Dispense" means the same as in A.R.S. § 32-1581(H).
5. "Drug" means the same as in A.R.S. § 32-1501(15).
6. "Hour" means 50 to 60 minutes of participation.
7. "Medical record" means the same as in A.R.S. § 12-2291.
8. "Nutrient" means the same as in A.R.S. § 32-1501(15)(a)(iii).
9. "Physical examination" means an evaluation of the health of an individual's body using inspection, palpation, percussion, and auscultation to determine cause of illness or

disease.

**Historical Note**

New Section made by final rulemaking at 19 A.A.R. 1302, effective July 6, 2013 (Supp. 13-2).

**R4-18-902. Qualifications for a Certificate to Dispense A.** To qualify for a certificate to dispense, an applicant shall have completed before the submission date of the application, Board approved training in the safe administration of natural substances, drugs, or devices.

- B.** The Board approves documentation of the following as evidence of completion of Board approved training in the safe administration of natural substances, drugs, or devices:
1. Graduation from an approved school of naturopathic medicine after January 1, 2005 as referenced in A.R.S. § 32-1525(B)(4); or
  2. Completion of a 60 hour or more pharmacological course on natural substances, drugs, or devices that is offered, approved, or recognized by one of the organizations in R4-18-205(B)(1) or R4-18-205(B)(2).
- C.** If an applicant intends to administer a natural substance or drug intravenously, the Board approved training completed by the applicant shall include administration of a natural substance or drug by intravenous means.

**Historical Note**

New Section made by final rulemaking at 19 A.A.R. 1302, effective July 6, 2013 (Supp. 13-2).

**R4-18-903. Application for a Certificate to Dispense; Renewal**

**A.** An applicant for a certificate to dispense shall submit:

1. An application to the Board that contains:
  - a. The applicant's:
    - i. Full name;
    - ii. Naturopathic license number, if known; and
    - iii. Social Security number;
  - b. If a corporation, a statement of whether the corporation holds tax exempt status;
  - c. A statement of whether the applicant holds a drug enforcement number issued by the United States Drug Enforcement Administration, and if so, the drug enforcement number;
  - d. A statement of whether the applicant has ever had the authority to prescribe, dispense, or administer a natural substance, drug, or device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency or court of law, and if so, an explanation that includes:
    - i. The name and address of the federal or state agency or court having jurisdiction over the matter, and
    - ii. The disposition of the matter;
  - e. A statement, signed by the applicant, that the applicant agrees to conform to all federal and state statutes, regulations, and rules; and
  - f. The date the application is submitted; and

2. Unless exempted by A.R.S. § 32-1530, the fee required by the Board.

**B.** An applicant for a naturopathic license may request a certificate to dispense as part of a naturopathic license application. When this request is made, approval of the naturopathic

license by the Board includes approval of the certificate to dispense.

**C.** A certificate holder shall renew a certificate to dispense on or before July 1 of each year by submitting:

1. An application to the Board that contains:
  - a. The applicant's full name;

- b. If a corporation, a statement of whether the corporation holds tax exempt status;
  - c. A statement of whether the applicant has had the authority to prescribe, dispense, or administer a natural substance, drug, device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency or court of law, during the one year period immediately preceding the renewal date and if so, an explanation that includes:
    - i. The name and address of the federal or state agency or court having jurisdiction over the matter; and
    - ii. The disposition of the matter; and
  - d. A statement, signed and dated by the applicant, verifying the information on the application is true and correct and the applicant is the licensee named on the application; and
2. Unless exempted by A.R.S. § 32-1530, the fee required by the Board.
- D.** The Board shall grant or deny the certificate to dispense or renewal of certificate to dispense according to the time-frames in 4 A.A.C. 18, Article 7, Table 1.

**Historical Note**

New Section made by final rulemaking at 19 A.A.R.

1302, effective July 6, 2013 (Supp. 13-2).

**R4-18-904. Dispensing; Intravenous Nutrients A.** To prevent toxicity due to the excessive intake of a natural substance, drug, or device, before dispensing the natural substance, drug, or device to an individual, a certified physician shall:

1. Conduct a physical examination of the individual,
2. Conduct laboratory tests as necessary that determine the potential for toxicity of the individual, and
3. Document the results of the physical examination and laboratory tests in the individual's medical record.

**B.** For the purposes of A.R.S. § 32-1504(A)(8), a substance is considered a nutrient suitable for intravenous administration if it complies with A.R.S. § 32-1501(15)(iii).

**Historical Note**

New Section made by final rulemaking at 19 A.A.R. 1302, effective July 6, 2013 (Supp. 13-2). Amended by emergency rulemaking at 21 A.A.R. 51, effective December 18, 2014, for 180 days (Supp. 14-4). Emergency renewed at 21 A.A.R. 928, effective June 5, 2015, for 180 days (Supp. 15-2). Amended by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3).

**§ 32-1501. Definitions**

In this chapter, unless the context otherwise requires:

1. "Accepted therapeutic purpose" means treatment of a disease, injury, ailment or infirmity that is competent and generally recognized as safe and effective.
2. "Active license" means a current valid license to practice naturopathic medicine.
3. "Adequate medical records" means legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, describe the treatment, accurately document the results, indicate advice and cautionary warning provided to the patient and provide sufficient information for a similarly qualified practitioner to assume continuity of the patient's care at any point in the course of treatment.
4. "Approved clinical training program" or "clinical training program" means a program for naturopathic medical students in which the training occurred or is being conducted by or in conjunction with an approved school of naturopathic medicine.
5. "Approved internship program" or "internship" means that the program in which the training occurred or is being conducted has been approved for internship training for physicians or for graduates of a school of naturopathic medicine by the board or was approved or accredited by an educational or professional association recognized by the board or by another state's or country's licensing agency recognized by the board.
6. "Approved postdoctoral training" or "postdoctoral training" means that the program in which the training occurred or is being conducted has been approved for specialty training or for graduate medical education in naturopathic medicine by the board or approved or accredited by an educational or professional association recognized by the board or by another state's or country's licensing agency recognized by the board.
7. "Approved preceptorship program" or "preceptorship" means that the program in which the training occurred or is being conducted has been approved for preceptorship training for physicians or for graduates of a school of naturopathic medicine by the board or was approved or accredited by an educational or professional association recognized by the board or by another state's or country's licensing agency recognized by the board.
8. "Approved school of naturopathic medicine" or "school of naturopathic medicine" means a school or college determined by the board to have an

educational program that meets standards prescribed by the council on naturopathic medical education, or its successor agency, and that offers a course of study that, on successful completion, results in the awarding of the degree of doctor of naturopathic medicine and whose course of study is either of the following:

(a) Accredited or a candidate for accreditation by an accrediting agency recognized by the United States secretary of education as a specialized accrediting agency for schools of naturopathic medicine or its successor.

(b) Accredited or a candidate for accreditation by an accrediting agency recognized by the council for higher education accreditation or its successor.

9. "Board" means the naturopathic physicians medical board.

10. "Chelation therapy" means an experimental medical therapy to restore cellular homeostasis through the use of intravenous, metal-binding and bioinorganic agents such as ethylene diamine tetraacetic acid. Chelation therapy does not include experimental therapy used to treat heavy metal poisoning.

11. "Completed application" means that the applicant paid the required fees and supplied all documents and information as requested by the board and in a manner acceptable to the board.

12. "Controlled substance" means a drug, substance or immediate precursor in schedules I through V of title 36, chapter 27, article 2 or the rules adopted pursuant to title 36, chapter 27, article 2.

13. "Direct supervision" means that a physician who is licensed pursuant to this chapter or chapter 13, 17 or 29 of this title:

(a) Is physically present and within sight or sound of the person supervised and is available for consultation regarding procedures that the physician has authorized and for which the physician remains responsible.

(b) Has designated a person licensed pursuant to this chapter or chapter 13, 17 or 29 of this title to provide direct supervision in the physician's absence.

14. "Doctor of naturopathic medicine" or "doctor" means a natural person who is licensed to practice naturopathic medicine under this chapter.

15. "Drug" has the same meaning prescribed in section 32-1901 but does not include:

(a) Intravenous administration of legend drugs, except for:

(i) Vitamins, chelation therapy and drugs used in emergency resuscitation and stabilization.

(ii) Minerals.

(iii) Nutrients. For the purposes of this item, "nutrient" means a substance that provides nourishment for growth or metabolism and that is manufactured and supplied for intravenous use by a manufacturer registered with the United States food and drug administration or compounded by a pharmacy licensed by the Arizona state board of pharmacy.

(b) Controlled substances listed as schedule I or II controlled substances as defined in the federal controlled substances act of 1970 (21 United States Code section 802), except morphine, any drug that is reclassified from schedule III to schedule II after January 1, 2014 and any homeopathic preparations that are also controlled substances.

(c) Cancer chemotherapeutics classified as legend drugs.

(d) Antipsychotics.

16. "General supervision" means that the physician is available for consultation regarding procedures that the physician has authorized and for which the physician remains responsible.

17. "Legend drug" means any drug that is defined by section 503(b) of the federal food, drug, and cosmetic act and under which definition its label is required to bear the statement "Rx only".

18. "Letter of concern" means a nondisciplinary advisory letter that is issued by the board to a person who is regulated under this chapter and that states that while there is insufficient evidence to support disciplinary action the board believes that the person should modify or eliminate certain practices and that continuation of the activities that led to the information being submitted to the board may result in action against the person's license, certificate or registration.

19. "Letter of reprimand" means a disciplinary letter that is issued by the board and that informs a person who is regulated under this chapter that the person's conduct violates state or federal law but does not require the board to restrict the person's license, certificate or registration because the person's conduct did not result in harm to a patient or to the public.

20. "Limit" means taking a nondisciplinary action that alters the physician's practice or professional activities if the board determines that there is

evidence that the physician is or may be mentally or physically unable to safely engage in the practice of medicine.

21. "Medical assistant" or "naturopathic medical assistant" means a person who is certified by the board as a medical assistant, who assists a doctor of naturopathic medicine and who may perform delegated procedures that are commensurate with the assistant's education and training under the direct supervision of a doctor of naturopathic medicine and that do not include diagnosing, designing or modifying established treatment programs or those procedures prohibited by the board or by this chapter.

22. "Medically incompetent" means a person who is licensed, certified or registered pursuant to this chapter and who lacks sufficient naturopathic medical knowledge or skills, or both, to a degree that is likely to endanger the health of patients.

23. "Natural substance" means a homeopathic, botanical, nutritional or other supplement that does not require a prescription pursuant to federal law before it is prescribed, dispensed or otherwise furnished to a patient and that is prescribed by a physician who is licensed pursuant to this chapter to enhance health, prevent disease or treat a medical condition diagnosed by the physician.

24. "Naturopathic medical student" means a person who is enrolled in a course of study at an approved school of naturopathic medicine.

25. "Naturopathic medicine" means medicine as taught in approved schools of naturopathic medicine and in clinical, internship, preceptorship and postdoctoral training programs approved by the board and practiced by a recipient of a degree of doctor of naturopathic medicine licensed pursuant to this chapter.

26. "Nurse" means a person who is licensed pursuant to chapter 15 of this title.

27. "Physician" means a doctor of naturopathic medicine who is licensed pursuant to this chapter.

28. "Practice of naturopathic medicine" means a medical system of diagnosing and treating diseases, injuries, ailments, infirmities and other conditions of the human mind and body, including by natural means, drugless methods, drugs, nonsurgical methods, devices, physical, electrical, hygienic and sanitary measures and all forms of physical agents and modalities.

29. "Restrict" means taking a disciplinary action that alters the physician's practice or professional activities if the board determines that there is evidence that the physician is or may be medically incompetent or guilty of unprofessional conduct.
30. "Specialist" means a physician who has successfully completed approved postdoctoral training, who is certified by a specialty board of examiners recognized by the board and who is certified by the board to practice the specialty pursuant to this chapter.
31. "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere:
- (a) Intentionally disclosing a professional secret or intentionally disclosing a privileged communication except as either of these may otherwise be required by law.
  - (b) Engaging in any dishonorable conduct reflecting unfavorably on the profession.
  - (c) Committing a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case conviction by any court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission of the felony or misdemeanor.
  - (d) Habitual intemperance in the use of alcohol or any substance abuse.
  - (e) Engaging in the illegal use of any narcotic or hypnotic drugs, or illegal substances.
  - (f) Engaging in conduct that the board determines is gross malpractice, repeated malpractice or any malpractice resulting in the death of a patient.
  - (g) Impersonating another doctor of naturopathic medicine or any other practitioner of the healing arts.
  - (h) Falsely acting or assuming to act as a member, an employee or an authorized agent of the board.
  - (i) Procuring or attempting to procure a license or a certificate pursuant to this chapter by fraud, by misrepresentation or by knowingly taking advantage of the mistake of another person or agency.
  - (j) Having professional connection with or lending one's name to enhance or continue the activities of an illegal physician or an illegal practitioner of any healing art.

- (k) Representing that a manifestly incurable disease, injury, ailment or infirmity can be permanently cured, or falsely or fraudulently representing that a curable disease, injury, ailment or infirmity can be cured within a stated time.
- (l) Offering, undertaking or agreeing to cure or treat a disease, injury, ailment or infirmity by a secret means, method, treatment, medicine, substance, device or instrumentality.
- (m) Refusing to divulge to the board on demand the means, method, treatment, medicine, substance, device or instrumentality used in the treatment of a disease, injury, ailment or infirmity.
- (n) Giving or receiving, or aiding or abetting the giving or receiving of, rebates, either directly or indirectly.
- (o) Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of naturopathic medicine or any naturopathic treatment method.
- (p) Engaging in immorality or misconduct that tends to discredit the naturopathic profession.
- (q) Having a license refused, revoked or suspended by any other state, district or territory of the United States or any other country, unless it can be shown that this action was not due to reasons that relate to the ability to safely and skillfully practice as a doctor of naturopathic medicine or to any act of unprofessional conduct in this paragraph.
- (r) Engaging in any conduct or practice that is contrary to recognized standards of ethics of the naturopathic profession, any conduct or practice that does or might constitute a danger to the health, welfare or safety of the patient or the public, or any conduct, practice or condition that does or might impair the ability to safely and skillfully practice as a doctor of naturopathic medicine.
- (s) Failing to observe any federal, state, county or municipal law relating to public health as a physician in this state.
- (t) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate this chapter or board rules.
- (u) Committing false, fraudulent, deceptive or misleading advertising or advertising the quality of a medical or health care service by a physician or by the physician's staff, employer or representative.

(v) Failing or refusing to maintain adequate medical records on a patient or failing or refusing to make medical records in the physician's possession promptly available to another physician or health care provider who is licensed pursuant to chapter 7, 8, 13, 15, 17 or 29 of this title on request and receipt of proper authorization to do so from the patient, a minor patient's parent, the patient's legal guardian or the patient's authorized representative or failing to comply with title 12, chapter 13, article 7.1.

(w) Referring a patient to a diagnostic or treatment facility or prescribing goods and services without disclosing in writing to the patient that the physician has a pecuniary interest in the facility, goods or services to which the patient is referred or prescribed. This subdivision does not apply to a referral by one physician or practitioner to another physician or practitioner within a group of physicians or practitioners practicing together.

(x) Engaging in sexual intimacies with a patient in the course of direct treatment.

(y) Failing to dispense drugs and devices in compliance with article 4 of this chapter.

(z) Administering, dispensing or prescribing any drug or a device for other than an accepted therapeutic purpose.

(aa) Falsely representing or holding oneself out as being a specialist or representation by a doctor of naturopathic medicine or the doctor's staff, employer or representative that the doctor is boarded or board certified if this is not true or that standing is not current.

(bb) Delegating professional duties and responsibilities to a person if the person has not been approved or qualified by licensure or by certification to perform these duties or responsibilities.

(cc) Failing to appropriately supervise a naturopathic medical student, a nurse, a medical assistant, a health care provider or a technician who is employed by or assigned to the physician during the performance of delegated professional duties and responsibilities.

(dd) Using experimental forms of diagnosis or treatment without adequate informed consent of the patient or the patient's legal guardian and without conforming to experimental criteria, including protocols, detailed records, periodic analysis of results and periodic review by a medical peer review committee as approved by the United States food and drug administration or its successor agency.

(ee) Failing to furnish information in a timely manner to the board or investigators or representatives of the board if this information is legally requested by the board and failing to allow properly authorized board personnel on demand to examine and have access to documents, reports and records maintained by the physician that relate to the physician's medical practice or medically related activities.

(ff) Failing to report in writing to the board evidence that a person who is licensed, certified or registered pursuant to this chapter is or may be medically incompetent, guilty of unprofessional conduct or mentally or physically unable to safely practice or assist in the practice of naturopathic medicine.

(gg) Conducting or engaging in an internship, preceptorship or clinical training program in naturopathic medicine without being approved and registered by the board for that internship, preceptorship or clinical training program.

(hh) Signing a blank, undated or predated prescription form.

(ii) Engaging in conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm or death to a patient.

(jj) Knowingly making a false or misleading statement in oral testimony to the board on a form required by the board or in written correspondence to the board, including attachments to that correspondence.

(kk) The failure of a physician who is the chief medical officer, the executive officer or the chief of staff of an internship, a preceptorship or a clinical training program to report in writing to the board that the privileges of a doctor of naturopathic medicine, a naturopathic medical student or a medical assistant have been denied, limited, revoked or suspended because that doctor's, student's or assistant's actions appear to indicate that the person is or may be medically incompetent, is or may be guilty of unprofessional conduct or is or may be unable to safely engage or assist in the practice of naturopathic medicine.

(ll) Having action taken against a doctor of naturopathic medicine by a licensing or regulatory board in another jurisdiction due to that doctor's mental or physical inability to engage safely in the practice of naturopathic medicine or the doctor's medical incompetence or for unprofessional conduct as defined by that licensing or regulatory board and that corresponds directly or indirectly to an act of unprofessional conduct prescribed by this paragraph. The action taken may include refusing, denying, revoking or suspending a license, otherwise limiting, restricting or

monitoring a licensee or placing a licensee on probation by that licensing or regulatory board.

(mm) Having sanctions imposed by an agency of the federal government, including restricting, suspending, limiting or removing a person from the practice of naturopathic medicine or restricting that person's ability to obtain financial remuneration.

(nn) Violating any formal order, probation, consent agreement or stipulation issued or entered into by the board pursuant to this chapter.

(oo) Refusing to submit to a body fluid examination pursuant to a board investigation of alleged substance abuse by a doctor of naturopathic medicine.

(pp) Charging a fee for services not rendered or dividing a professional fee for patient referrals among health care providers or health care institutions or between these providers and institutions or a contractual arrangement that has this effect.

(qq) Obtaining a fee by fraud, deceit or misrepresentation.

(rr) Charging or collecting a clearly excessive fee. In determining whether a fee is clearly excessive, the board shall consider the fee or range of fees customarily charged in this state for similar services, in light of modifying factors such as the time required, the complexity of the service and the skill required to perform the service properly. This subdivision does not apply if there is a clear written contract for a fixed fee between the physician and the patient that was entered into before the service was provided.

(ss) With the exception of heavy metal poisoning, using chelation therapy in the treatment of arteriosclerosis or as any other form of therapy without adequate informed patient consent and without conforming to generally accepted experimental criteria, including protocols, detailed records, periodic analysis of results and periodic review by a medical peer review committee.

(tt) Using a controlled substance unless it is prescribed by another physician for use during a prescribed course of treatment.

(uu) Prescribing, dispensing or administering anabolic androgenic steroids for other than therapeutic purposes.

(vv) Except in an emergency or urgent care situation, prescribing or dispensing a controlled substance to a member of the naturopathic physician's immediate family.

(ww) Prescribing, dispensing or furnishing a prescription medication or a prescription-only device as defined in section 32-1901 to a person unless the licensee first conducts a physical examination of that person or has previously established a doctor-patient relationship. The physical examination may be conducted during a real-time telemedicine encounter with audio and video capability unless the examination is for the purpose of obtaining a written certification from the physician for the purposes of title 36, chapter 28.1. This subdivision does not apply to:

(i) A licensee who provides temporary patient supervision on behalf of the patient's regular treating licensed health care professional.

(ii) An emergency medical situation as defined in section 41-1831.

(iii) Prescriptions written to prepare a patient for a medical examination.

(iv) Prescriptions written or prescription medications issued for use by a county or tribal public health department for immunization programs or emergency treatment or in response to an infectious disease investigation, a public health emergency, an infectious disease outbreak or an act of bioterrorism. For the purposes of this item, "bioterrorism" has the same meaning prescribed in section 36-781.

(v) Prescriptions written or antimicrobials dispensed to a contact as defined in section 36-661 who is believed to have had significant exposure risk as defined in section 36-661 with another person who has been diagnosed with a communicable disease as defined in section 36-661 by the prescribing or dispensing physician.

(vi) Prescriptions written by a licensee through a telemedicine program that is covered by the policies and procedures adopted by the administrator of a hospital or outpatient treatment center.

(xx) If medical treatment is considered experimental or investigational, failing to include in a patient's record a consent to treatment document that is signed by the patient or the patient's parent or legal guardian and that indicates that the patient or the patient's parent or legal guardian has been informed of the risk of any treatment to be provided and the expected cost of that treatment.

(yy) When issuing a written certification as defined in section 36-2801, failing or refusing to include in the adequate medical records of a patient a copy of all of the following:

(i) The medical records relied on by the physician to support the diagnosis or confirmed diagnosis of the patient's debilitating medical condition.

(ii) The written certification.

(iii) The patient's profile on the Arizona board of pharmacy controlled substances prescription monitoring program database.

(zz) Dispensing a schedule II controlled substance that is an opioid.

**History:**

Amended by L. 2021, ch. 61,s. 5, eff. 9/29/2021. Amended by L. 2018, ch. 243,s. 3, eff. 8/3/2018. Amended by L. 2017, ch. 164,s. 2, eff. 8/9/2017. Amended by L. 2014, ch. 122,s. 2, eff. 7/24/2014. Amended by L. 2014, ch. 102,s. 2, eff. 7/24/2014.

**§ 32-1502. Naturopathic physicians medical board; appointment; qualifications; term of office; immunity**

A. The naturopathic physicians medical board is established consisting of the following members:

1. Four physician members appointed by the governor. Each physician member shall be:

(a) A resident of this state for at least five years immediately preceding the appointment.

(b) A doctor of naturopathic medicine with a degree from a naturopathic school or college approved by the board who has engaged in full-time practice of naturopathic medicine for at least five years immediately preceding the appointment.

2. Three public members appointed by the governor. Each public member shall:

(a) Be a resident of this state for at least five years immediately preceding the appointment.

(b) Not be connected, in any manner, with or have any interest in a school of medicine, a health care institution or any person practicing any form of healing or treatment of bodily or mental ailments.

(c) Demonstrate an interest in the health problems in this state.

B. Before appointment by the governor, a prospective member of the board shall submit a full set of fingerprints to the governor for the purpose of obtaining a state and federal criminal records check pursuant to section 41-1750 and Public Law 92-544. The department of public safety may exchange this fingerprint data with the federal bureau of investigation.

C. The terms of office of the physician members and the public members are five years to begin and end on June 30. Each physician member and each public member continue to hold office until the appointment and qualification of their successors, subject to the following exceptions:

1. A member of the board may be removed from office if the governor finds the member was guilty of malfeasance, misfeasance or dishonorable conduct.

**ARS 32-1502 Naturopathic physicians medical board;  
appointment; qualifications; term of office; immunity (Arizona  
Revised Statutes (2023 Edition))**

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2. The term of any member automatically ends on resignation, permanent removal from this state or removal from this state for a period of more than six months.

D. There shall be no monetary liability on the part of and no cause of action shall arise against the members of the board, the secretary-treasurer or permanent or temporary personnel of the board for any act done or proceeding undertaken or performed in good faith and in furtherance of the purposes of this chapter.

**History:**

Amended by L. 2017, ch. 327,s. 8, eff. 8/9/2017.

**§ 32-1503. Board organization; meetings; compensation;  
committees**

- A. The board shall annually elect, from among its membership, a chairman, a vice-chairman and a secretary-treasurer, who shall hold their respective offices at the pleasure of the board.
- B. The board shall hold a regular meeting at least semiannually on a date and at a time and place it designates. In addition, the board may hold special meetings it deems necessary.
- C. A majority of the members of the board constitutes a quorum, and a majority vote of a quorum present at any meeting governs all actions taken by the board, except as provided in section 32-1525, subsection G and section 32-1526, subsection A.
- D. Members of the board are eligible to receive compensation established by the board of not more than one hundred fifty dollars for each day of actual service in the business of the board.
- E. In order to carry out the board's duties and functions, the chairman may establish committees from the board membership and define the duties of these committees.

**§ 32-1504. Powers and duties**

A. The board shall:

1. Adopt rules that are necessary or proper for the administration of this chapter.
2. Administer and enforce all provisions of this chapter and all rules adopted by the board under the authority granted by this chapter.
3. Adopt rules regarding the qualifications of medical assistants who assist doctors of naturopathic medicine and shall determine the qualifications of medical assistants who are not otherwise regulated.
4. Adopt rules for the approval of schools of naturopathic medicine. The board may incorporate by reference the accrediting standards for naturopathic medical schools published by accrediting agencies recognized by the United States department of education or recognized by the council for higher education accreditation.
5. Adopt rules relating to clinical, internship, preceptorship and postdoctoral training programs, naturopathic graduate medical education and naturopathic continuing medical education programs. The rules for naturopathic continuing medical education programs shall require at least ten hours each year directly related to pharmacotherapeutics.
6. Periodically inspect and evaluate clinical, internship, preceptorship and postdoctoral training programs and naturopathic graduate medical education programs and randomly evaluate naturopathic continuing medical education programs.
7. Adopt rules relating to the dispensing of natural substances, drugs and devices.
8. Adopt rules necessary for the safe administration of intravenous nutrients. These rules shall identify and exclude substances that do not meet the criteria of nutrients suitable for intravenous administration.
9. Adopt and use a seal.
10. Have the full and free exchange of information with the licensing and disciplinary boards of other states and countries and with the American association of naturopathic physicians, the Arizona naturopathic medical association, the association of naturopathic medical colleges, the federation of naturopathic medical licensing boards and the naturopathic medical

societies of other states, districts and territories of the United States or other countries.

B. The board may:

1. Adopt rules that prescribe annual continuing medical education for the renewal of licenses issued under this chapter.
2. Employ permanent or temporary personnel it deems necessary to carry out the purposes of this chapter and designate their duties.
3. Adopt rules relating to naturopathic medical specialties and determine the qualifications of doctors of naturopathic medicine who may represent or hold themselves out as being specialists.
4. If reasonable cause exists to believe that the competency of an applicant or a person who is regulated by the board is in question, require that person to undergo any combination of physical, mental, biological fluid and laboratory tests.
5. Be a dues paying member of national organizations that support licensing agencies in their licensing and regulatory duties and pay the travel expenses involved for a designated board member or the executive director to represent the board at the annual meeting of these organizations.
6. Adopt rules for conducting licensing examinations required by this chapter.
7. Delegate to the executive director the board's authority pursuant to sections 32-1509 and 32-1551.

**§ 32-1505. Naturopathic physicians medical board fund**

A. The naturopathic physicians medical board fund is established. The board shall administer the fund. Pursuant to sections 35-146 and 35-147, the board shall deposit ten per cent of all monies from whatever source that come into the possession of the board in the state general fund and deposit the remaining ninety per cent in the naturopathic physicians medical board fund.

B. Monies deposited in the naturopathic physicians medical board fund are subject to section 35-143.01.

**History:**

Amended by L. 2015, ch. 108,s. 1, eff. 4/16/2013, retroactive.

**§ 32-1507. Change in status; assessment of costs**

A. Each person who holds a license or certificate pursuant to this chapter shall inform the board in writing, within thirty days, of any change in status of that person's initial application including any change of name, residence, practice address and telephone number and of each subsequent change of status. A licensee's or a certificate holder's residential address and residential telephone number or numbers are not available to the public unless they are the only address and numbers of record.

B. The board may assess the costs incurred by the board in locating a person who is licensed or certified pursuant to this chapter to that person.

C. The board shall deposit, pursuant to sections 35-146 and 35-147, monies collected pursuant to this section in the naturopathic physicians medical board fund.

**§ 32-1508. Display of licenses and certificates**

A. A person who holds a license or certificate pursuant to this chapter shall display that document in a conspicuous place that is accessible to view by the public.

B. A person who practices, conducts affairs or is employed at more than one location and who maintains a continuing activity as authorized by the license or certificate shall display a duplicate of that document issued by the board at each location.

**§ 32-1509. Executive director; compensation; duties**

A. Subject to title 41, chapter 4, article 4, the board shall appoint an executive director who serves at the pleasure of the board. The executive director shall not be a board member and shall not have any financial interests in the practice of naturopathic medicine or the training of naturopathic physicians. The board may authorize the executive director to represent the board and to vote on behalf of the board at meetings of national organizations of which the board is a dues paying member.

B. The executive director and other board staff are eligible to receive compensation as determined pursuant to section 38-611.

C. The executive director or that person's designee shall:

1. Subject to title 41, chapter 4, article 4 and, as applicable, articles 5 and 6, employ, evaluate, dismiss, discipline and direct professional, clerical, technical, investigative and administrative personnel necessary to carry on the work of the board.

2. As directed by the board, prepare and submit recommendations to the board for amendments to this chapter for consideration by the legislature.

3. Subject to title 41, chapter 4, article 4, employ medical consultants and agents necessary to conduct investigations, gather information and perform those duties the executive director determines are necessary and appropriate to enforce this chapter.

4. Issue licenses and certificates pursuant to section 32-1526 to applicants who meet the requirements of this chapter.

5. Maintain a record of board actions and proceedings, including the issuance, denial, renewal, suspension or revocation of licenses and certificates.

6. Manage the board's offices.

7. Prepare minutes, records, reports, registries, directories, books and newsletters and record all board transactions and orders.

8. Collect all monies due and payable to the board.

9. Pay all bills for authorized expenditures of the board and its staff.

10. Prepare an annual budget.

11. Submit a copy of the budget each year to the governor, the speaker of the house of representatives and the president of the senate.
12. Initiate an investigation if evidence appears to demonstrate that a person licensed or certified by the board may be engaged in unprofessional conduct or may be medically incompetent or mentally or physically unable to safely practice medicine.
13. Issue subpoenas if necessary to compel the attendance and testimony of witnesses and the production of books, records, documents and other evidence.
14. Sign and execute and provide assistance to the attorney general in preparing disciplinary orders, rehabilitative orders and notices of hearings as directed by the board.
15. Enter into contracts for goods and services pursuant to title 41, chapter 23 that are necessary to carry out board policies and directives.
16. Execute board directives.
17. Represent the board with the federal government, other states or jurisdictions of the United States, this state, political subdivisions of this state, the news media and the public.
18. Maintain a roster of all persons who are licensed or certified under this chapter that indicates:
  - (a) The person's name.
  - (b) The person's current address of record.
  - (c) The date of issuance and the number of the person's license or certificate.
  - (d) The status of the person's license or certificate.
19. Maintain an accurate account of all receipts, expenditures and refunds granted pursuant to this chapter.
20. Conduct periodic inspection of the dispensing practices and the prescribing practices of doctors of naturopathic medicine and report dispensing and prescribing restrictions imposed by the board against doctors of naturopathic medicine to other state and federal regulatory agencies.

21. Affix the seal of the board to necessary documents. The imprint of the seal with the signature of the executive director is evidence of official board action.
  22. On behalf of the board, enter into stipulated agreements with persons who are under the jurisdiction of the board for the treatment, rehabilitation and monitoring of chemical substance abuse or misuse.
  23. Review all complaints filed pursuant to section 32-1551. If delegated by the board, the executive director may dismiss complaints.
  24. If delegated by the board, refer cases directly to a formal interview or a formal hearing.
  25. If delegated by the board, enter into a consent agreement if there is evidence of danger to the public health and safety.
  26. If delegated by the board, grant uncontested requests for retired status or cancellation of a license.
  27. Perform all other duties required by the board.
- D. Medical consultants and agents appointed pursuant to subsection C, paragraph 3 of this section are eligible to receive compensation determined by the executive director of not more than two hundred dollars for each day of service.
- E. A person who is aggrieved by an action taken by the executive director may request a board review of that action by filing with the board a written request within thirty days after that person has been notified of the action. Notification shall be by personal delivery or certified mail to the person's last known address on file with the board. The board shall review the decision at its next regularly scheduled meeting and either approve, modify or reject the executive director's action.

**History:**

L12, ch 321, sec 54.

**DEPARTMENT OF TRANSPORTATION**  
Title 17, Chapter 4, Articles 8



# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

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**MEETING DATE:** Mar 7, 2023

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** Feb 28, 2023

**SUBJECT:** ARIZONA DEPARTMENT OF TRANSPORTATION  
Title 17, Chapter 4 Article 8

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### Summary

This Five Year Review Report (5YRR) from the Arizona Department of Transportation relates to three (3) rules and one (1) table in Title 17, Chapter 4, Articles 8 (Motor Vehicle Records). Rule 801 relates to definitions, rule 802 relates to motor vehicle records requests, rule 803 relates to record copy charges, and Table 1 relates to certified and uncertified motor vehicle record fees.

### Proposed Action

In the last 5YRR, approved by the Council in March 2018, the Department had agreed to complete a rulemaking by December 2018 and completed this rulemaking as projected. In the current 5YRR, the Department proposes to amend the rules identified in subsection 5 via expedited rulemaking that they will request upon approval of this 5YRR and hope to submit a notice of final expedited rulemaking by September 2023.

#### **1. Has the agency analyzed whether the rules are authorized by statute?**

The Department cites both general and specific statutory authority for these rules.

**2. Summary of the agency's economic impact comparison and identification of stakeholders:**

These rules were last amended by expedited rulemaking in 2018 (24 A.A.R. 3498, December 21, 2018); and an economic, small business and consumer impact statement was not required. The last full economic, small business and consumer impact statement completed for A.A.C. R17-4-801 and A.A.C. R17-4-802 was for the rulemaking completed in 2007 (13 A.A.R. 4376, December 14, 2007). A.A.C. R17-4-803 and Table 1 were added in the 2018 rulemaking, but previously existed as A.A.C. R17-1-202 and Table 1, and had been added and amended through exempt rulemaking previously so economic, small business and consumer impact statements were not included with those rulemakings.

The economic impact of these rules has remained essentially the same as indicated in the 2007 economic, small business and consumer impact statement. At that time the Department stated there were no costs imposed by this rulemaking other than the resources necessary for promulgating the rule and there was an unquantifiable benefit to persons interested in requesting a motor vehicle record (MVR) as the rules clarify the requirements and restrictions for requesting an MVR.

**3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

In rulemaking, the Department routinely adopts the least costly and burdensome options for any process or procedure required of the regulated public or industry. Costs to persons regulated by these rules are minimal and include the costs associated with completing a request form provided by the Department and providing the Department with all required documentation in support of the records request. The Department believes that these rules impose no significant burden or costs to persons regulated by the rules, other than the minimal fee authorized by statute and prescribed by the rule. The highest fee charged is \$5 per record, which is required under A.R.S. § 28-446. The Department provides requesters the ability to request an MVR electronically, by mail, or in person at a Motor Vehicle Division customer service office or an authorized third party. The Department has determined that the rules in Article 8 impose the least burden and costs to persons regulated by the rules, including paperwork and other compliance costs necessary to achieve the underlying objectives.

**4. Has the agency received any written criticisms of the rules over the last five years?**

The Department indicates that they have not received any written criticisms of the rules in the last five years.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability?**

The Department states the rules are not clear, concise, and understandable and should be updated as follows:

R17-4-801: update terminology to be consistent with current nomenclature

R17-4-802: add subsection to provide clarity to the MVR request process.

R17-4-802(A) and (B): remove verbiage for clarity

R17-4-802(C): add language to available MVR types, reliable “commercial driver license record” as “extended commercial driver license record,” and reorganize record types in alphabetical order.

R17-4-802(D): remove this subsection in an effort to streamline this rule

R17-4-802(E): remove and add verbiage for clarity, correct the A.R.S. § 28-455(C)(13) reference to (C)(12) and add A.R.S. § 28-455(C)(11).

R17-4-802(F): remove this subsection to comply with Laws 2021, Chapter 335.

Table 1: remove verbiage for clarity

**6. Has the agency analyzed the rules’ consistency with other rules and statutes?**

The Department indicates that the rules are generally consistent with other rules and statutes with the following exceptions:

R17-4-802(E) and (F): Laws 2021, Chapter 335, removed guidelines, relating to providing express consent of the release of personal information through an opt-in process. Therefore the rules are inconsistent with A.R.S. § 28-455.

**7. Has the agency analyzed the rules’ effectiveness in achieving its objectives?**

The Department states the rules are effective in achieving their objective.

**8. Has the agency analyzed the current enforcement status of the rules?**

The Department indicates that the rules are generally enforced as they are written with the following exceptions:

R17-4-802(E) and (F): Laws 2021, Chapter 335, removed guidelines, relating to providing express consent of the release of personal information through an opt-in process. Therefore the rules are inconsistent with A.R.S. § 28-455.

**9. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Department indicates the rules are not more stringent than a corresponding federal law.

**10. For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

The Department indicates these rules do not require the issuance of a permit, license, or agency authorization.

**11. Conclusion**

As mentioned above, the Department indicates that the rules are generally effective in achieving their objective; consistent with other rules and statutes; and enforced as they are written.

The Department is ready to initiate an expedited rulemaking to implement the changes identified above upon approval of this report and intends to submit a notice of final expedited rulemaking by September 2023.

For these reasons, Council staff believe the Department has submitted an adequate report and recommends approval.

Director's Office

**Douglas A. Ducey**, Governor  
**John S. Halikowski**, Director  
**Kismet Weiss**, Deputy Director/Chief Operating Officer  
**Gregory Byres**, Deputy Director for Transportation

December 22, 2022

Ms. Nicole Sornsins, Chair  
Governor's Regulatory Review Council  
100 N 15th Avenue, Suite 305  
Phoenix, Arizona 85007

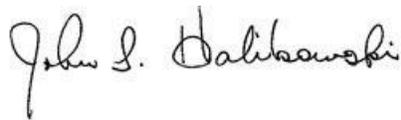
Re: Arizona Department of Transportation, 17 A.A.C. Chapter 4, Article 8, Five-Year Review Report

Dear Ms. Sornsins:

The Arizona Department of Transportation submits for Council approval the accompanying Five-year Review Report of 17 A.A.C. Chapter 4, Article 8, which is due on December 30, 2022. This document complies with all requirements under A.R.S. § 41-1056 and A.A.C. R1-6-301. The Department hereby certifies that it is in full compliance with the requirements of A.R.S. § 41-1091.

For information regarding the report, please communicate directly with Candace Olson, Rules Analyst, at (480) 267-6610 or at COLson2@azdot.gov.

Sincerely,



John S. Halikowski  
Director

Enclosure: ADOT Five-year Review Report



# Rules and Policy Development

**A.A.C. Title 17 – Transportation**

**Chapter 4**

**Department of Transportation**

**Title, Registration, and Driver Licenses**

**Article 8 – Motor Vehicle Records**

## **Five-Year Review Report**

***Douglas A. Ducey***

***Governor***

***John S. Halikowski***

***ADOT Director***

**Arizona Department of Transportation**

**Five-Year Review Report**

**17 A.A.C. Chapter 4, Article 8**

**December 2022**

**1. Authorization of the rule by existing statutes**

General Statutory Authority: A.R.S. § 28-366

Specific Statutory Authority: A.R.S. §§ 28-446, 28-449, 28-455, and 28-458

**2. The objective of each rule:**

Rule	Objective
R17-4-801	This rule provides industry representatives and the public with a better understanding of terms specific to the rules contained in this Article.
R17-4-802	This rule identifies the requirements for requesting and releasing a motor vehicle record (MVR).
R17-4-803	This rule provides the fees charged by the Department for copies of the various types of records the Department is statutorily required to maintain.

**3. Are the rules effective in achieving their objectives? Yes X No**

**4. Are the rules consistent with other rules and statutes? Yes     No X**

Rule	Explanation
R17-4-802(E) and (F)	Laws 2021, Chapter 335, removed guidelines, including form provisions, relating to the opportunity to provide express consent of the release of personal information through an opt-in process, so the Consent To Release Motor Vehicle Record - General form as detailed in subsections (E) and (F) is inconsistent with A.R.S. § 28-455.

**5. Are the rules enforced as written? Yes     No X**

Rule	Explanation
R17-4-802(E) and (F)	Laws 2021, Chapter 335, removed guidelines, including form provisions, relating to the opportunity to provide express consent of the release of personal information through an opt-in process and as such the Department no longer uses a Consent To Release Motor Vehicle Record - General form as detailed in subsections (E) and (F).

**6. Are the rules clear, concise, and understandable? Yes     No X**

While the Department believes the rules under this Article are generally clear, concise, and understandable, the Department has determined that the following changes would improve consistency and clarity:

Rule	Explanation
R17-4-801	a. Commercial driver license record: Add the word “extended” to the term so that it

	<p>becomes “extended commercial driver license record” in order to update and be consistent with the terminology used by the Department.</p> <p>b. Requester: Replace the word “the” that is before “person” with an “a” for a grammatical change.</p>
R17-4-802	Add a new subsection stipulating the requirement to complete an applicable request form to provide clarity to the MVR request process.
R17-4-802(A) and (B)	Remove the verbiage, “of a motor vehicle record” that is after “requester” since this language is contained in the definition of “requester.”
R17-4-802(C)	Add language to include certified extended commercial driver license record and uncertified and certified photos as an available MVR type, relabel “commercial driver license record” as “extended commercial driver license record,” and reorganize the various types in an alphabetical order.
R17-4-802(D)	Remove this subsection in an effort to streamline this rule since this language is contained in the applicable request form and the search criteria is subjective to what the requester is able to provide in order to locate the correct record and this language as such is just a sample of the types of information that may be needed.
R17-4-802(E)	<p>a. Remove the verbiage, “motor vehicle record” from the subsection heading since the language is unnecessary.</p> <p>b. Correct the A.R.S. § 28-455(C)(13) reference to (C)(12) and add A.R.S. § 28-455(C)(11) as needing the Consent To Release Motor Vehicle Record - One-Time form instead of the Consent To Release Motor Vehicle Record - General form due to changes made by Laws 2021, Chapter 335.</p> <p>c. Add, “as provided by the Department” after the mention of the form in order to provide clarity of where the form comes from.</p> <p>d. Remove the verbiage regarding the general consent to release process since the Department no longer provides a general consent to release process due to Laws 2021, Chapter 335.</p>
R17-4-802(F)	Remove this subsection since the Department no longer provides a general consent to release process due to Laws 2021, Chapter 335.
Table 1	Remove the following verbiage, “Does not include...etc.,” after “any photocopied item” in the last row of the table since the language is unnecessary and unclear.

7. **Has the agency received written criticisms of the rules within the last five years?** Yes \_\_\_ No X

8. **Economic, small business, and consumer impact comparison:**

These rules were last amended by expedited rulemaking in 2018 (24 A.A.R. 3498, December 21, 2018); and an economic, small business and consumer impact statement was not required. The last full economic, small business and consumer impact statement completed for A.A.C. R17-4-801 and A.A.C. R17-4-802 was for the rulemaking completed in 2007 (13 A.A.R. 4376, December 14, 2007). A.A.C. R17-4-803 and Table 1 were added in the 2018 rulemaking, but previously existed as A.A.C. R17-1-202 and Table 1, and had been added and amended through exempt rulemaking previously so economic, small business and consumer impact statements were not included with those rulemakings.

The economic impact of these rules has remained essentially the same as indicated in the 2007 economic, small business and consumer impact statement. At that time the Department stated there were no costs imposed by this rulemaking other than the resources necessary for promulgating the rule and there was an unquantifiable benefit to persons interested in requesting an MVR as the rules clarify the requirements and restrictions for requesting an MVR.

Since the last rulemaking, the Department incurred substantial costs to complete the overhaul of the Motor Vehicle Division's computer systems, which included the databases, the computer programming, the ways the customer service representatives performed transactions, the shift of its online services from ServiceArizona to AZMVDNow, and the ways and types of data the Department is able to retrieve. These changes were not a result of any rulemaking, but due to a need of the Department to further modernize its systems and provide for better capabilities. This change did impact the interface for the Department's Motor Vehicle Division Electronic Data Services customers, but should not have caused any new costs since it didn't require any new equipment but would have had an impact on learning the new interface.

There is no economic impact of these rules on political subdivisions, businesses, private persons, and consumers and no additional administrative costs since there has not been any changes to the established fees and no new fees or operational requirements. The established fees required under Table 1 are in keeping with the requirements of A.R.S. §§ 12-351 and 28-446.

There is an unquantifiable benefit to persons interested in requesting an MVR as the rules clarify the requirements and restrictions for requesting an MVR and continues to enforce the security measures associated with the disclosure of personal information thus making an individual's personal information more secure. Those who may obtain an MVR must meet one of the permissible uses detailed under A.R.S. § 28-455. Some of these entities include the public, insurance companies, private investigators, government agencies, financial institutions, businesses that require an MVR before hiring an applicant or to comply with insurance requirements, judicial service businesses, and process servers.

The Department has determined that there is no less intrusive or less costly method that would fulfill the requirements of the Federal Driver's Privacy Protection Act of 1994 (DPPA) and A.R.S. § 28-455.

In fiscal year 2022, the Department issued approximately 36,990 uncertified special MVRs, 680,444 uncertified title and registration MVRs, 4,005 certified title and registration MVRs, 159,808 uncertified driver 39-month MVRs, 32,924 certified driver five-year MVRs, 8,052 certified driver extended MVRs, 4,133 certified extended commercial driver license MVRs, 13,573 uncertified photos, and 1,249 certified photos. The Department collected \$2,868,888 in revenue from these MVRs.

In addition, in the first three quarters (January - September) of 2022, there were 1,295,826 uncertified title and registration MVRs, 6,472 certified title and registration MVRs, 3,248,218 39-month driver MVRs, 226,466 5-year driver MVRs, 14,719 extended history driver MVRs, and 409,543,666 hybrid MVRs searched and found to companies with access to the Motor Vehicle Record Request System (MVRRS). A hybrid MVR occurs when a Department's Motor Vehicle Division Electronic Data Services customer requests a revised or modified version of the current MVR, for example the customer may require some data elements from a driver MVR combined with some data elements from the title and registration MVR. An additional 319,699,630 bulk title and registration MVRs were provided to some companies.

9. **Has the agency received any business competitiveness analyses of the rules?** Yes \_\_\_ No X

10. **Has the agency completed the course of action indicated in the agency’s previous five-year-review report?**

In the last five-year review report, the Department proposed to amend both rules in Article 8 as identified in item 6. In addition, while reviewing Article 8, the Department made the determination that it would be more appropriate and would better serve the public to relocate R17-1-202, MVD Record Copy Charges and its corresponding Table 1, which details the fees charged by the Department for copies of the various types of records, to Article 8. This relocation would require the removal of the following definitions from R17-1-201, Definitions, to R17-4-801: “batch”, “interactive”, “reasonable costs”, and “support document”. The Department would also need to change the use of “Division” to “Department in the text of the relocated MVD Record Copy Charges and change the use of “agency” in the definition of “support document” to “department”. The Department proposed to have the Notices of Final Expedited Rulemaking filed for the Council’s December 2018 agenda. The Department completed its proposed course of action, which was approved by the Council on December 4, 2018. The following are the additional changes proposed in item 6 of that last five-year review report:

Rule	Explanation
R17-4-801	<p>The Department has determined to amend the following terms:</p> <ul style="list-style-type: none"> <li>a. Customer number: Amend it to indicate that a customer number is assigned to a person with a record on the Department’s database.</li> <li>b. Director: Remove the term since it is not used in the rest of the Article.</li> <li>c. Division: Remove the term since the Department proposes to replace all “Division” references with “Department” to reflect organizational changes made within the Department and “Department” is already defined in A.R.S. § 28-101.</li> </ul> <p>The Department will add definitions for “commercial driver license record” and “support document” due to the addition of these record types to R17-4-802. <i>(Completed December 4, 2018)</i></p>
R17-4-802	<p>The Department has determined the following amendments will enhance the clarity of the rule:</p> <ul style="list-style-type: none"> <li>a. Identification requirements: Change “valid photo identification” into “valid identification information as indicated on the form or by the Department” since not all requesters can provide a photo, for example, requests received in the mail.</li> <li>b. MVR types: Add language to include uncertified commercial driver license record and uncertified and certified support documents as an available MVR type and relabel “driver history record” as “driver extended history record.”</li> <li>c. Permissible use record request: Add a clarifying statement that the requester may need to provide additional information in order to locate a record.</li> <li>d. Non-permissible use record request: To clarify any confusion by the use of “non-permissible” and direct the focus on the Department’s use of the consent to release forms, change the header to “Consent to release motor vehicle record”, revise and restructure the first sentence to indicate that under the use of the permissible use under A.R.S. § 28-455(C)(13) the one-time consent form is used and then create another sentence detailing the use of the general consent form. Add the provision that a requester using the permissible use under A.R.S. § 28-</li> </ul>

	<p>455(C)(11) shall provide the detailed items of information, which needs to be clarified for the title and registration MVR since it is not necessary to provide both the vehicle identification number and license plate number. Update the website address.</p> <p>e. General consent to release information: Modify the mailing address to be more consistent with other rules.</p> <p>f. "Division": The term needs to be replaced by "Department" to reflect organizational changes made within the Department.</p> <p><i>(Completed December 4, 2018)</i></p>
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**11. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

In rulemaking, the Department routinely adopts the least costly and burdensome options for any process or procedure required of the regulated public or industry. Costs to persons regulated by these rules are minimal and include the costs associated with completing a request form provided by the Department and providing the Department with all required documentation in support of the records request. The Department believes that these rules impose no significant burden or costs to persons regulated by the rules, other than the minimal fee authorized by statute and prescribed by the rule. The highest fee charged is \$5 per record, which is required under A.R.S. § 28-446. The Department provides requesters the ability to request an MVR electronically, by mail, or in-person at a Motor Vehicle Division customer service office or an authorized third party. The Department has determined that the rules in Article 8 impose the least burden and costs to persons regulated by the rules, including paperwork and other compliance costs necessary to achieve the underlying objectives.

**12. Are the rules more stringent than corresponding federal laws? Yes  No**

The manner in which the Department may release information from MVRs is regulated by the DPPA, 18 USC 2721-2725; and A.R.S. Title 28, Chapter 2, Article 5. The DPPA stipulates who may receive personal information from MVRs and the penalties. In addition, the Department issues an extended commercial driver license MVR in accordance with 49 CFR 384.225, which includes a provision on who may receive such information. These rules identify the requirements for requesting and releasing an MVR, the types of MVRs provided, and the fees charged. The DPPA and 49 CFR 384.225 do not impose the criteria needed to request a record nor the length of time covered in a driver MVR. The Department has determined that these rules are not more stringent than the corresponding federal laws.

**13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

These rules do not require the issuance of a permit, license, or agency authorization.

**14. Proposed course of action**

The Department proposes to amend the rules as identified in item 6 through expedited rulemaking. The Department plans to request approval from the Governor's Office, pursuant to A.R.S. § 41-1039, upon approval of this report. The Department intends to submit the Notice of Final Expedited Rulemaking to the Council by September 2023.

State of Arizona  
House of Representatives  
Fifty-fifth Legislature  
First Regular Session  
2021

**CHAPTER 335**  
**HOUSE BILL 2143**

AN ACT

AMENDING SECTIONS 28-364, 28-365, 28-413, 28-455, 28-456 AND 28-1150, ARIZONA REVISED STATUTES; AMENDING SECTION 28-1601, ARIZONA REVISED STATUTES, AS AMENDED BY SENATE BILL 1551, SECTION 2, FIFTY-FIFTH LEGISLATURE, FIRST REGULAR SESSION, AS TRANSMITTED TO THE GOVERNOR; AMENDING SECTIONS 28-2055, 28-2058, 28-2091, 28-2095, 28-2098, 28-3225, 28-3312, 28-4805, 28-7143, 28-7314, 28-7315 AND 32-2351, ARIZONA REVISED STATUTES; RELATING TO TRANSPORTATION.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 28-364, Arizona Revised Statutes, is amended to  
3 read:

4 28-364. Powers of the director

5 A. The director may provide technical transportation planning  
6 expertise to local governments when requested, coordinate local government  
7 transportation planning with regional and state transportation planning  
8 and guide local transportation planning to ~~assure~~ ENSURE compliance with  
9 federal requirements. The planning authority granted by this subsection  
10 does not preempt planning responsibilities and decisions of local  
11 governments.

12 B. If the governor declares a state of emergency, the director may  
13 contract and do all things necessary to provide emergency transportation  
14 services for the residents in the affected areas whether the emergency  
15 transportation is by street, rail or air.

16 C. On a determination that it is in this state's best interest, the  
17 director may authorize payment for necessary relocation costs in advance  
18 of work being performed if an existing facility owned by the United States  
19 must be relocated or adjusted due to construction, modification or  
20 improvement of a state highway. The director shall base each advance  
21 payment on an estimate of cost of the proposed relocation or adjustment  
22 prepared by the federal government and acceptable to the director and  
23 shall base the final compensation on the actual agreed cost.

24 D. The director of the department of transportation in consultation  
25 with the director of the department of public safety shall develop  
26 procedures to exchange information for any purpose related to sections  
27 28-1324, 28-1325, 28-1326, 28-1462 and 28-3318.

28 E. The director may establish a system or process that does all of  
29 the following:

30 1. Allows for mailing notices of service or other legal documents  
31 or records of the department electronically or digitally to a person who  
32 consents to receiving these notices, documents or records through a secure  
33 electronic or digital system.

34 2. Enables a person to establish a financial account in the  
35 department's database. The account shall be accessible by the person or  
36 the person's authorized representative to review statements of all  
37 transactions associated with the person's account and to make prepayments  
38 or payments for authorized transactions with the department.  
39 Notwithstanding any other law, monies in financial accounts established  
40 pursuant to this section that remain unexpended for a period of five years  
41 or more revert to the Arizona highway user revenue fund and shall be  
42 distributed pursuant to section 28-6538.

43 3. Allows a person to comply with the photograph update and proof  
44 of vision test requirements prescribed by section 28-3173 through  
45 electronic or digital means that meet the department's standards.

1           4. ENABLES THE DEPARTMENT TO ACCEPT CERTIFICATE OF TITLE BRANDS  
2 FROM OTHER STATES OR JURISDICTIONS AND TO RECORD THESE BRANDS ON THE  
3 APPROPRIATE VEHICLE RECORDS.

4           F. The director, in consultation with the Arizona medical board or  
5 the state board of optometry, may do all of the following:

6           1. Establish medical and vision standards for driver license  
7 applicants and examinations.

8           2. Establish courses of training, training facilities and  
9 qualifications and methods of training for driver license examining  
10 personnel.

11           3. Establish procedures for the certification of driver license  
12 examining personnel and driver license instructors personnel.

13           4. Direct research in the field of licensing drivers. The director  
14 may accept public or private grants for the research.

15           5. Conduct research in the field of examination or reexamination of  
16 licensing individual drivers with medical or vision problems.

17           6. Set minimum vision standards for the operation of a motor  
18 vehicle in this state.

19           G. The director may implement electronic or digital versions of  
20 driver licenses, nonoperating identification licenses, vehicle  
21 registration cards, license plates or ~~any~~ other official ~~record~~ RECORDS of  
22 the department.

23           Sec. 2. Section 28-365, Arizona Revised Statutes, is amended to  
24 read:

25           28-365. Disposition of fees

26           Except as otherwise provided by statute, the director shall  
27 immediately deposit, pursuant to sections 35-146 and 35-147, fees  
28 collected under this ~~chapter~~ TITLE in the Arizona highway user revenue  
29 fund.

30           Sec. 3. Section 28-413, Arizona Revised Statutes, is amended to  
31 read:

32           28-413. Reciprocal driver license agreement; foreign  
33 countries

34           A. The department may waive the requirements for a written  
35 examination and the driving examination required pursuant to section  
36 28-3164 for an operator of a motor vehicle ~~holding~~ WHO HOLDS a valid  
37 driver license issued by a foreign country in which the operator  
38 previously resided and who applies for an initial driver license in this  
39 state as an original applicant, if all of the following conditions are  
40 met:

41           1. The director determines that the standards of the foreign  
42 country for licensing operators of motor vehicles are substantially  
43 similar to those of this state.

44           2. The foreign country extends the same reciprocal driver license  
45 application privileges to persons licensed in this state.

1           3. The director and the foreign country have exchanged letters or  
2 other documentation to confirm the reciprocal extension of privileges to  
3 operate motor vehicles.

4           4. The original applicant under this section complies with the  
5 mandatory motor vehicle insurance provisions of chapter 9, articles 1 and  
6 4 of this title.

7           B. A person who holds a valid driver license that meets the  
8 requirements of subsection A, ~~OF THIS SECTION~~ may apply to the department  
9 for a class D, G or M license. The person applying for the original  
10 license shall ~~surrender~~ PRESENT the foreign country driver license to the  
11 department ~~upon~~ ON successful application.

12           C. The department shall publish on its public ~~internet site~~ WEBSITE  
13 a current list of foreign countries for which reciprocal operating  
14 privileges have been extended and withdrawn.

15           D. This section ~~shall~~ DOES not apply to commercial driver  
16 licensing.

17           ~~E. The director may adopt rules to implement this section.~~

18           Sec. 4. Section 28-455, Arizona Revised Statutes, is amended to  
19 read:

20           28-455. Release of personal information; fees

21           A. In accordance with section 28-458 and the driver's privacy  
22 protection act of 1994 (18 United States Code sections 2721 through 2725)  
23 and notwithstanding section 28-447, the department shall not knowingly  
24 disclose or otherwise make available to any person:

25           1. Personal information obtained by the department in connection  
26 with a motor vehicle record except as otherwise provided in this section.

27           2. Highly restricted personal information obtained by the  
28 department in connection with a motor vehicle record without the express  
29 consent of the person to whom the information applies except for uses  
30 allowed in subsection C, paragraphs 1, 4, 6 and 9 of this section. This  
31 paragraph does not affect the use of organ donation information on an  
32 individual's driver license or affect the administration of organ donation  
33 in this state.

34           B. The department shall disclose personal information for use in  
35 connection with the following matters:

36           1. Motor vehicle or driver safety and theft.

37           2. Motor vehicle emissions.

38           3. Motor vehicle product alterations, recalls or advisories.

39           4. Performance monitoring of motor vehicles and dealers by motor  
40 vehicle manufacturers.

41           5. Removal of nonowner records from the original owner records of  
42 motor vehicle manufacturers to carry out the purposes of titles I and IV  
43 of the anti car theft act of 1992 (18 United States Code sections 2311  
44 through 2322), the automobile information disclosure act (15 United States  
45 Code sections 1231, 1232 and 1233), the clean air act of 1963 (42 United

1 States Code sections 7401 through 7671q) and 49 United States Code  
2 chapters 301, 305 and 321 through 331.

3 C. Subject to subsection A of this section, the department may  
4 disclose personal information as follows:

5 1. For use by any government agency, including any court or law  
6 enforcement agency, in carrying out its functions or any private person or  
7 entity acting on behalf of a government agency in carrying out its  
8 functions.

9 2. For use in connection with matters of:

10 (a) Performance monitoring of motor vehicles, motor vehicle parts  
11 and dealers.

12 (b) Motor vehicle market research activities, including survey  
13 research.

14 (c) Removal of nonowner records from the original owner records of  
15 motor vehicle manufacturers.

16 3. For use in the normal course of business by a legitimate  
17 business or its agents, employees or contractors, but only:

18 (a) To verify the accuracy of personal information submitted by the  
19 individual to the business or its agents, employees or contractors.

20 (b) If the information submitted is not correct or is no longer  
21 correct, to obtain the correct information for the purpose of preventing  
22 fraud by, pursuing legal remedies against or recovering on a debt or  
23 security interest against the individual.

24 4. For use by an attorney licensed to practice law or by a licensed  
25 private investigator in connection with any civil, criminal,  
26 administrative or arbitration proceeding in any court or government agency  
27 or before any self-regulatory body, including the service of process,  
28 investigation in anticipation of litigation and the execution or  
29 enforcement of judgments and orders, or pursuant to a court order.

30 5. For use in research activities and for use in producing  
31 statistical reports if the personal information is not published,  
32 redisclosed or used to contact individuals.

33 6. For use by any insurer that writes automobile liability or motor  
34 vehicle liability policies and that is under the jurisdiction of the  
35 department of insurance and financial institutions or insurance support  
36 organization or by a self-insured entity or its agents, employees or  
37 contractors in connection with claims investigation activities, antifraud  
38 activities, rating or underwriting.

39 7. For use in providing notice to the owners of towed or impounded  
40 vehicles.

41 8. For use by any licensed private investigative agency or licensed  
42 security service for any purpose allowed under this section.

43 9. For use by an employer or its agent or insurer to obtain or  
44 verify information relating to a holder of a commercial driver license  
45 that is required under 49 United States Code sections 31301 through 31317.

1           10. For use by a toll operator as defined in section 28-7751 in  
2 connection with the operation of a toll facility or the enforcement of  
3 tolls, administrative charges and penalties as defined in section 28-7751.

4           11. For any other use in response to requests for individual motor  
5 vehicle records if the state has obtained the express consent of the  
6 person to whom the personal information pertains.

7           ~~12. For bulk distribution for surveys, marketing or solicitations~~  
8 ~~if the department has obtained the express consent of the person to whom~~  
9 ~~the personal information pertains.~~

10          ~~13.~~ 12. For use by any requester if the requester demonstrates it  
11 has obtained the written consent of the individual to whom the information  
12 pertains.

13          ~~14.~~ 13. For any other use that is specifically authorized by law  
14 and that is related to the operation of a motor vehicle or public safety,  
15 including the following:

16           (a) Use by a financial institution or enterprise under the  
17 jurisdiction of the department of insurance and financial institutions or  
18 a federal monetary authority.

19           (b) Use by a motor vehicle dealer who is licensed and bonded by the  
20 department or a state organization of licensed and bonded motor vehicle  
21 dealers.

22           (c) Use by a person who is involved in an accident or the owner of  
23 a vehicle involved in an accident if the person who requests the  
24 information submits proof to the department of involvement in the  
25 accident.

26           (d) Use by a person applying for a bonded title if all of the  
27 following conditions exist:

28           (i) The requester verifies to the satisfaction of the director that  
29 the vehicle on which the requester is requesting the record is in the  
30 requester's possession.

31           (ii) The record is requested in order for the requester to notify  
32 the registered owner of the requester's intent to apply to the department  
33 for a bonded title.

34           (iii) The requester provides a verification of a vehicle inspection  
35 that was performed by an authorized department employee or agent.

36           (e) Use by an operator of a self-service storage facility who  
37 alleges both of the following:

38           (i) That the vehicle on which the operator is requesting the record  
39 is in the operator's possession.

40           (ii) That the record is requested to allow the operator to notify  
41 the registered owner and any lienholders of record of the operator's  
42 intent to foreclose its lien and to sell the vehicle.

43           (f) For any other use as determined by the director and established  
44 by rule.

1 D. The department may establish and carry out procedures under  
2 which the department, on receiving a request for personal information that  
3 does not fall within one of the exceptions prescribed in subsection B or C  
4 of this section, may mail a copy of the request to the individual about  
5 whom the information was requested. The mailing shall inform the  
6 individual of the request and contain a statement that the information  
7 will not be released unless the individual waives the individual's right  
8 to privacy under this section.

9 E. In addition to the permissible uses prescribed in subsection C  
10 of this section, the department may disclose its motor vehicle records  
11 information, including personal information, as a bulk record only under  
12 any of the following conditions:

13 1. If the director determines either of the following:

14 (a) The sale or release of the record is necessary for the public  
15 health or safety.

16 (b) The use is for general research or general statistical purposes  
17 that do not provide specific factors from a record.

~~18 2. For surveys, marketing or solicitations if the department has  
19 obtained the express consent of the person to whom the personal  
20 information pertains.~~

21 ~~3.~~ 2. For the release of motor vehicle title and motor vehicle  
22 registration information, vehicle identification numbers, title brands,  
23 odometer readings and brands and title lien information to a requester if  
24 the requester is in the business of preparing vehicle history reports and  
25 the information is used to develop a vehicle history report.

~~26 F. The director shall provide in a clear and conspicuous manner on  
27 forms for the issuance or renewal of driver licenses, nonoperating  
28 identification licenses and title and registration the opportunity for  
29 express consent so that each person who is the subject of a record of the  
30 department may opt in, for any purpose as prescribed by the director.  
31 Express consent shall be conveyed in a form prescribed by the director and  
32 shall include at least the following:~~

~~33 1. Clear and conspicuous notice informing the person who is giving  
34 express consent that by giving express consent the person is allowing the  
35 department to disclose information contained in the person's motor vehicle  
36 record to any person requesting information for any purpose.~~

~~37 2. A written signature or an electronic signature.~~

~~38 3. An explanation of the difference between a one-time  
39 authorization and general consent or opt in.~~

~~40 6. Subject to the requirements of subsection F of this section,  
41 express consent may be conveyed as either of the following:~~

~~42 1. A one-time authorization submitted by a requester on a consent  
43 to release form or by other written format as prescribed by the director.~~

~~44 2. General consent or opt in on certain department forms.~~

1 F. THE DEPARTMENT SHALL NOT SELL RECORDS WITH PERSONAL IDENTIFYING  
2 INFORMATION FOR A COMMERCIAL PURPOSE EXCEPT TO A PERSON AUTHORIZED TO  
3 RECEIVE THE RECORDS UNDER THE PERMISSIBLE USE PROVISIONS OF THIS SECTION  
4 AND THE DRIVER'S PRIVACY PROTECTION ACT OF 1994 (18 UNITED STATES CODE  
5 SECTIONS 2721 THROUGH 2725).

6 ~~H.~~ G. Driver histories shall not be disclosed under subsection E  
7 of this section.

8 ~~I.~~ H. Except as provided in subsection ~~J.~~ I of this section and  
9 section 28-446, subsection B, records provided pursuant to subsections B  
10 and C of this section are subject to the fees prescribed in section  
11 28-446, subsections A and C.

12 ~~J.~~ I. For records searched and provided for the purposes described  
13 in subsection E of this section, the director:

14 1. Shall charge a search fee that is a minimum of \$600 per million  
15 records searched.

16 2. Shall charge a records fee that is a minimum of \$30 per thousand  
17 records provided.

18 3. May prorate the charge for fractional quantities that are  
19 searched or provided.

20 ~~4. May charge only the search fee if the request is in accordance~~  
21 ~~with subsection E, paragraph 2 of this section.~~

22 ~~K.~~ J. Records requests that require a database search for specific  
23 criteria within a record are subject to a search fee. In addition to this  
24 search fee, each motor vehicle record provided to a records requester as a  
25 result of a criteria search incurs record fees in accordance with  
26 subsection ~~I.~~ H of this section.

27 Sec. 5. Section 28-456, Arizona Revised Statutes, is amended to  
28 read:

29 28-456. Subsequent sale or disclosure of record information  
30 by authorized recipient

31 A. Except as provided in ~~subsections~~ SUBSECTION B ~~and C~~ of this  
32 section, an authorized recipient of personal information may resell or  
33 redisclose the information only for a use permitted under section 28-455,  
34 subsection B or C.

35 B. An authorized recipient under section 28-455, subsection C,  
36 paragraph 11 may resell or redisclose personal information for any lawful  
37 purpose.

38 ~~C. An authorized recipient under section 28-455, subsection C,~~  
39 ~~paragraph 12 may resell or redisclose personal information pursuant to~~  
40 ~~section 28-455, subsection C, paragraph 12.~~

41 ~~D.~~ C. Any authorized recipient, except a recipient under section  
42 28-455, subsection C, paragraph 11, that resells or rediscloses personal  
43 information covered by this section shall keep for a period of five years  
44 records identifying each person or entity that receives information and

1 the permitted purpose for which the information will be used and shall  
2 make the records available to the department on request.

3 Sec. 6. Section 28-1150, Arizona Revised Statutes, is amended to  
4 read:

5 28-1150. Overdimensional permit council

6 A. ~~Am~~ THE overdimensional permit council is established consisting  
7 of the following nine members who are appointed by the governor:

8 1. One member representing the department of public safety.

9 2. One member representing the department of transportation.

10 3. Four members representing motor carriers.

11 4. One member from a city or town with a population of more than  
12 one hundred thousand persons.

13 5. One member from a city or town with a population of one hundred  
14 thousand persons or less.

15 6. One member representing the governor's office of ~~community and~~  
16 highway safety.

17 B. The members serve staggered three year terms.

18 C. The overdimensional permit council shall:

19 1. Meet at least annually.

20 2. Select from its members a person to serve as chairperson.

21 3. Advise and assist the department of transportation in developing  
22 rules required to administer this article and article 18 of this chapter.

23 4. Advise and consult with the motor carrier industry, department  
24 of transportation and state and local law enforcement agencies concerning  
25 matters relating to overdimensional permits.

26 ~~5. Establish a mailing list that includes any party expressing an  
27 interest in the council's activities. The council shall provide the list  
28 to the department of transportation, and the department of transportation  
29 shall send notice by first class mail to each person on the list at least  
30 fifteen days before the date on which each meeting of the council is to be  
31 held.~~

32 ~~6.~~ 5. Review each proposed ordinance that a local authority  
33 submits pursuant to section 28-1103, subsection G to determine if the  
34 proposed ordinance is substantially identical, uniform and consistent with  
35 the rules adopted by the department for oversized or overweight vehicles  
36 pursuant to section 28-1103, subsection F.

37 D. Members of the overdimensional permit council are not eligible  
38 to receive compensation or reimbursement for expenses.

39 E. The overdimensional permit council is subject to title 38,  
40 chapter 3, article 3.1.

41 F. THE DEPARTMENT SHALL PROVIDE FOR ELECTRONIC NOTIFICATION OF  
42 OVERDIMENSIONAL PERMIT COUNCIL MEETINGS TO INTERESTED PARTIES.



1           ~~5.~~ 4. The court does not have a record of extending the time for  
2 payment of the civil penalty or providing for installment payments.

3           ~~F.~~ D. If the court is prohibited from initiating collection  
4 procedures on an unpaid civil penalty, ~~AND~~ from notifying the department  
5 ~~to suspend or restrict a person's driver license, permit or privilege to~~  
6 ~~drive a motor vehicle in this state or from notifying the department to~~  
7 refuse to renew a vehicle registration, pursuant to subsection ~~G.~~ C of  
8 this section, the court shall notify the department and the department  
9 shall remove the violation from the person's driving record.

10          ~~F.~~ E. With the approval of the supreme court, the presiding judge  
11 of any court may periodically conduct a program aimed at reducing the  
12 amount of outstanding fines, penalties, assessments and surcharges.  
13 Notwithstanding any other law, except a fine ordered as a result of a  
14 violation of section 28-1381 or 28-1382, the program may include  
15 authorizing up to a fifty percent reduction in the total amount of a court  
16 ordered fine, penalty, assessment or surcharge that is due and that is  
17 delinquent for at least twelve months followed by an increased enforcement  
18 effort for a fine, penalty, assessment or surcharge that is not paid. The  
19 supreme court shall adopt rules of procedure for the programs.

20          ~~G.~~ F. If penalties are reduced pursuant to subsection ~~F.~~ E of this  
21 section, associated surcharges and assessments shall be reduced in  
22 proportion to the reduction. This subsection does not apply to section  
23 12-116.

24          ~~H.~~ G. If a person presents reasonable evidence to the court that a  
25 civil penalty and any other fees, fines, assessments or surcharges  
26 required by the court have been paid, the court shall cease its collection  
27 activities for that civil penalty and order the department to immediately  
28 rescind its actions related to the court's order or request to ~~suspend or~~  
29 ~~restrict the person's driver license, permit or privilege to drive~~  
30 ~~pursuant to subsection A of this section or~~ refuse to renew the person's  
31 vehicle registration pursuant to article 5 of this chapter.

32          ~~I. If, on or before the effective date of this amendment to this~~  
33 ~~section, the department suspended or restricted a driving privilege, other~~  
34 ~~than a commercial driver license, pursuant to this section, the department~~  
35 ~~shall rescind the suspension or restriction and reinstate the person's~~  
36 ~~driving privilege if the suspension or restriction resulted from the~~  
37 ~~person being found responsible for a civil traffic violation and not~~  
38 ~~paying a civil penalty imposed for that civil traffic violation.~~

39          Sec. 8. Section 28-2055, Arizona Revised Statutes, is amended to  
40 read:

41           28-2055. Certificate of title; content requirements; transfer  
42                                   on death provision

43          A. The department or an authorized third party shall do both of the  
44 following:

1           1. Create the certificate of title with space for notation of liens  
2 and encumbrances on the vehicle at the time of transfer.

3           2. Provide forms for assignment of title or interest and warranty  
4 by the owner that ~~contains~~ INCLUDE the odometer mileage disclosure  
5 statement pursuant to section 28-2058.

6           B. At the request of the owner ~~and on payment of a fee prescribed~~  
7 ~~by the department by rule~~, the certificate of title may contain, by  
8 attachment, a transfer on death provision where the owner may designate a  
9 beneficiary of the vehicle.

10          C. If a motor vehicle, trailer or semitrailer has been registered  
11 in any other state or country, the department shall retain in its records  
12 the name of the state or country in which the prior registration took  
13 place.

14          Sec. 9. Section 28-2058, Arizona Revised Statutes, is amended to  
15 read:

16           28-2058. Transfer of title; odometer mileage disclosure  
17 statement

18          A. When the owner of a registered or unregistered vehicle transfers  
19 or assigns the owner's title or interest to the vehicle:

20           1. If the vehicle is registered:

21           (a) The owner shall endorse on the certificate of title or title  
22 transfer form an assignment with the warranty of title.

23           (b) Except as provided in section 28-2094, the owner shall deliver  
24 the certificate of title or title transfer form to the purchaser or  
25 transferee at the time of delivery of the vehicle to the purchaser or  
26 transferee.

27           (c) The registration of the vehicle expires and the owner shall  
28 transfer the license plates, surrender the license plates to the  
29 department or an authorized third party or submit an affidavit of license  
30 plate destruction within thirty days after the owner transfers or assigns  
31 the owner's title or interest in the vehicle.

32           (d) Except as provided in section 28-2091, the acquiring owner  
33 shall apply for registration or a certificate of title, or both, within  
34 fifteen days after the relinquishing owner transfers or assigns the  
35 relinquishing owner's CERTIFICATE OF title or interest in the  
36 vehicle. The director may prorate the registration period as the director  
37 deems necessary to coincide with emissions inspection requirements.

38           (e) Except if the acquiring owner is an insurer who acquires the  
39 vehicle pursuant to a claim settlement, the acquiring owner shall display  
40 on the vehicle a temporary registration plate, another permit or a valid  
41 license plate as prescribed by the department until ownership of the  
42 vehicle is transferred in the department's records.

43           2. Regardless of whether or not the vehicle is registered:

1 (a) Except as provided in subsection B of this section, the owner  
2 shall deliver to the purchaser or transferee an odometer mileage  
3 disclosure statement in a form prescribed by the director.

4 (b) Except as provided in sections 28-2051, 28-2060 and 28-2091,  
5 the purchaser or transferee shall present the certificate of title or  
6 title transfer form to the department with the required fee within fifteen  
7 days after the transfer and:

8 (i) The department shall issue a new certificate of title.

9 (ii) If required, the purchaser or transferee shall apply for and  
10 obtain registration, and the department shall issue new license plates to  
11 the purchaser or transferee.

12 B. The odometer disclosure requirement of subsection A of this  
13 section does not apply to:

14 1. A motor vehicle that is ten model years of age IF THE MODEL YEAR  
15 IS 2010 or older.

16 2. A MOTOR VEHICLE THAT IS TWENTY MODEL YEARS OF AGE IF THE MODEL  
17 YEAR IS 2011 OR NEWER.

18 ~~3.~~ 3. A motor vehicle that has a gross vehicle weight rating of  
19 sixteen thousand pounds or more.

20 ~~4.~~ 4. A vehicle that is not self-propelled.

21 ~~5.~~ 5. A motor vehicle that is sold directly by the manufacturer to  
22 an agency of the United States in conformity with contractual  
23 specifications.

24 ~~6.~~ 6. A new motor vehicle that is purchased for resale and not for  
25 use by the purchaser.

26 Sec. 10. Section 28-2091, Arizona Revised Statutes, is amended to  
27 read:

28 ~~28-2091.~~ Salvage certificate of title; stolen vehicle  
29 certificate of title; nonrepairable vehicle  
30 certificate of title; recovered vehicles;  
31 violation; classification; definitions

32 A. If a vehicle that is subject to the issuance of a certificate of  
33 title or registration pursuant to this chapter becomes a salvage vehicle,  
34 stolen vehicle or nonrepairable vehicle and is acquired by an insurance  
35 company as a result of a total loss insurance settlement, the insurance  
36 company or its authorized agent shall submit an application, as determined  
37 by the insurance company or its authorized agent, to the department within  
38 thirty days after the certificate of title is properly assigned by the  
39 owner to the insurance company, with all liens released, on a form  
40 prescribed by the department for either a salvage certificate of title,  
41 stolen vehicle certificate of title or nonrepairable vehicle certificate  
42 of title. The selected certificate of title shall include the following:

43 1. A properly endorsed certificate of title.

44 2. A lien satisfaction, if applicable.

45 3. The appropriate fees.

1           B. Within thirty days after oral or written acceptance by the owner  
2 of an offer in settlement of total loss, if an insurance company or its  
3 authorized agent is unable to obtain the documents prescribed by  
4 subsection A, paragraphs 1 and 2 of this section, the insurance company or  
5 its agent, on a form provided by the department, may submit an application  
6 to the department for a salvage certificate of title, stolen vehicle  
7 certificate of title or nonrepairable vehicle certificate of title. The  
8 application shall include evidence that the insurance company or its agent  
9 has made two or more written attempts to obtain the documents prescribed  
10 by subsection A, paragraphs 1 and 2 of this section. The application  
11 shall include the appropriate fees prescribed by subsection A, paragraph 3  
12 of this section. The insurance company shall indemnify and hold harmless  
13 the department for any claims resulting from the issuance of a salvage  
14 certificate of title, stolen vehicle certificate of title or nonrepairable  
15 vehicle certificate of title pursuant to this subsection.

16           C. Except for vehicles registered pursuant to section 28-2482,  
17 28-2483 or 28-2484, if the owner retains possession of a salvage vehicle  
18 or nonrepairable vehicle, the owner shall comply with this section before  
19 receiving a total loss settlement from the insurance company or otherwise  
20 disposing of the vehicle.

21           D. Any other owner of a vehicle that is a salvage vehicle or  
22 nonrepairable vehicle shall apply for a salvage certificate of title or  
23 nonrepairable vehicle certificate of title pursuant to this section.

24           E. On receipt of a proper application, the department shall issue a  
25 salvage certificate of title, stolen vehicle certificate of title or  
26 nonrepairable vehicle certificate of title for the vehicle.

27           F. If the department issues a nonrepairable vehicle certificate of  
28 title for a vehicle, the registration of the vehicle is cancelled. The  
29 front of a nonrepairable vehicle certificate of title shall be branded  
30 with the word "nonrepairable". The ownership of a vehicle for which a  
31 nonrepairable vehicle certificate of title has been issued shall not be  
32 reassigned more than two times on that certificate of title or a title  
33 transfer form. If a nonrepairable vehicle certificate of title is issued  
34 for a vehicle, the department shall not perform any title transfers or  
35 issue any further paper certificate of title for that vehicle.

36           G. An owner of a vehicle that is not a salvage vehicle who sells  
37 the vehicle as scrap or for purposes of dismantling or destroying shall  
38 assign the certificate of title or a title transfer form to the purchaser,  
39 and the purchaser shall comply with section 28-2094.

40           H. On sale of the vehicle, an owner of a salvage vehicle for which  
41 a salvage certificate of title has been obtained or an owner of a  
42 nonrepairable vehicle for which a nonrepairable vehicle certificate of  
43 title has been obtained shall assign and deliver the salvage certificate  
44 of title or nonrepairable vehicle certificate of title or a title transfer

1 form to the purchaser and shall notify the department of the name and  
2 address of the purchaser.

3 I. Except as provided in subsection L of this section, the  
4 department shall issue a certificate of title to a vehicle that has been  
5 issued a salvage certificate of title or stolen vehicle certificate of  
6 title as a result of a total loss settlement by reason of theft if the  
7 vehicle is recovered and was not wrecked or stripped of essential parts  
8 and the insurance company or its authorized agent submits an affidavit to  
9 the department in a form prescribed by the department stating either of  
10 the following:

11 1. The vehicle is a recovered theft and both of the following:

12 (a) The vehicle was not wrecked or stripped of essential parts.

13 (b) To the insurance company's or its authorized agent's actual  
14 knowledge, no air bag or component part necessary to the proper function  
15 of the air bag system deployed in the vehicle or was removed from the  
16 vehicle.

17 2. The vehicle is a recovered theft and, to the insurance company's  
18 or its authorized agent's actual knowledge, an air bag or an air bag  
19 module deployed in the vehicle or was removed from the vehicle. The  
20 insurance company or its authorized agent shall list the location in the  
21 vehicle of each deployment or removal of an air bag or an air bag module.

22 J. On receipt of an affidavit submitted pursuant to subsection I,  
23 paragraph 2 of this section, the department shall mark its records to  
24 indicate the deployment or removal of the air bag or air bag module from  
25 the vehicle and the location of each deployment or removal.

26 K. The insurance company or its authorized agent shall give the  
27 purchaser of a vehicle that is a recovered theft, as described in  
28 subsection I of this section, a copy of the affidavit submitted pursuant  
29 to subsection I of this section.

30 L. If the vehicle is a recovered theft and components of the  
31 vehicle's air bag system, other than the air bag or the air bag module  
32 described in subsection I, paragraph 2 of this section, or other parts of  
33 the vehicle were removed compromising the functional integrity of the air  
34 bag system or the structural integrity of the vehicle, the insurance  
35 company or its authorized agent shall submit an affidavit to the  
36 department in a form prescribed by the department stating that the vehicle  
37 is a recovered theft and that components of the vehicle's air bag system,  
38 other than the air bag or the air bag module described in subsection I,  
39 paragraph 2 of this section, or other parts of the vehicle were removed  
40 compromising the functional integrity of the air bag system or the  
41 structural integrity of the vehicle. The department shall not issue a  
42 certificate of title to the vehicle but may issue a restored salvage  
43 certificate of title pursuant to section 28-2095 if all of the following  
44 apply:

45 1. The vehicle is repairable.

1           2. The department successfully completes a level three inspection  
2 as prescribed in section 28-2011.

3           3. The vehicle meets other requirements the director prescribes.

4           M. Except as provided in subsection N of this section, any person  
5 who sells a vehicle that is issued a certificate of title pursuant to  
6 subsection I of this section and who has actual knowledge that an air bag,  
7 an air bag module or components of the vehicle's air bag system  
8 compromising the functional integrity of the air bag system deployed or  
9 were removed from the vehicle shall not fail to disclose the deployment or  
10 removal to the buyer before completion of the sale with the intention of  
11 concealing the deployment or removal. A person who violates this  
12 subsection is guilty of a class 1 misdemeanor.

13           N. Subsection M of this section does not apply to either of the  
14 following:

15           1. An insurance company or its authorized agent who issues an  
16 affidavit pursuant to subsection I of this section unless the insurance  
17 company or its authorized agent intentionally fails to disclose the  
18 deployment or removal of an air bag, an air bag module or components of  
19 the vehicle's air bag system that compromise the functional integrity of  
20 the air bag system.

21           2. A person who owns a vehicle that is issued a certificate of  
22 title pursuant to subsection I of this section if the person repairs or  
23 replaces the air bag or air bag module in the vehicle.

24           O. Any person who sells a vehicle for which a salvage certificate  
25 of title has been issued and who knows a salvage certificate of title has  
26 been issued for the vehicle shall **CLEARLY AND CONSPICUOUSLY** disclose **IN**  
27 **WRITING OR BY ELECTRONIC MEANS** to the buyer before completion of the sale  
28 that the vehicle is a salvage vehicle **AND HAS A SALVAGE CERTIFICATE OF**  
29 **TITLE**.

30           P. If a vehicle that has a certificate of title as a salvage  
31 vehicle is to be scrapped, dismantled or destroyed, the owner or purchaser  
32 shall comply with section 28-2094.

33           Q. The provisions of this chapter that refer to certificates of  
34 title apply to salvage certificates of title, stolen vehicle certificates  
35 of title and nonrepairable vehicle certificates of title issued pursuant  
36 to this section unless they conflict with this section.

37           R. If a component part of a vehicle on which the vehicle  
38 identification number is affixed is to be replaced and if the vehicle is  
39 being repaired by a person other than its owner, the person shall notify  
40 the owner in writing and in the manner prescribed by the department that  
41 the part has been replaced, and the owner shall comply with section  
42 28-2165. This subsection does not apply if the department has not issued  
43 a salvage certificate of title or a nonrepairable certificate of title and  
44 if the vehicle manufacturer or the manufacturer's authorized agent meets  
45 all of the following conditions:

- 1           1. The frame is the component part replaced.
- 2           2. The frame replacement is performed by the vehicle manufacturer
- 3 or the manufacturer's authorized agent.
- 4           3. If the original frame contained a vehicle identification number
- 5 or serial number, the original vehicle identification number or serial
- 6 number, in a similar size and style, is restamped in the replacement frame
- 7 by the manufacturer or the manufacturer's authorized agent.
- 8           4. Any existing manufacturer warranties remaining on the vehicle
- 9 are not voided.
- 10          5. The manufacturer or the manufacturer's authorized agent
- 11 obliterates all vehicle identification numbers or serial numbers contained
- 12 on the original frame.
- 13          S. Except as otherwise provided, a person who violates this section
- 14 is guilty of a class 2 misdemeanor.
- 15          T. For the purposes of this section:
- 16           1. "Essential parts" means integral and body parts, the removal,
- 17 alteration or substitution of which will tend to conceal the identity or
- 18 substantially alter the appearance of the vehicle.
- 19           2. "Nonrepairable vehicle" means a vehicle of a type that is
- 20 otherwise subject to the issuance of a certificate of title and
- 21 registration pursuant to this chapter and that either:
- 22           (a) Has no resale value except as a source of parts or scrap metal
- 23 and the owner or insurer designates the vehicle solely as a source of
- 24 parts or scrap metal.
- 25           (b) Is a completely stripped vehicle that is recovered from theft
- 26 and that is missing the engine or motor, the transmission, all of the
- 27 bolt-on sheet metal body panels, all of the doors and hatches,
- 28 substantially all of the interior components and substantially all of the
- 29 grill and light assemblies or that the owner designates has little or no
- 30 resale value except its worth as a source of scrap metal or as a source of
- 31 a vehicle identification number that could be used illegally.
- 32           (c) Is a completely burned vehicle that has been burned to the
- 33 extent that there are no usable or repairable body or interior components,
- 34 tires and wheels, engine or motor or transmission and that the owner
- 35 irreversibly designates as having little or no resale value except as a
- 36 source of scrap metal or as a source of a vehicle identification number
- 37 that could be used illegally.
- 38           3. "Salvage vehicle" means a vehicle, other than a nonrepairable
- 39 vehicle, of a type that is subject to the issuance of a certificate of
- 40 title and registration pursuant to this chapter and that has been stolen,
- 41 wrecked, destroyed, flood or water damaged or otherwise damaged to the
- 42 extent that the owner, leasing company, financial institution or insurance
- 43 company considers it uneconomical to repair the vehicle.



1 before completion of the sale that the vehicle is a restored salvage  
2 vehicle **AND HAS A RESTORED SALVAGE CERTIFICATE OF TITLE.**

3 I. For the purposes of this section:

4 1. For passenger vehicles, "component parts" includes the cowl or  
5 firewall, front end assembly, rear clip, including the roof panel, the  
6 roof panel if installed separately and the frame or any portion of the  
7 frame, or in the case of a unitized body, the supporting structure that  
8 serves as the frame, each door, the hood, each fender or quarter panel,  
9 the deck lid or hatchback, each bumper, transmissions or transaxles and an  
10 engine or motor. For the purposes of this paragraph:

11 (a) "Front end assembly" includes the hood, fenders, bumper,  
12 radiator and supporting members for these items. For vehicles with a  
13 unitized body, the front end assembly also includes the frame support  
14 members.

15 (b) "Rear clip" includes the roof, quarter panels, trunk lid, floor  
16 pan, rear bumper and support members for these items.

17 2. For trucks or truck-type or bus-type vehicles, "component parts"  
18 includes the cab, the frame or any portion of the frame, and in the case  
19 of a unitized body, the supporting structure that serves as a frame, the  
20 cargo compartment floor panel, the passenger compartment floor pan, the  
21 roof panel, transmissions or transaxles, engines or motors, each door, the  
22 hood, each fender or quarter panel, each bumper, the tailgate and all  
23 component parts that are included in paragraph 1 of this subsection and  
24 that are not listed in this paragraph if the part is replaced.

25 3. For motorcycles, "component parts" includes the engine or motor,  
26 transmission or transaxle, frame, front fork, crankcase and fairing and  
27 any other body molding.

28 4. "Restored salvage vehicle" means a vehicle that has been  
29 restored and for which a salvage certificate of title or a dismantle  
30 certificate of title has been issued.

31 Sec. 12. Section 28-2098, Arizona Revised Statutes, is amended to  
32 read:

33 **28-2098. Vehicle sales; no certificate of title; violation;**  
34 **classification; penalties**

35 A. Notwithstanding any other law, a registered scrap metal dealer  
36 or a licensed automotive recycler may purchase a vehicle without obtaining  
37 a certificate of title if the scrap metal dealer or automotive recycler  
38 complies with subsection B of this section, the transactional value of the  
39 vehicle does not exceed ~~twelve hundred dollars~~ **\$1,200**, the vehicle is at  
40 least twelve model years old and the owner does not have the paper  
41 certificate of title to the vehicle for any of the following reasons:

42 1. The owner or the owner's authorized agent has not obtained a  
43 title in the owner's or agent's name for the vehicle.

44 2. The owner has lost the paper certificate of title for the  
45 vehicle.

1           3. The owner has returned the title to the department. If this  
2 paragraph applies, a vehicle may be transferred to only a scrap metal  
3 dealer or an automotive recycler.

4           B. For purchases under this section, the registered scrap metal  
5 dealer or licensed automotive recycler shall do all of the following:

6           1. Take a picture at the time of the transaction of all of the  
7 following:

8           (a) The ~~setter~~ OWNER.

9           (b) The vehicle.

10          (c) The vehicle's vehicle identification number or federal  
11 identification sticker.

12          2. Pay for the vehicle with a check and not with cash.

13          3. Obtain a statement that contains all of the information required  
14 by subsection C of this section, that is signed by the ~~setter~~ OWNER and  
15 that affirms the conditions prescribed in subsection A of this section.

16          C. When the department is able to accept an electronic form, the  
17 statement prescribed by subsection B of this section shall be submitted  
18 electronically in a form that is prescribed by the department and shall  
19 contain all of the following:

20          1. A statement that the vehicle will not be titled again and will  
21 be dismantled or scrapped.

22          2. A description of the vehicle, including the year, make, model  
23 and vehicle identification number.

24          3. The owner's name and address and the number from the owner's  
25 driver license, nonoperating identification license issued pursuant to  
26 section 28-3165 or photo identification card issued by a tribal government  
27 or the United States military.

28          4. A certification that the owner either:

29           (a) Never obtained a title to the vehicle in the owner's name.

30           (b) Was issued a title for the vehicle and the title was lost or  
31 stolen.

32           (c) Has returned the title to the department.

33          5. A certification that the vehicle is both of the following:

34           (a) At least twelve model years old.

35           (b) Not subject to a security interest or lien.

36          6. An acknowledgment that the owner and the scrap metal dealer or  
37 automotive recycler understand that the statement required by this  
38 subsection will be filed with the department and that it is a class 1  
39 misdemeanor to knowingly falsify any information on the statement.

40          7. The owner's signature and the date of the transaction.

41          8. The name and address of the business acquiring the vehicle.

42          9. The national motor vehicle title information system  
43 identification number.

44          10. A business agent's signature and date, including the agent's  
45 printed name and title if the agent is signing on behalf of a corporation.

1 D. A registered scrap metal dealer or licensed automotive recycler  
2 that purchases a vehicle under this section:

3 1. Shall maintain a photocopy or electronic scan of the owner's  
4 driver license, nonoperating identification license issued pursuant to  
5 section 28-3165 or photo identification card issued by a tribal government  
6 or the United States military.

7 2. May maintain a copy of the ~~seller's~~ OWNER'S photo identification  
8 and reference that photo identification without making a separate  
9 photocopy for each transaction for subsequent purchases.

10 3. Shall hold the vehicle at least three business days after the  
11 date that the registered scrap metal dealer or licensed automotive  
12 recycler reports the purchase pursuant to subsection I of this section  
13 before the registered scrap metal dealer or licensed automotive recycler  
14 may crush, dismantle or shred the vehicle.

15 E. The department may develop an electronic system for a registered  
16 scrap metal dealer or a licensed automotive recycler to verify at the time  
17 of a transaction that a motor vehicle offered for sale has not been  
18 reported stolen.

19 F. Before purchasing a motor vehicle under this section, a  
20 registered scrap metal dealer or a licensed automotive recycler shall  
21 verify that the motor vehicle offered for sale has not been reported  
22 stolen. In addition to submitting information to the department pursuant  
23 to this section and the national motor vehicle title information system as  
24 required by 28 Code of Federal Regulations part 25, subpart B, after the  
25 department develops an electronic verification system pursuant to this  
26 section, a registered scrap metal dealer or a licensed automotive recycler  
27 shall verify that a vehicle is not stolen by using the electronic  
28 verification system before purchasing a vehicle without a certificate of  
29 title. If the electronic verification system indicates that the vehicle  
30 is stolen, the registered scrap metal dealer or licensed automotive  
31 recycler may not purchase the vehicle and shall report the findings to ~~the~~  
32 ~~department~~ A LAW ENFORCEMENT AGENCY. A registered scrap metal dealer or a  
33 licensed automotive recycler is not required to apprehend a person that  
34 attempts to sell a motor vehicle that was reported stolen.

35 G. A registered scrap metal dealer or a licensed automotive  
36 recycler must use a department vehicle lien or encumbrance database that  
37 is in place on February 1, 2018 or a comparable database to check for  
38 liens or encumbrances on vehicles purchased under this section if the  
39 database substantially complies with section 28-2134 which requires the  
40 release of a satisfied lien.

41 H. A person who knowingly gives false, fraudulent or erroneous  
42 information in connection with the signed statement prescribed in  
43 subsection B of this section, who falsely certifies the truthfulness and  
44 accuracy of information supplied in connection with the statement or who  
45 knowingly sells a vehicle that is subject to an unsatisfied lien is guilty

1 of a class 1 misdemeanor and shall pay a fine of ~~two thousand five hundred~~  
2 ~~dollars~~ \$2,500.

3 I. Within forty-eight hours after the close of business each day, a  
4 registered scrap metal dealer or licensed automotive recycler that  
5 purchases or receives vehicles for scrap or for parts shall report to the  
6 national motor vehicle title information system ~~and maintain and deliver~~  
7 ~~electronically to the department in a format approved by the department~~ a  
8 list of each vehicle purchased that day for scrap or for parts. The list  
9 shall contain all of the following:

- 10 1. The name, address and contact information for the reporting  
11 entity.  
12 2. The vehicle identification number.  
13 3. The date that the vehicle was obtained.  
14 4. The name of the person from whom the vehicle was obtained.  
15 5. Whether the vehicle was or will be crushed, disposed of or  
16 offered for sale or other purposes.  
17 6. Whether the vehicle will be exported out of the United States.  
18 7. The national motor vehicle title information system  
19 identification number of the business acquiring the vehicle.

20 ~~J. The department shall disclose the information that the~~  
21 ~~department obtains pursuant to subsection I of this section only to law~~  
22 ~~enforcement agencies and for the purposes of canceling certificates of~~  
23 ~~title. Otherwise this information is the confidential business~~  
24 ~~information of the respective reporting entity.~~

25 ~~K.~~ J. Each reporting entity shall retain all statements and  
26 records required under subsection B of this section for a period of two  
27 years. A registered scrap metal dealer and a licensed automotive recycler  
28 shall print a form or maintain an electronic record to show that the  
29 registered scrap metal dealer or licensed automotive recycler completed a  
30 search on the department's electronic system to verify that a vehicle that  
31 the registered scrap metal dealer or licensed automotive recycler  
32 purchases pursuant to this section is not stolen. The form must contain  
33 the vehicle's vehicle identification number and the date on which the  
34 search was conducted. The registered scrap metal dealer and licensed  
35 automotive recycler must electronically retain the form or electronic  
36 record for at least five years. The department must retain records of  
37 searches on the department's electronic system pursuant to this section  
38 ~~for at least ten years~~ AS SPECIFIED IN ITS RECORD RETENTION SCHEDULE.

39 ~~L.~~ K. A person who engages in the activities of a scrap metal  
40 dealer or an automotive recycler, whether or not registered or licensed as  
41 such, and who knowingly and wilfully fails to deliver a vehicle title  
42 pursuant to section 28-2094 or the statement required under subsection B  
43 of this section to the department or to report vehicle information  
44 described in subsection I of this section to the national motor vehicle  
45 title information system within forty-eight hours after the completion of

1 a transaction is in violation of this section and is subject to a civil  
2 penalty of up to ~~one thousand dollars~~ \$1,000 per violation. A local or  
3 state law enforcement agency, a county attorney or the attorney general  
4 may bring an action in any court of competent jurisdiction to enforce this  
5 section. Any civil penalties assessed shall be deposited as follows:

6 1. Fifty percent shall be deposited, pursuant to sections 35-146  
7 and 35-147, in the state highway fund established by section 28-6991.

8 2. Fifty percent shall be deposited, pursuant to sections 35-146  
9 and 35-147, in the automobile theft authority fund established by section  
10 41-3451.

11 ~~M. The director shall incorporate by reference the national motor  
12 vehicle title information system prescribed in 28 Code of Federal  
13 Regulations, part 25, subpart B, and a peace officer may enforce its  
14 provisions.~~

15 ~~N.~~ L. The seller of material from scrap vehicles shall certify to  
16 the purchaser that all scrap vehicles used for the material in the sale  
17 have been properly reported to the department or the national motor  
18 vehicle title information system.

19 ~~O.~~ M. Notwithstanding any other law, only this title governs the  
20 purchase by a scrap metal dealer of a vehicle solely for the purpose of  
21 processing the vehicle into a scrap vehicle or into prepared grades of  
22 scrap metal as defined in section 44-1641.

23 Sec. 13. Section 28-3225, Arizona Revised Statutes, is amended to  
24 read:

25 28-3225. Commercial learner's permit

26 A. A person who is at least eighteen years of age may apply to the  
27 department for ~~an instruction~~ A LEARNER'S permit for a class A, B or C  
28 license. The department may issue ~~an instruction~~ A LEARNER'S permit to  
29 the applicant after the applicant passes all parts of the examination and  
30 meets all other requirements for a class A, B or C license other than the  
31 driving test.

32 B. The permit entitles the permittee to drive a motor vehicle  
33 requiring a class A, B or C license on the public highways for six months  
34 from the date of issuance when the following conditions are met:

35 1. The permittee has the permit in the permittee's immediate  
36 possession.

37 2. The permittee is accompanied by a person ~~with~~ WHO HAS the same  
38 class or higher class of license issued by this state or any other  
39 qualifying state and who occupies a seat beside the driver.

40 3. If the permittee is under twenty-one years of age, the permittee  
41 does not operate a commercial motor vehicle interstate.

1           Sec. 14. Section 28-3312, Arizona Revised Statutes, is amended to  
2 read:

3           28-3312. Mandatory disqualification of commercial driver  
4                                   licenses; definition

5           A. The department shall disqualify a person who is required to have  
6 a commercial driver license, who is a commercial driver license holder or  
7 who is a commercial ~~instruction~~ LEARNER'S permit holder from driving a  
8 commercial motor vehicle as follows:

9           1. Except as provided in subsection E of this section and except as  
10 otherwise provided in this subsection, for at least one year if a person:

11           (a) Refuses a test in violation of section 28-1321.

12           (b) Is convicted of a first violation of any of the following:

13           (i) Driving a commercial motor vehicle under the influence of  
14 intoxicating liquor or a controlled substance or while having an alcohol  
15 concentration of 0.04 or more.

16           (ii) Leaving the scene of an accident involving a motor vehicle  
17 driven by the person.

18           (iii) Using a motor vehicle in the commission of a felony.

19           (iv) A violation of chapter 4, article 3 of this title while  
20 operating a noncommercial motor vehicle.

21           (v) Driving a commercial motor vehicle while, as a result of prior  
22 violations of this title committed while operating a commercial motor  
23 vehicle, the person's commercial driver license is revoked, suspended or  
24 canceled or the person is disqualified from operating a commercial motor  
25 vehicle.

26           (vi) Causing a fatality through the negligent operation of a  
27 commercial motor vehicle, including a conviction of manslaughter, homicide  
28 or negligent homicide resulting from operation of a motor vehicle.

29           2. For at least three years, if the person is convicted of any of  
30 the violations prescribed in paragraph 1 of this subsection and the  
31 violation occurred while the person was transporting a hazardous material  
32 in the quantity and under the circumstances that require placarding of the  
33 transport vehicle under the department's safety rules pursuant to chapter  
34 14 of this title.

35           3. For the life of the person, if the person is convicted of two or  
36 more violations of any of the offenses prescribed in paragraph 1 of this  
37 subsection or of any combination of those offenses arising from two or  
38 more separate incidents. The department shall consider only offenses  
39 committed from and after December 31, 1989 in applying this paragraph.

40           4. Permanently if the person is convicted of using any motor  
41 vehicle in the commission of a felony involving the manufacture,  
42 distribution or dispensing of a controlled substance or possession with  
43 intent to manufacture, distribute or dispense a controlled substance.

44           5. For at least sixty consecutive days, if the person is convicted  
45 of two serious traffic violations committed in a motor vehicle arising

1 from separate incidents occurring within a ~~three year~~ THREE-YEAR period  
2 from the date of the violation.

3 6. For at least one hundred twenty days served in addition to any  
4 other disqualification, if the person is convicted of a third or  
5 subsequent serious traffic violation committed in a motor vehicle arising  
6 from separate incidents occurring within a ~~three year~~ THREE-YEAR period  
7 from the date of the violation.

8 7. For at least sixty consecutive days, if the department  
9 determines that the person falsified information or documentation as part  
10 of the licensing process.

11 8. For at least one year, if the person is convicted of fraud  
12 related to the issuance of a commercial ~~instruction~~ LEARNER'S permit or  
13 commercial driver license.

14 9. PERMANENTLY IF THE PERSON IS CONVICTED OF ANY OF THE FOLLOWING  
15 OFFENSES OR AN OFFENSE COMMITTED IN ANOTHER JURISDICTION THAT IF COMMITTED  
16 IN THIS STATE WOULD BE A VIOLATION OF ANY OF THE FOLLOWING OFFENSES AND A  
17 COMMERCIAL MOTOR VEHICLE WAS USED IN THE COMMISSION OF THE OFFENSE:

18 (a) SEX TRAFFICKING PURSUANT TO SECTION 13-1307.

19 (b) TRAFFICKING OF PERSONS FOR FORCED LABOR OR SERVICES PURSUANT TO  
20 SECTION 13-1308.

21 (c) CHILD SEX TRAFFICKING PURSUANT TO SECTION 13-3212.

22 B. Except as provided in subsection C of this section, a person WHO  
23 IS required to have a commercial driver license or a commercial driver  
24 license holder AND who is found responsible for violating an  
25 out-of-service order pursuant to section 28-5241 is disqualified from  
26 driving a commercial motor vehicle as follows:

27 1. For a period of one hundred eighty days if the person is found  
28 responsible for a first violation of an out-of-service order.

29 2. For a period of two years if the person is found responsible for  
30 a second violation of any out-of-service order during any ~~ten year~~  
31 TEN-YEAR period arising from separate incidents.

32 3. For a period of three years if the person is found responsible  
33 for a third or subsequent violation of any out-of-service order during any  
34 ~~ten year~~ TEN-YEAR period arising from separate incidents.

35 C. A person WHO IS required to have a commercial driver license or  
36 a commercial driver license holder AND who is found responsible for  
37 violating an out-of-service order pursuant to section 28-5241 while  
38 transporting hazardous materials or while operating a commercial motor  
39 vehicle designed or used to transport sixteen or more passengers,  
40 including the driver, is disqualified from driving a commercial motor  
41 vehicle as follows:

42 1. For a period of one hundred eighty days if the person is found  
43 responsible for a first violation of an out-of-service order.

1           2. For a period of three years if the person is found responsible  
2 for a second or subsequent violation of any out-of-service order during  
3 any ~~ten year~~ TEN-YEAR period arising from separate incidents.

4           D. A person WHO IS required to have a commercial driver license or  
5 a commercial driver license holder AND who is convicted of or found  
6 responsible for violating any federal, state or local railroad grade  
7 crossing law, ordinance or regulation is disqualified from driving a  
8 commercial motor vehicle as follows:

9           1. For a period of sixty days if a person is convicted of or found  
10 responsible for a first violation.

11           2. For a period of one hundred twenty days if a person is convicted  
12 of or found responsible for a second violation during any ~~three year~~  
13 THREE-YEAR period.

14           3. For a period of one year if a person is convicted of or found  
15 responsible for a third or subsequent violation during any ~~three year~~  
16 THREE-YEAR period.

17           E. If a federal agency determines that a commercial motor vehicle  
18 licensee is driving in a manner that constitutes an imminent hazard, the  
19 department, on receipt of notification by the federal government, shall  
20 disqualify the driver for a period not to exceed one year. The  
21 disqualification shall run concurrently with any other disqualification  
22 imposed on the driver. For the purposes of this subsection, "imminent  
23 hazard" means the existence of a condition that presents a substantial  
24 likelihood that death, serious illness, severe personal injury or a  
25 substantial endangerment to health, property or the environment may occur  
26 before the reasonably foreseeable completion date of a formal proceeding  
27 to decrease the risk of death, illness, injury or endangerment.

28           F. The department shall keep records of findings of responsibility  
29 for a civil traffic violation and of conviction of any moving criminal  
30 traffic violation for a commercial driver licensee for violations in any  
31 type of motor vehicle and for a person required to have a commercial  
32 driver license if the violations arise from the operation of a commercial  
33 motor vehicle. The department shall make the records available to other  
34 states, the United States secretary of transportation, the driver and any  
35 motor carrier or prospective motor carrier or the motor carrier's  
36 designated agent within ten days after receiving a report of a conviction  
37 or finding of responsibility in this state or receipt of a report of a  
38 conviction or finding of responsibility or disqualification received from  
39 another state.

40           G. Disqualification for a serious traffic violation committed by a  
41 commercial driver license holder while operating a noncommercial motor  
42 vehicle applies only if the conviction results in the revocation,  
43 cancellation or suspension of the person's commercial driver license or  
44 noncommercial driver license.

1 H. The department may adopt rules establishing guidelines and  
2 conditions under which the department may reduce a disqualification for  
3 life pursuant to subsection A, paragraph 3 of this section to a  
4 disqualification of at least ten years. If a person's disqualification is  
5 reduced pursuant to rules adopted pursuant to this subsection and the  
6 person is subsequently convicted of a violation described in subsection A,  
7 paragraph 1 of this section, the person is permanently disqualified from  
8 driving a commercial vehicle and is not eligible to apply for a reduction  
9 of the disqualification pursuant to rules adopted pursuant to this  
10 subsection.

11 I. Except as provided in subsection E of this section, the  
12 beginning date of the disqualification shall be ten days after the date  
13 the department receives the report of conviction or finding of  
14 responsibility.

15 J. For the purposes of this section, "serious traffic violation"  
16 means a conviction or finding of responsibility for any of the following:

17 1. Excessive speeding involving a single offense for a speed of  
18 fifteen miles per hour or more above the posted speed limit.

19 2. Reckless driving as provided by section 28-693.

20 3. Aggressive driving as provided by section 28-695.

21 4. Racing as defined in section 28-708.

22 5. Improper or erratic traffic lane changes as provided by section  
23 28-729.

24 6. Following the vehicle ahead too closely as provided by section  
25 28-730.

26 7. A violation of this title that is connected with a fatal traffic  
27 accident.

28 8. Driving a commercial motor vehicle if the person has not been  
29 issued a valid commercial driver license pursuant to this chapter.

30 9. Driving a commercial motor vehicle without a commercial driver  
31 license in the person's possession.

32 10. Driving a commercial motor vehicle without having a valid  
33 endorsement for the type of commercial motor vehicle or motor vehicle  
34 combination being operated.

35 11. Driving a commercial motor vehicle while using a portable  
36 wireless communication device as provided by section 28-914.

37 Sec. 15. Section 28-4805, Arizona Revised Statutes, is amended to  
38 read:

39 28-4805. Towing company; partial reimbursement; registration;  
40 payment forfeiture

41 A. If a vehicle is abandoned pursuant to section 28-4802 and a fee  
42 is collected by the department, the towing company that towed the  
43 abandoned vehicle, if still in business, is entitled to receive twenty  
44 percent of the fee collected as a partial reimbursement of the costs  
45 incurred by the towing company.

1 B. A TOWING COMPANY THAT IS OWED PARTIAL REIMBURSEMENT UNDER  
2 SUBSECTION A OF THIS SECTION IS REQUIRED TO REGISTER WITH THE STATE'S  
3 PROCUREMENT OFFICE IN ORDER TO QUALIFY FOR PAYMENT. FAILURE TO REGISTER  
4 WITH THE STATE'S PROCUREMENT OFFICE WILL RESULT IN DENIAL OF PAYMENT AND  
5 FORFEITURE OF THE PAYMENT.

6 C. THE DEPARTMENT SHALL MAKE THREE GOOD FAITH ATTEMPTS TO CONTACT  
7 THE TOWING COMPANY IDENTIFIED AS HAVING TOWED AN ABANDONED VEHICLE  
8 PURSUANT TO SECTION 28-4802 IN ORDER TO FACILITATE PAYMENT OF THE PARTIAL  
9 REIMBURSEMENT UNDER SUBSECTION A OF THIS SECTION. NOTWITHSTANDING ANY  
10 OTHER LAW AND AFTER THE GOOD FAITH EFFORT REQUIRED BY THIS SUBSECTION, IF  
11 THE DEPARTMENT DOES NOT RECEIVE A RESPONSE FROM OR IS UNABLE TO MAKE  
12 CONTACT WITH THE TOWING COMPANY AFTER THIRTY DAYS, THE PAYMENT IS SUBJECT  
13 TO FORFEITURE AND WILL REVERT TO THE ABANDONED VEHICLE ADMINISTRATION FUND  
14 ESTABLISHED BY SECTION 28-4804.

15 Sec. 16. Section 28-7143, Arizona Revised Statutes, is amended to  
16 read:

17 28-7143. Moving and related expenses; payment; substitute  
18 payments

19 A. As a part of the cost of construction and on proper application  
20 to the department, the department shall pay to a displaced person,  
21 business or farm operation:

22 1. Actual reasonable expenses in moving the displaced person and  
23 the displaced person's family, business, farm operation or other personal  
24 property.

25 2. Actual direct losses of tangible personal property as a result  
26 of moving or discontinuing a business or farm operation, but not more than  
27 the reasonable expenses that would have been required to relocate the  
28 property as determined by the department.

29 3. Actual reasonable expenses in searching for a replacement  
30 business or farm.

31 4. Actual reasonable expenses necessary to reestablish a displaced  
32 farm, nonprofit organization or small business at its new site pursuant to  
33 criteria established by the department, but not more than ~~twenty-five~~  
34 ~~thousand dollars~~ \$50,000.

35 B. A displaced person who is eligible for payments under subsection  
36 A of this section, who is displaced from a dwelling and who elects to  
37 accept the payments authorized by this subsection in lieu of the payments  
38 authorized by subsection A of this section may receive an expense and  
39 dislocation allowance determined according to a schedule established by  
40 the director.

1 C. A displaced person who is eligible for payments under subsection  
2 A of this section, who is displaced from the person's place of business or  
3 farm operation and who is eligible under criteria established by the  
4 department may elect to accept, instead of the payment authorized by  
5 subsection A of this section, a fixed payment in an amount that is  
6 determined according to criteria established by the department and that is  
7 at least ~~one thousand dollars~~ \$1,000 but not more than ~~forty thousand~~  
8 ~~dollars~~ \$40,000. A person whose sole business at the displacement  
9 dwelling is the rental of the property to others does not qualify for a  
10 payment under this subsection.

11 Sec. 17. Section 28-7314, Arizona Revised Statutes, is amended to  
12 read:

13 28-7314. Publisher powers and duties; award of contract

14 A. The publisher may:

15 1. Subject to approval of the director, direct the organization of  
16 the section of publications and employ or enter into contracts for  
17 distribution and wholesale sale of the magazine.

18 2. Make quarterly reports to the director of expenditures by the  
19 section and the work accomplished under the publisher's direction and  
20 include other matters as the director deems proper or requires.

21 3. Make expenditures to advertise and promote the sale and  
22 distribution of the publications authorized by this article.

23 4. Approve claims for expenditures in connection with the  
24 publication of the magazine and for expenditures in connection with the  
25 publication.

26 5. Subject to the approval of the director, contract for the  
27 publication, production, sale and distribution of sole source creative  
28 products. ~~As used in~~ FOR THE PURPOSES OF this paragraph, "sole source  
29 creative products" means items that in the professional judgment of the  
30 publisher are available from a single source, such as material protected  
31 by copyright, specific photographs and original artwork, for the magazine  
32 or maps, pamphlets and other descriptive material.

33 6. ACCEPT DONATIONS TO THE ARIZONA HIGHWAYS MAGAZINE TO PROMOTE  
34 TOURISM IN THIS STATE AS PRESCRIBED IN SECTION 28-7312.

35 B. The director may award a contract to the bidder that has the  
36 facilities and equipment to perform all phases of production in a  
37 workmanlike and timely manner with the quality and workmanship desired in  
38 the publication. A contract period for printing and publishing shall not  
39 exceed five years.

40 C. The publisher may refund all ~~cancelled~~ CANCELED purchases and  
41 subscriptions on claims signed by the publisher.

1           Sec. 18. Section 28-7315, Arizona Revised Statutes, is amended to  
2 read:

3           28-7315. Arizona highways magazine fund

4           A. An Arizona highways magazine fund is established.

5           B. The fund consists of monies:

6           1. Appropriated by the legislature from the state highway fund of  
7 not more than ~~five hundred thousand dollars~~ \$500,000 annually.

8           2. Received from the sales of subscriptions, single copies, maps,  
9 pamphlets and other descriptive material.

10          3. Deposited pursuant to section 28-2429.

11          4. DONATED TO THE ARIZONA HIGHWAYS MAGAZINE TO PROMOTE TOURISM IN  
12 THIS STATE AS PRESCRIBED IN SECTION 28-7312.

13          C. The monies appropriated to the fund shall be spent in conformity  
14 with the laws governing state financial operations, except that:

15          1. Balances remaining at the end of the fiscal year do not revert  
16 to the general or state highway fund.

17          2. Expenditures are exempt from section 35-173.

18          D. The state treasurer shall invest and divest monies in the  
19 Arizona highways magazine fund as provided by section 35-313, and monies  
20 earned from investment shall be credited to the fund.

21         Sec. 19. Section 32-2351, Arizona Revised Statutes, is amended to  
22 read:

23         32-2351. Definitions

24         In this chapter, unless the context otherwise requires:

25         1. "Agent" means any person who, for compensation, enrolls or  
26 attempts to enroll residents of this state in a professional driver  
27 training school through personal or telephone contact, advertisement, mail  
28 or any other type of publication.

29         2. "Director" means the director of the department of  
30 transportation.

31         3. "Instructor" means any person, whether acting for himself as an  
32 operator of a professional driver training school or for any such school  
33 for compensation, who teaches, conducts classes of, gives demonstrations  
34 to, or supervises the practice of persons learning to operate or drive  
35 motor vehicles or preparing to take an examination for a driver license or  
36 instruction permit, and any person who supervises the work of any other  
37 instructor.

38         4. "Professional driver training school" or "school" means a  
39 business enterprise conducted by an individual, association, partnership,  
40 or corporation that educates and trains persons, either practically or  
41 theoretically, or both, to operate or drive commercial motor vehicles,  
42 that prepares applicants for an examination given by the state for a  
43 commercial driver license or ~~instruction~~ LEARNER'S permit and that charges  
44 a consideration or tuition for these services.

1           Sec. 20. License reinstatement

2           If, before the effective date of this act, a person's driving  
3 privilege is suspended or revoked pursuant to section 28-1601, Arizona  
4 Revised Statutes, on the effective date of this act the department of  
5 transportation shall automatically rescind the suspension or revocation  
6 and reinstate the person's driving privilege. The department of  
7 transportation shall not charge a fee for the reinstatement.

8           Sec. 21. Short title

9           In recognizing his life of service to the state of Arizona, this act  
10 may be cited as the "John Carlson Memorial Act".

11           Sec. 22. Conditional enactment

12           Section 28-1601, Arizona Revised Statutes, as amended by this act,  
13 does not become effective unless Senate Bill 1551, fifty-fifth  
14 legislature, first regular session, relating to driving privileges,  
15 becomes law.

APPROVED BY THE GOVERNOR MAY 7, 2021.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 7, 2021.

## TITLE 17. TRANSPORTATION

## CHAPTER 4. DEPARTMENT OF TRANSPORTATION - TITLE, REGISTRATION, AND DRIVER LICENSES

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 3368, effective November 10, 2007 (Supp. 07-3). Amended by final rulemaking at 24 A.A.R. 1543, effective May 1, 2018 (Supp. 18-2).

**Table A. Recodified****Historical Note**

Table A adopted by final rulemaking at 5 A.A.R. 2928, effective August 5, 1999 (Supp. 99-3). Table recodified to 17 A.A.C. 1, Article 1 at 7 A.A.R. 919, effective January 24, 2001 (Supp. 01-1).

**ARTICLE 8. MOTOR VEHICLE RECORDS****R17-4-801. Definitions**

“Batch” means a query-command method that initiates simultaneous production of an electronic file or series of requests that may have delayed results.

“Certified record” means a copy of a document designated as a true copy by the agency officer entrusted with custody of the original to be used for purposes prescribed under A.R.S. § 28-442.

“Commercial driver license record” has the same meaning as a CDLIS motor vehicle record as defined in 49 CFR 384.105.

“Customer number” means the system-generated, or other distinguishing number, assigned by the Department to each person with a record on the Department’s database, which includes the driver license number assigned to a person for a driver license, identification card, or instruction permit.

“Driver record” means a motor vehicle record more specifically defined to include any data that pertains to a driver license, identification card, instruction permit, or driver related activities.

“Interactive” means an electronic query-command method individually initiated by a person that produces immediate results.

“Reasonable costs” has the same meaning as defined in A.R.S. § 12-351.

“Requester” means the person, as defined in A.R.S. § 41-1001, requesting a motor vehicle record.

“Special MVR” means a motor vehicle record that is comprised of the least possible subset of information necessary to respond to the type of request received.

“Support document” means any customer record maintained by the Department in an electronic, hardcopy, or microfilm file storage format.

“Title and registration record” means a motor vehicle record more specifically defined to include any data that pertains to a vehicle title or registration record.

**Historical Note**

Adopted effective June 29, 1990 (Supp. 90-2). Section recodified to R17-5-701 at 7 A.A.R. 3483, effective July 20, 2001 (Supp. 01-3). New Section made by final rulemaking at 13 A.A.R. 4376, effective February 2, 2008 (Supp. 07-4). Amended by final expedited rulemaking at 24 A.A.R. 3498, effective December 4, 2018 (Supp. 18-4).

**R17-4-802. Motor Vehicle Record Request**

- A. Identification requirements. The requester of a motor vehicle record shall present valid identification as indicated on the motor vehicle record request form or at the request of the Department at the time a motor vehicle record request is made.
- B. Charges and exemptions. The requester of a motor vehicle record shall pay the appropriate motor vehicle record copy charge under R17-4-803, unless exempt under A.R.S. § 28-446.
- C. Motor vehicle record types. Under this Article, the Department may release any of the following motor vehicle record types:
  1. Title and Registration record, uncertified;
  2. Title and Registration record, certified;
  3. Driver 39-month record, uncertified;
  4. Driver five-year record, certified;
  5. Driver extended history record, certified;
  6. Special MVR, uncertified;
  7. Commercial driver license record, uncertified;
  8. Support documents, uncertified; and
  9. Support documents, certified.
- D. Search Criteria. A requester who has a permissible use under A.R.S. § 28-455, except as indicated under subsection (E) when using the permissible use under A.R.S. § 28-455(C)(11), shall provide at least one of the items of information listed in this subsection when requesting a motor vehicle record. The requester may need to provide additional information as needed in order to locate the record.
  1. For a title and registration motor vehicle record:
    - a. Vehicle identification number,
    - b. License plate number, or
    - c. Vehicle owner’s full name.
  2. For a driver motor vehicle record:
    - a. The full name of the person whose record is requested, or
    - b. Customer number.
- E. Consent to release motor vehicle record. A requester who uses the permissible use under A.R.S. § 28-455(C)(13) shall present a properly signed Consent To Release Motor Vehicle Record - One-Time form from the person whose motor vehicle record is requested. A requester who uses the permissible use under A.R.S. § 28-455(C)(11) shall present a properly signed Consent To Release Motor Vehicle Record - General form from the person whose motor vehicle record is requested if that person has not previously submitted this form to the Department. In addition, a requester who uses the permissible use under A.R.S. § 28-455(C)(11) shall provide the items of information listed in this subsection. The Consent To Release Motor Vehicle Record forms are available at all Customer Service and Authorized Third Party Provider offices and online at <https://www.azdot.gov>.
  1. For a title and registration motor vehicle record:
    - a. Two items under subsection (D)(1), and
    - b. The vehicle owner’s residence address.
  2. For a driver motor vehicle record:
    - a. The name and customer number of the person whose record is requested, and
    - b. The person’s date of birth, or
    - c. The person’s address, or
    - d. The person’s Arizona driver license expiration date.
- F. General consent to release information. The Department shall record a person’s general consent to release information on the person’s driver and title and registration records.
  1. The general consent to release information is valid until revoked, in writing, by the person.
  2. A person may submit the written notice of revocation:

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- a. In person, at a Customer Service office or Authorized Third Party Provider; or
- b. By mail, to Motor Vehicle Division, P.O. Box 2100, Mail Drop 500M, Phoenix, AZ 85001-2100.

Section made by final rulemaking at 13 A.A.R. 4376, effective February 2, 2008 (Supp. 07-4). Amended by final expedited rulemaking at 24 A.A.R. 3498, effective December 4, 2018 (Supp. 18-4).

**G.** Insurance companies requesting a driver record. The Department shall not release to an insurer, broker, managing general agent, authorized agent or insurance producer any information in a person’s driving record pertaining to a traffic violation that occurred 40 months or more before the date of a request for the release of the information.

**R17-4-803. Record Copy Charges**

In accordance with A.R.S. §§ 12-351 and 28-446, for each separate request, the Department shall assess a charge as provided in Table 1. Certified and Uncertified Motor Vehicle Record Fees. Therefore, a fee is collected if the request results in a motor vehicle record or “No Record Found.”

**Historical Note**

Adopted effective August 16, 1991 (Supp. 91-3). Section repealed, new Section adopted effective April 19, 1994 (Supp. 94-2). Section recodified to R17-4-508 at 7 A.A.R. 3479, effective July 20, 2001 (Supp. 01-3). New

**Historical Note**

New Section made by final expedited rulemaking at 24 A.A.R. 3498, effective December 4, 2018 (Supp. 18-4).

**Table 1. Certified and Uncertified Motor Vehicle Record Fees**

Description	Method of Delivery	Amount
A certified record:	Over-the-counter immediate or drop-off service; Mail-in request; or Electronic interactive.	\$5
	Electronic batch.	\$3
A certified support document:	Over-the-counter immediate or drop-off service; or Mail-in request.	\$5
An uncertified record:	Over-the-counter immediate service; Mail-in request; or Electronic interactive.	\$3
	Electronic batch; or Over-the-counter drop-off service.	\$2
An uncertified support document:	Over-the-counter immediate or drop-off service; or Mail-in request.	\$3
An uncertified Special MVR:	Over-the-counter immediate or drop-off service; Mail-in request; or Electronic interactive.	\$1.50
Civil subpoena support documentation:	Served by a process server.	Reasonable costs
Any photocopied item: (Does not include... etc.)	Over-the-counter immediate or drop-off service; or Mail-in request.	25¢ per page

**Historical Note**

Table 1 made by final expedited rulemaking at 24 A.A.R. 3498, effective December 4, 2018 (Supp. 18-4).

**R17-4-804. Repealed**

**Historical Note**

Adopted effective June 29, 1990 (Supp. 90-2). Repealed effective November 21, 1995 (Supp. 95-4).

**Historical Note**

Adopted effective June 29, 1990 (Supp. 90-2). Section recodified to R17-5-704 at 7 A.A.R. 3483, effective July 20, 2001 (Supp. 01-3).

**R17-4-805. Recodified**

**Historical Note**

Adopted effective June 29, 1990 (Supp. 90-2). Section recodified to R17-5-702 at 7 A.A.R. 3483, effective July 20, 2001 (Supp. 01-3).

**R17-4-808. Recodified**

**Historical Note**

Adopted effective June 29, 1990 (Supp. 90-2). Section recodified to R17-5-705 at 7 A.A.R. 3483, effective July 20, 2001 (Supp. 01-3).

**ARTICLE 9. RESERVED**

**R17-4-806. Recodified**

**Historical Note**

Adopted effective June 29, 1990 (Supp. 90-2). Section recodified to R17-5-703 at 7 A.A.R. 3483, effective July 20, 2001 (Supp. 01-3).

**R17-4-901. Recodified**

**Historical Note**

Adopted effective March 31, 1978 (Supp. 78-2). Former Section R17-4-59 renumbered without change as Section R17-4-901 (Supp. 87-2). Former Section R17-4-901 repealed, new Section R17-4-901 adopted effective June 15, 1988 (Supp. 88-2). Section recodified to R17-1-501 at 7 A.A.R. 3477, effective July 20, 2001 (Supp. 01-3).

**R17-4-807. Recodified**

**R17-4-902. Recodified**

**§ 28-366. Director; rules**

The director shall adopt rules pursuant to title 41, chapter 6 as the director deems necessary for:

1. Collection of taxes and license fees.
2. Public safety and convenience.
3. Enforcement of the provisions of the laws the director administers or enforces.
4. The use of state highways and routes to prevent the abuse and unauthorized use of state highways and routes.

**§ 28-446. Fees for copies; exemptions**

A. The department may furnish information from the records that are required to be kept by this title or may furnish copies from the records. The department may charge a fee for providing the information or copies that does not exceed three dollars for each item.

B. The department shall not charge any of the following for copies of records, for certified copies of records or for information furnished from its records:

1. This state or its departments, agencies or political subdivisions.
2. A court.
3. The federal government or its agencies.
4. A law enforcement agency in a foreign country.
5. A toll operator as defined in section 28-7751.

C. The department shall furnish either of the following to any person on payment of a fee of five dollars:

1. Certified copies of public records designated pursuant to section 28-447.
2. Vehicle title history information.

D. This section does not apply to information required by law to be kept confidential or to statistical information, the purpose of which relates to traffic accidents, traffic offenses or traffic enforcement.

E. The director shall deposit, pursuant to sections 35-146 and 35-147, fees collected under this section in the Arizona highway user revenue fund.

**§ 28-449. Information requests for public records**

A. The director may designate as custodian of the department's public records as many employees of the department as the director deems necessary.

B. A person who requests a copy of or information from a public record designated pursuant to section 28-447 shall present personal identification and state the reason for making the request. The department shall verify the name and address of the person making the request by requiring the person to produce information the department determines is necessary to ensure that the name and address of the person are the person's true name and address.

C. The department may supply the requested information by mail or electronically.

D. The department shall maintain a file of requests for information for six months. The department shall maintain the file by the name of the person whose record was requested.

**§ 28-455. Release of personal information; fees**

A. In accordance with section 28-458 and the driver's privacy protection act of 1994 (18 United States Code sections 2721 through 2725) and notwithstanding section 28-447, the department shall not knowingly disclose or otherwise make available to any person:

1. Personal information obtained by the department in connection with a motor vehicle record except as otherwise provided in this section.
2. Highly restricted personal information obtained by the department in connection with a motor vehicle record without the express consent of the person to whom the information applies except for uses allowed in subsection C, paragraphs 1, 4, 6 and 9 of this section. This paragraph does not affect the use of organ donation information on an individual's driver license or affect the administration of organ donation in this state.

B. The department shall disclose personal information for use in connection with the following matters:

1. Motor vehicle or driver safety and theft.
2. Motor vehicle emissions.
3. Motor vehicle product alterations, recalls or advisories.
4. Performance monitoring of motor vehicles and dealers by motor vehicle manufacturers.
5. Removal of nonowner records from the original owner records of motor vehicle manufacturers to carry out the purposes of titles I and IV of the anti car theft act of 1992 (18 United States Code sections 2311 through 2322), the automobile information disclosure act (15 United States Code sections 1231, 1232 and 1233), the clean air act of 1963 (42 United States Code sections 7401 through 7671q) and 49 United States Code chapters 301, 305 and 321 through 331.

C. Subject to subsection A of this section, the department may disclose personal information as follows:

1. For use by any government agency, including any court or law enforcement agency, in carrying out its functions or any private person or entity acting on behalf of a government agency in carrying out its functions.
2. For use in connection with matters of:

- (a) Performance monitoring of motor vehicles, motor vehicle parts and dealers.
  - (b) Motor vehicle market research activities, including survey research.
  - (c) Removal of nonowner records from the original owner records of motor vehicle manufacturers.
3. For use in the normal course of business by a legitimate business or its agents, employees or contractors, but only:
- (a) To verify the accuracy of personal information submitted by the individual to the business or its agents, employees or contractors.
  - (b) If the information submitted is not correct or is no longer correct, to obtain the correct information for the purpose of preventing fraud by, pursuing legal remedies against or recovering on a debt or security interest against the individual.
4. For use by an attorney licensed to practice law or by a licensed private investigator in connection with any civil, criminal, administrative or arbitration proceeding in any court or government agency or before any self-regulatory body, including the service of process, investigation in anticipation of litigation and the execution or enforcement of judgments and orders, or pursuant to a court order.
5. For use in research activities and for use in producing statistical reports if the personal information is not published, redisclosed or used to contact individuals.
6. For use by any insurer that writes automobile liability or motor vehicle liability policies and that is under the jurisdiction of the department of insurance and financial institutions or insurance support organization or by a self-insured entity or its agents, employees or contractors in connection with claims investigation activities, antifraud activities, rating or underwriting.
7. For use in providing notice to the owners of towed or impounded vehicles.
8. For use by any licensed private investigative agency or licensed security service for any purpose allowed under this section.
9. For use by an employer or its agent or insurer to obtain or verify information relating to a holder of a commercial driver license that is required under 49 United States Code sections 31301 through 31317.

10. For use by a toll operator as defined in section 28-7751 in connection with the operation of a toll facility or the enforcement of tolls, administrative charges and penalties as defined in section 28-7751.

11. For any other use in response to requests for individual motor vehicle records if the state has obtained the express consent of the person to whom the personal information pertains.

12. For use by any requester if the requester demonstrates it has obtained the written consent of the individual to whom the information pertains.

13. For any other use that is specifically authorized by law and that is related to the operation of a motor vehicle or public safety, including the following:

(a) Use by a financial institution or enterprise under the jurisdiction of the department of insurance and financial institutions or a federal monetary authority.

(b) Use by a motor vehicle dealer who is licensed and bonded by the department or a state organization of licensed and bonded motor vehicle dealers.

(c) Use by a person who is involved in an accident or the owner of a vehicle involved in an accident if the person who requests the information submits proof to the department of involvement in the accident.

(d) Use by a person applying for a bonded title if all of the following conditions exist:

(i) The requester verifies to the satisfaction of the director that the vehicle on which the requester is requesting the record is in the requester's possession.

(ii) The record is requested in order for the requester to notify the registered owner of the requester's intent to apply to the department for a bonded title.

(iii) The requester provides a verification of a vehicle inspection that was performed by an authorized department employee or agent.

(e) Use by an operator of a self-service storage facility who alleges both of the following:

(i) That the vehicle on which the operator is requesting the record is in the operator's possession.

(ii) That the record is requested to allow the operator to notify the registered owner and any lienholders of record of the operator's intent to foreclose its lien and to sell the vehicle.

(f) For any other use as determined by the director and established by rule.

D. The department may establish and carry out procedures under which the department, on receiving a request for personal information that does not fall within one of the exceptions prescribed in subsection B or C of this section, may mail a copy of the request to the individual about whom the information was requested. The mailing shall inform the individual of the request and contain a statement that the information will not be released unless the individual waives the individual's right to privacy under this section.

E. In addition to the permissible uses prescribed in subsection C of this section, the department may disclose its motor vehicle records information, including personal information, as a bulk record only under any of the following conditions:

1. If the director determines either of the following:

(a) The sale or release of the record is necessary for the public health or safety.

(b) The use is for general research or general statistical purposes that do not provide specific factors from a record.

2. For the release of motor vehicle title and motor vehicle registration information, vehicle identification numbers, title brands, odometer readings and brands and title lien information to a requester if the requester is in the business of preparing vehicle history reports and the information is used to develop a vehicle history report.

F. The department shall not sell records with personal identifying information for a commercial purpose except to a person authorized to receive the records under the permissible use provisions of this section and the driver's privacy protection act of 1994 (18 united states code sections 2721 through 2725).

G. Driver histories shall not be disclosed under subsection E of this section.

H. Except as provided in subsection I of this section and section 28-446, subsection B, records provided pursuant to subsections B and C of this section are subject to the fees prescribed in section 28-446, subsections A and C.

I. For records searched and provided for the purposes described in subsection E of this section, the director:

1. Shall charge a search fee that is a minimum of \$600 per million records searched.
2. Shall charge a records fee that is a minimum of \$30 per thousand records provided.
3. May prorate the charge for fractional quantities that are searched or provided.

J. Records requests that require a database search for specific criteria within a record are subject to a search fee. In addition to this search fee, each motor vehicle record provided to a records requester as a result of a criteria search incurs record fees in accordance with subsection H of this section.

**History:**

Amended by L. 2021, ch. 335, s. 4, eff. 9/29/2021. Amended by L. 2019, ch. 252, s. 29, eff. 7/1/2020.

**§ 28-458. Motor vehicle records release; department review panel**

The director shall select a department review panel to do all of the following:

1. Meet as necessary to review applications for the release of motor vehicle records information.
2. Verify the accuracy of an applicant's information that is required by the director.
3. Based on the review and verification of the application and information required by the director, determine the applicant's eligibility to receive motor vehicle records information for purposes authorized by law.

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)**

Title 9, Chapter 28, Article 6



# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

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**MEETING DATE:** June 1, 2022; July 6, 2022; August 2, 2022; September 7, 2022; March 7, 2023

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** February 13, 2023

**SUBJECT:** ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)  
Title 9, Chapter 28, Articles 6

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### Summary

This Five-Year Review Report (5YRR) from the Arizona Health Care Cost Containment System (AHCCCS) relates to six (6) rules in Title 9, Chapter 28, Article 6 (RFP and Contract Process).

The rules in Article 6 relate to Request for Proposal and contract process for the Arizona Long-Term Care System (ALTCS). The ALTCS is health insurance for individuals who are age 65 or older, or who have a disability, and who require nursing facility level of care. Services may be provided in an institution or in a home or community-based setting. Pursuant to A.R.S. 36-2944, the director at least every five years shall prepare and issue a request for proposal and a proposed contract format to qualified group disability insurers, hospital and medical service corporations, health care services organizations and any other qualified public or private persons to be a program contractor and provide long-term care services. The director may adopt rules regarding the request for proposal process, which was done in Title 9, Chapter 28, Article 6.

As a reminder, this 5YRR was previously considered over several meeting cycles. Specifically, the Council had raised concerns regarding AHCCCS's oversight, monitoring, and sanctions with regards to provision of Non-Emergency Medical Transportation (NEMT) services. At the September 7, 2022 Council Meeting, the Council voted to return the report

related to Title 9, Chapter 28, Article 6 and directed AHCCCS to submit a revised report for the current meeting cycle. Specifically, AHCCCS indicated it was working with its NEMT Workgroup, and had reached out to its Managed Care Organizations (MCOs), to investigate and address the concerns raised by the Council and the Council indicated it would like to see a revised report outlining any proposed changes to the rules to address the issues that resulted from those discussions.

AHCCCS has indicated to Council staff they will be submitting the updated 5YRR to be responsive to the program updates that have occurred in the last six (6) months prior to the February 28, 2023 Study Session. Council staff will circulate the revised 5YRR to the Council when it is received.

February 21, 2023

Nicole Sornsin, Chair  
Governor's Regulatory Review Council  
100 North 15th Avenue, Suite 305  
Phoenix, Arizona 85007

RE: AHCCCS Title 9, Chapter 22, Article 6, and Chapter 28, Article 6 -  
Returned Five Year Review Reports

Ms. Sornsin:

This letter is submitted under A.A.C. Title 1, Chapter 6, Article 305, with the submission of a revised five-year review report. Per GRRC's comment regarding a lack of AHCCCS regulatory mechanisms to track and compile data regarding the timeliness of Non-Emergency Medical Transportation (NEMT) services, AHCCCS has made changes to the Five Year Review Reports' courses of action. Following GRRC's approval of the reports, AHCCCS will request approval from the Governor's Office to initiate a regular rulemaking to make those changes identified in rule and laid out in the report. Those changes identified in the five year review reports meet the requirements in A.R.S. 41-1056(A).

AHCCCS has taken GRRC's concerns regarding timeliness of NEMT services and began by speaking with each of the managed care health plans to determine what regulation of such services currently looked like. It was identified that the reason a trip might not be completed, and who cancelled a trip (a member or a provider) was not being captured in the information the health plans captured on a monthly basis and reported to AHCCCS. Therefore, AHCCCS has updated policy language to make it clear to providers the reasons that this additional level of granularity is required, and has updated contract language to make it clear this is also an additional reporting requirement of the health plan to report to AHCCCS. In this way, both the front line providers of these services, and the health plans as case managers of members' care will be monitoring and reporting NEMT services; and AHCCCS will also receive all of this data on a monthly basis and be able to identify systemic issues or concerning patterns much more quickly to prevent undue burdens on AHCCCS members. This reporting requirement can most clearly be seen in the chart that each health plan is required to use. The amendments to policy and contract language, as well as this deliverable chart can all be found in Attachment A submitted with the revised Five-year review reports.

Additionally, although this was not part of GRRC's concerns when they returned the five-year review report to AHCCCS, the Administration wanted to update the council that additional information has been sent out to members and posted on AHCCCS's website regarding the level of services members may request when taking an NEMT trip. Either due to the current condition of the member, or as an ongoing status, members may request with their health plans a higher level of assistance on NEMT trips;

for example, instead of curb-to-curb drop off, they can request hand-to-hand that would take them directly from the assistance of one provider to the assistance of the other provider.

Through these changes in policy, rule, and outreach directly to members, AHCCCS believes we have addressed GRRC's concerns with the NEMT services. We also feel confident that this will prevent a temporary improvement due to the ongoing reporting, the monthly capturing of data, and members' abilities to request the care level they need at any time in NEMT services. Policy and contract language is also where the health plans and providers would expect to find additional data reporting required of them, instead of in administrative rule.

Please let me know if there are any questions about these changes.

Sincerely,



Kasey Rogg  
General Counsel

Attachments: Five Year Review Report R9-22-Art 6  
Five Year Review Report R9-28-Art 6  
Attachment A

**Arizona Health Care Cost Containment System (AHCCCS)**

**5 YEAR REVIEW REPORT**

**A.A.C. Title 9, Chapter 28, Articles 6**

**February 2023**

**1. Authorization of the rule by existing statutes**

General Statutory Authority: A.R.S. § 36-2932

Implementing statute: A.R.S. §§ 36-2944, 36-2943, 36-2959, and 36-2999.51

**2. The objective of each rule:**

Rule	Objective
R9-28-601	The objective of the rule is to list the authority for the Request for Proposal (RFP) and describe the applicability of Title 9 Chapter 28 Article 6
R9-28-602	The objective of this rule is to prescribe the contents of the RFP and the proposal process.
R9-28-603	The objective of this rule is to prescribe the process the Administration follows when awarding contracts.
R9-28-604	The objective of this rule is to prescribe the means of protesting an RFP or award including the administrative appeal process.
R9-28-605	The objective of this rule is to prescribe means by which an offeror or contractor may request from the Director a waiver of the requirement for hospital subcontracts.
R9-28-606	The objective of this rule is to prescribe sanctions the Director may impose on contractors for noncompliance and the factors considered when doing so.

**3. Are the rules effective in achieving their objectives?** Yes X No   

**4. Are the rules consistent with other rules and statutes?** Yes X No   

**5. Are the rules enforced as written?** Yes X No   

**6. Are the rules clear, concise, and understandable?** Yes X No   

**7. Has the agency received written criticisms of the rules within the last five years?** Yes    No X

**8. Economic, small business, and consumer impact comparison:**

There has not been a rulemaking since the last Five Year Review Report. Therefore, the economic impact is not significantly different than the original economic impact.

**9. Has the agency received any business competitiveness analyses of the rules?** Yes    No X

10. **Has the agency completed the course of action indicated in the agency’s previous five-year-review report?**

There was no proposed course of action in the prior 5YRR.

11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

The Administration believes the rules as written impose the least burden and cost when meeting their objectives.

12. **Are the rules more stringent than corresponding federal laws?** Yes \_\_\_ No X

13. **For rules adopted after July 29, 2010, that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

Not applicable.

14. **Proposed course of action:**

Following GRRC approval of this Five-Year Review Report, AHCCCS plans to undertake a workgroup with internal stakeholders in the RFP process, which will include the health plans and managed care contractors, to determine whether larger changes should be made to the RFP process. Since any substantive changes to the RFP process could implicate the eligibility of contractors’ proposals, AHCCCS plans to undertake a regular rulemaking that allows for the full-length rulemaking process to ensure all stakeholders have an opportunity to be heard.

In addition, AHCCCS recently added new contract terms and policy language requiring contractors to report additional level of detail for each Non-Emergency Medical Transportation trip provided to a member on their health plan. Please see **Attachment A** for a detailed review of this new contract and policy language.

## **Attachment A: Updates to AHCCCS Policy & Contract Language for NEMT tracking**

### ***Changes to Policy Language***

The AHCCCS Contractor Operations Manual (ACOM) Policies are incorporated by reference in the Medicaid Managed Care Organization (MCO) Contracts. The purpose of the ACOM is to consolidate and provide ease of access to the Administrative, Claims, Financial, and Operational Policies of AHCCCS. The ACOM Manual provides information to Contractors and subcontractors who have delegated responsibilities under a contract. The ACOM should be referenced in conjunction with State and Federal regulations, other Agency manuals, and applicable contracts.

The Contractor is responsible for complying with the requirements set forth within the ACOM and is responsible for ensuring that its subcontractors are notified when modifications are made to policies therein. Upon adoption by AHCCCS, updates to the ACOM notifications are distributed to any stakeholder or tribal member that has signed up for AHCCCS Policy Update Notifications and are also made available on the AHCCCS website.

All substantive policy changes go through a rigorous policy review process internally, including approval by AHCCCS Policy Committee, made up of agency leadership. Then the policy goes through public notice & comment, as well as being presented at a quarterly tribal consultation and a subsequent 45-day tribal notice and comment. These processes allow all contractors, providers, and stakeholders to be included in the policy revision process, as well as meeting requirements placed by the Centers for Medicare & Medicaid Services upon all State Medicaid Agencies.

ACOM 417 establishes appointment accessibility and availability standards and establishes a common process for Contractors to monitor and report appointment accessibility and availability. The Contractor is responsible for adhering to all requirements as specified in Contract, Policy, 42 CFR Part 457 and 42 CFR Part 438.

**G. Transportation Timeliness Review** is amended as follows:

For medically necessary non-emergent transportation, the Contractor shall ensure that a member arrives on time for an appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home.

The Contractor shall meet the following performance target: 95% of all completed pickups and drop off trips in a quarter must be timely. The Contractor shall evaluate compliance with these standards on a quarterly basis for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.

The Contractor shall also track scheduled trips that were not completed for any reason.

**H. Tracking and Reporting** is amended as follows:

1. The Contractor shall track provider compliance with appointment availability and transportation timeliness as specified in Contract and outlined below.

A cover letter shall be included with Attachment A including, at a minimum, the following:

- a. A description of the methods used to collect the information,
- b. An explanation of whether the Contractor is surveying all providers in their network or a sample. If the Contractor is selecting a sample, the explanation shall include the methodology for how the sample size meets a 95% statistically significant confidence level, including the calculations used to confirm the confidence level,
- c. A summary of the findings and an explanation of trends in either direction (positive or negative),
- d. An analysis of the potential causes for these findings and trends, and
- e. A description of any interventions applied to areas of concern including, any corrective actions taken.

2. The Contractor shall submit Attachment B for each line of business, with a cover letter for each submission including, at a minimum, the following:

- a. A summary of the findings and any identified positive or negative trends ~~in either direction (positive or negative)~~ for timeliness, and incomplete scheduled trips and their reasons for each submission,
- b. An analysis of the potential causes for these findings and trends, and
- c. A description of any interventions applied to areas of concern including, any corrective actions taken.

The Contractor shall provide additional corrective action steps for any reporting quarter where the average percent of all timely completed trips for that quarter falls below the performance target of 95%. These steps shall include a timeline of when the contractor expects to again achieve the performance target of 95% of trips being completed timely.

3. DDD and CHP shall also submit a copy of Attachment A and B, for each of their Subcontracted Health Plans. DDD and CHP shall also submit a cover letter containing the information as specified above related to their Subcontracted Health Plans.

4. Annually, as a component of the NDMP, the Contractor shall:

- a. Conduct a review of its network sufficiency when there has been a significant decrease in appointment availability performance over the previous year, and
- b. For each standard specified within this Policy under the General Appointment Standards, General Behavioral Health Standards and Additional Behavioral Health Standards compare its annual average performance to the previous Contract year's average performance. For any standard that decreased by more than five percentage points, conduct a review of the sufficiency of its provider network.

ACOM 417 also contains two attachments, and Attachment B is a tracking spreadsheet they are required to complete on a monthly basis. Previously, ACOM 417B tracked the percentage of timely pick ups and drop offs. However, due to workgroup and data gathering that came out of GRRC’s prior questions on this topic, it was identified that this did not capture all possible scenarios where trips were not completed. Therefore, the Attachment B language is amended as follows: (Red text is new language)

<b>TRANSPORTATION TIMELINESS REPORT FOR COMPLETED TRIPS - ROLLING QUARTERS</b>	<b>MM/YY</b>	<b>MM/YY</b>	<b>MM/Y Y</b>	<b>Qtr Total</b>
<b>TOTAL AMBULATORY DROP OFFS</b>				0
<b>TOTAL NON-AMBULATORY DROP OFFS</b>				0
<b>TOTAL DROP OFFS</b>	0	0	0	0
<b>TIMELY AMBULATORY DROP OFFS</b>				0
<b>TIMELY NON-AMBULATORY DROP OFFS</b>				0
<b>TOTAL TIMELY DROP OFFS</b>	0	0	0	0
<b>% TOTAL DROP OFFS TIMELY</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
<b>TOTAL AMBULATORY PICKUPS</b>				0
<b>TOTAL NON-AMBULATORY PICKUPS</b>				0
<b>TOTAL PICKUPS</b>	0	0	0	0
<b>TIMELY AMBULATORY PICKUPS</b>				0
<b>TIMELY NON-AMBULATORY PICKUPS</b>				0
<b>TOTAL TIMELY PICKUPS</b>	0	0	0	0
<b>% TOTAL PICKUPS TIMELY</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
<b>TOTAL COMPLETED TRIPS</b>	0	0	0	0
<b>TOTAL COMPLETED TIMELY TRIPS</b>	0	0	0	0
<b>% TOTAL COMPLETED TRIPS TIMELY</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

<b>TRANSPORTATION REPORT FOR INCOMPLETE TRIPS - ROLLING QUARTERS [INCOMPLETE DUE TO:]</b>	<b>MM/Y Y</b>	<b>MM/YY</b>	<b>MM/YY</b>	<b>Qtr Total</b>
<b>PROVIDER/DRIVER</b>				0
<b>MEMBER</b>				0
<b>OTHER*</b>				0
<b>TOTAL INCOMPLETE</b>	0	0	0	0

\*Report the top five 'other' reasons for incomplete trips:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

These changes will allow AHCCCS to monitor incomplete trips or delayed trips for many more reasons, as well as if any patterns arise in completed or incomplete NEMT trips, allows a more rapid intervention by AHCCCS to improve care for members should an issue pattern arise.

The instructions for this attachment provide a greater level of detail:

<b>TRANSPORTATION TIMELINESS REPORT FOR COMPLETED TRIPS - ROLLING QUARTERS</b>	
<b>TOTAL AMBULATORY DROP OFFS</b>	The number of completed ambulatory drop off trips transporting a member to a medically necessary appointment.
<b>TOTAL NON-AMBULATORY DROP OFFS</b>	The number of completed non-ambulatory drop off trips transporting a member to a medically necessary appointment.
<b>TOTAL DROP OFFS</b>	Auto filled formula.
<b>TIMELY AMBULATORY DROP OFFS</b>	The number of completed ambulatory drop off trips where a member arrived on time, but no sooner than one hour before their appointment.
<b>TIMELY NON-AMBULATORY DROP OFFS</b>	The number of completed non-ambulatory drop off trips where a member arrived on time, but no sooner than one hour before their appointment.
<b>TOTAL TIMELY DROP OFFS</b>	Auto filled formula.
<b>% TOTAL DROP OFFS TIMELY</b>	Auto filled formula.
<b>TOTAL AMBULATORY PICKUPS</b>	The number of completed ambulatory pickup trips transporting from member to a medically necessary appointment.
<b>TOTAL NON-AMBULATORY PICKUPS</b>	The number of completed non-ambulatory pickup trips transporting from member to a medically necessary appointment.
<b>TOTAL PICKUPS</b>	Auto filled formula.
<b>TIMELY AMBULATORY PICKUPS</b>	The number of completed ambulatory pickups from a member's appointment that occurred no later than one hour from the conclusion of their appointment.
<b>TIMELY NON-AMBULATORY PICKUPS</b>	The number of completed non-ambulatory pickups from a member's appointment that occurred no later than one hour from the conclusion of their appointment.
<b>TOTAL TIMELY PICKUPS</b>	Auto filled formula.
<b>% TOTAL PICKUPS TIMELY</b>	Auto filled formula.

TRANSPORTATION REPORT FOR INCOMPLETE TRIPS - ROLLING QUARTERS	
<b>INCOMPLETE:</b>	<i>Defined as a trip that was scheduled but not completed for any reason. Incomplete trips do not include those trips rescheduled and completed.</i>
<b>INCOMPLETE DUE TO: PROVIDER/DRIVER</b>	The number of trips scheduled but not completed due to provider/driver issues, such as lack of available driver.
<b>INCOMPLETE DUE TO: MEMBER</b>	The number of trips scheduled but not completed due to member issues, such as members not available for pick up.
<b>INCOMPLETE DUE TO: OTHER</b>	The number of trips scheduled but not completed for any other reason. The top five reasons must be included.

**Changes to Contract Language**

In addition, AHCCCS Complete Care is the name AHCCCS uses to refer to the contracted managed care integrated health plans that administer services for the majority of AHCCCS members. Therefore, the language of AHCCCS MCO contracts has also been updated, in addition to policy language. Amending the contract language is an important additional step to implementing this 95% of trips target because performance (or non-performance) under the terms of the contract is how AHCCCS documents whether a health plan has successfully executed their contract with AHCCCS during the five years that they hold a managed care contract. It also informs the Request for Proposal process when the managed care contracts are re-opened and re-negotiated.

**The contract language is amended as follows:**

The Contractor shall ensure members have timely access to medically necessary non-emergent transportation for routine appointments. Additionally, the Contractor shall have a process in place for members to request and receive medically necessary transportation for urgent appointments. The Contractor shall schedule transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment. The Contractor shall meet a performance target of 95% of all completed pickups and drop off trips in a quarter completed timely. The Contractor shall develop and implement performance auditing protocol to evaluate compliance with the standards above for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.



# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

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**MEETING DATE:** June 1, 2022; July 6, 2022; August 2, 2022; September 7, 2022

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** May 11, 2022

**SUBJECT:** ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)  
Title 9, Chapter 28, Articles 6 & 7

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### Summary

This Five-Year Review Report (5YRR) from the Arizona Health Care Cost Containment System (AHCCCS) relates to six (6) rules in Title 9, Chapter 28, Article 6 (RFP and Contract Process) and five (5) rules in Article 7 (Standards for Payments).

The rules in Article 6 relate to Request for Proposal and contract process for the Arizona Long-Term Care System (ALTCS). The ALTCS is health insurance for individuals who are age 65 or older, or who have a disability, and who require nursing facility level of care. Services may be provided in an institution or in a home or community-based setting. Pursuant to A.R.S. 36-2944, the director at least every five years shall prepare and issue a request for proposal and a proposed contract format to qualified group disability insurers, hospital and medical service corporations, health care services organizations and any other qualified public or private persons to be a program contractor and provide long-term care services. The director may adopt rules regarding the request for proposal process, which was done in Title 9, Chapter 28, Article 6.

The rules in Article 7 relate to Standards for Payments regarding ALTCS. Specifically, these rules describe general reimbursement requirements, the requirements for assessments to nursing facilities, the requirements for supplemental payments for nursing facilities, and the criteria for determining the county that is financially responsible for the state's share of the ALTCS funding as referenced in A.R.S. §36-2913.

In the previous 5YRR for these rules, approved by the Council in October 2017, AHCCCS did not indicate any proposed changes to the rules.

### **Proposed Action**

In the current report, AHCCCS does not propose to make any changes to the rules.

**1. Has the agency analyzed whether the rules are authorized by statute?**

AHCCCS cites both general and specific authority for these rules.

**2. Summary of the agency's economic impact comparison and identification of stakeholders:**

AHCCCS indicates that for Articles 6 and 7 there has not been a rulemaking since the last 5YRR. Therefore, the economic impact is not significantly different from the original economic impact.

**3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

AHCCCS believes the rules as written impose the least burden and cost when meeting their objectives.

**4. Has the agency received any written criticisms of the rules over the last five years?**

AHCCCS indicates it has not received written criticisms of the rules in the last five years.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability?**

AHCCCS indicates the rules are clear, concise, and understandable.

**6. Has the agency analyzed the rules' consistency with other rules and statutes?**

AHCCCS indicates the rules are consistent with other rules and statutes.

**7. Has the agency analyzed the rules' effectiveness in achieving its objectives?**

AHCCCS indicates the rules are effective in achieving their objectives.

**8. Has the agency analyzed the current enforcement status of the rules?**

AHCCCS indicates the rules are enforced as written.

**9. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

AHCCCS indicates the rules are not more stringent than corresponding federal law.

**10. For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

Not applicable. The rules do not require a permit, license, or agency authorization.

**11. Conclusion**

This 5YRR relates to six (6) rules in Title 9, Chapter 28, Article 6 (RFP and Contract Process) and five (5) rules in Article 7 (Standards for Payments). AHCCCS indicates the rules are generally clear, concise, understandable, consistent, effective, and enforced as written. AHCCCS does not intend to take any action regarding these rules.

Council staff recommends approval of this report.

January 28, 2022

**VIA EMAIL: [grrc@azdoa.gov](mailto:grrc@azdoa.gov)**

Nicole Sornsins, Chair  
Governor's Regulatory Review Council  
100 North 15th Avenue, Suite 305  
Phoenix, Arizona 85007

RE: AHCCCS Title 9, Chapter 28, Article 6, Five Year Review Report

Dear Ms. Sornsins:

Please find enclosed the Five-Year Review Report of AHCCCS for Title 9, Chapter 28, Article 6 which is due on January 31, 2022.

AHCCCS hereby certifies compliance with A.R.S. 41-1091.

For questions about this report, please contact Nicole Fries at 602-417-4232 or [nicole.fries@azahcccs.gov](mailto:nicole.fries@azahcccs.gov).

Sincerely,



Kasey Rogg  
Assistant Director

Attachments

**Arizona Health Care Cost Containment System (AHCCCS)**

**5 YEAR REVIEW REPORT**

**A.A.C. Title 9, Chapter 28, Articles 6**

**January 2022**

**1. Authorization of the rule by existing statutes**

General Statutory Authority: A.R.S. § 36-2932

Implementing statute: A.R.S. §§ 36-2944, 36-2943, 36-2959, and 36-2999.51

**2. The objective of each rule:**

Rule	Objective
R9-28-601	The objective of the rule is to list the authority for the Request for Proposal (RFP) and describe the applicability of Title 9 Chapter 28 Article 6
R9-28-602	The objective of this rule is to prescribe the contents of the RFP and the proposal process.
R9-28-603	The objective of this rule is to prescribe the process the Administration follows when awarding contracts.
R9-28-604	The objective of this rule is to prescribe the means of protesting an RFP or award including the administrative appeal process.
R9-28-605	The objective of this rule is to prescribe means by which an offeror or contractor may request from the Director a waiver of the requirement for hospital subcontracts.
R9-28-606	The objective of this rule is to prescribe sanctions the Director may impose on contractors for noncompliance and the factors considered when doing so.

**3. Are the rules effective in achieving their objectives?** Yes  X  No  \_\_

**4. Are the rules consistent with other rules and statutes?** Yes  X  No  \_\_

**5. Are the rules enforced as written?** Yes  X  No  \_\_

**6. Are the rules clear, concise, and understandable?** Yes  X  No  \_\_

**7. Has the agency received written criticisms of the rules within the last five years?** Yes  \_\_  No  X

**8. Economic, small business, and consumer impact comparison:**

There has not been a rulemaking since the last Five Year Review Report. Therefore, the economic impact is not significantly different than the original economic impact.

**9. Has the agency received any business competitiveness analyses of the rules?** Yes  \_\_  No  X

10. **Has the agency completed the course of action indicated in the agency's previous five-year-review report?**

Not applicable.

11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

The Administration believes the rules as written impose the least burden and cost when meeting their objectives.

12. **Are the rules more stringent than corresponding federal laws?** Yes \_\_\_ No X

13. **For rules adopted after July 29, 2010, that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

Not applicable.

14. **Proposed course of action:**

The agency did not provide any recommended changes to this article, therefore there is no proposed course of action.

- 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;

36-2932. Arizona long-term care system; powers and duties of the director; expenditure limitation

A. The Arizona long-term care system is established. The system includes the management and delivery of hospitalization, medical care, institutional services and home and community based services to members through the administration, the program contractors and providers pursuant to this article together with federal participation under title XIX of the social security act. The director in the performance of all duties shall consider the use of existing programs, rules and procedures in the counties and department where appropriate in meeting federal requirements.

B. The administration has full operational responsibility for the system, which shall include the following:

1. Contracting with and certification of program contractors in compliance with all applicable federal laws.
2. Approving the program contractors' comprehensive service delivery plans pursuant to section 36-2940.
3. Providing by rule for the ability of the director to review and approve or disapprove program contractors' requests for proposals for providers and provider subcontracts.
4. Providing technical assistance to the program contractors.
5. Developing a uniform accounting system to be implemented by program contractors and providers of institutional services and home and community based services.
6. Conducting quality control on eligibility determinations and preadmission screenings.
7. Establishing and managing a comprehensive system for assuring the quality of care delivered by the system as required by federal law.
8. Establishing an enrollment system.
9. Establishing a member case management tracking system.
10. Establishing and managing a method to prevent fraud by applicants, members, eligible persons, program contractors, providers and noncontracting providers as required by federal law.
11. Coordinating benefits as provided in section 36-2946.
12. Establishing standards for the coordination of services.
13. Establishing financial and performance audit requirements for program contractors, providers and noncontracting providers.
14. Prescribing remedies as required pursuant to 42 United States Code section 1396r. These remedies may include the appointment of temporary management by the director, acting in collaboration with the director of the department of health services, in order to continue operation of a nursing care institution providing services pursuant to this article.
15. Establishing a system to implement medical child support requirements, as required by federal law. The administration may enter into an intergovernmental agreement with the department of economic security to implement this paragraph.
16. Establishing requirements and guidelines for the review of trusts for the purposes of establishing eligibility for the system pursuant to section 36-2934.01 and posteligibility treatment of income pursuant to subsection L of this section.

17. Accepting the delegation of authority from the department of health services to enforce rules that prescribe minimum certification standards for adult foster care providers pursuant to section 36-410, subsection B. The administration may contract with another entity to perform the certification functions.

18. Assessing civil penalties for improper billing as prescribed in section 36-2903.01, subsection K.

C. For nursing care institutions and hospices that provide services pursuant to this article, the director shall contract periodically as deemed necessary and as required by federal law for a financial audit of the institutions and hospices that is certified by a certified public accountant in accordance with generally accepted auditing standards or conduct or contract for a financial audit or review of the institutions and hospices. The director shall notify the nursing care institution and hospice at least sixty days before beginning a periodic audit. The administration shall reimburse a nursing care institution or hospice for any additional expenses incurred for professional accounting services obtained in response to a specific request by the administration. On request, the director of the administration shall provide a copy of an audit performed pursuant to this subsection to the director of the department of health services or that person's designee.

D. Notwithstanding any other provision of this article, the administration may contract by an intergovernmental agreement with an Indian tribe, a tribal council or a tribal organization for the provision of long-term care services pursuant to section 36-2939, subsection A, paragraphs 1, 2, 3 and 4 and the home and community based services pursuant to section 36-2939, subsection B, paragraph 2 and subsection C, subject to the restrictions in section 36-2939, subsections D and E for eligible members.

E. The director shall require as a condition of a contract that all records relating to contract compliance are available for inspection by the administration subject to subsection F of this section and that these records are maintained for five years. The director shall also require that these records are available on request of the secretary of the United States department of health and human services or its successor agency.

F. Subject to applicable law relating to privilege and protection, the director shall adopt rules prescribing the types of information that are confidential and circumstances under which that information may be used or released, including requirements for physician-patient confidentiality. Notwithstanding any other law, these rules shall provide for the exchange of necessary information among the program contractors, the administration and the department for the purposes of eligibility determination under this article.

G. The director shall adopt rules to specify methods for the transition of members into, within and out of the system. The rules shall include provisions for the transfer of members, the transfer of medical records and the initiation and termination of services.

H. The director shall adopt rules that provide for withholding or forfeiting payments made to a program contractor if it fails to comply with a provision of its contract or with the director's rules.

I. The director shall:

1. Establish by rule the time frames and procedures for all grievances and requests for hearings consistent with section 36-2903.01, subsection B, paragraph 4.

2. Apply for and accept federal monies available under title XIX of the social security act in support of the system. In addition, the director may apply for and accept grants, contracts and private donations in support of the system.

3. Not less than thirty days before the administration implements a policy or a change to an existing policy relating to reimbursement, provide notice to interested parties. Parties interested in receiving notification of policy changes shall submit a written request for notification to the administration.

J. The director may apply for federal monies available for the support of programs to investigate and prosecute violations arising from the administration and operation of the system. Available state monies appropriated for

the administration of the system may be used as matching monies to secure federal monies pursuant to this subsection.

K. The director shall adopt rules that establish requirements of state residency and qualified alien status as prescribed in section 36-2903.03. The administration shall enforce these requirements as part of the eligibility determination process. The rules shall also provide for the determination of the applicant's county of residence for the purpose of assignment of the appropriate program contractor.

L. The director shall adopt rules in accordance with the state plan regarding posteligibility treatment of income and resources that determine the portion of a member's income that shall be available for payment for services under this article. The rules shall provide that a portion of income may be retained for:

1. A personal needs allowance for members receiving institutional services of at least fifteen per cent of the maximum monthly supplemental security income payment for an individual or a personal needs allowance for members receiving home and community based services based on a reasonable assessment of need.
2. The maintenance needs of a spouse or family at home in accordance with federal law. The minimum resource allowance for the spouse or family at home is twelve thousand dollars adjusted annually by the same percentage as the percentage change in the consumer price index for all urban consumers (all items; United States city average) between September 1988 and the September before the calendar year involved.
3. Expenses incurred for noncovered medical or remedial care that are not subject to payment by a third party payor.

M. In addition to the rules otherwise specified in this article, the director may adopt necessary rules pursuant to title 41, chapter 6 to carry out this article. Rules adopted by the director pursuant to this subsection may consider the differences between rural and urban conditions on the delivery of services.

N. The director shall not adopt any rule or enter into or approve any contract or subcontract that does not conform to federal requirements or that may cause the system to lose any federal monies to which it is otherwise entitled.

O. The administration, program contractors and providers may establish and maintain review committees dealing with the delivery of care. Review committees and their staff are subject to the same requirements, protections, privileges and immunities prescribed pursuant to section 36-2917.

P. If the director determines that the financial viability of a nursing care institution or hospice is in question, the director may require a nursing care institution and a hospice providing services pursuant to this article to submit quarterly financial statements within thirty days after the end of its financial quarter unless the director grants an extension in writing before that date. Quarterly financial statements submitted to the department shall include the following:

1. A balance sheet detailing the institution's assets, liabilities and net worth.
2. A statement of income and expenses, including current personnel costs and full-time equivalent statistics.

Q. The director may require monthly financial statements if the director determines that the financial viability of a nursing care institution or hospice is in question. The director shall prescribe the requirements of these statements.

R. The total amount of state monies that may be spent in any fiscal year by the administration for long-term care shall not exceed the amount appropriated or authorized by section 35-173 for that purpose. This article shall not be construed to impose a duty on an officer, agent or employee of this state to discharge a responsibility or to create any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose.



### 36-2943. Provider subcontracts; hospital reimbursement

A. Subcontracts for services rendered by providers pursuant to section 36-2940 shall be awarded through competitive statewide proposals in as nearly the same manner as that provided in section 41-2534. If there is not a sufficient number of qualified proposals, a subcontract may be negotiated with a provider and shall be awarded pursuant to section 41-2536. In order to deliver covered services to members enrolled or expected to be enrolled in the system within a county, the program contractor may negotiate and award without bid a provider subcontract if during the contract year there is an insufficient number of subcontracts awarded to providers. The term of the subcontract shall not extend beyond the next bid and subcontract award process as provided in this section, and the subcontract shall be at rates no greater than the weighted average rates for the appropriate level of care paid to similar providers in the same county. This section does not allow a program contractor to forego the competitive bid process pursuant to section 41-2534 unless there is an unanticipated increase in members enrolled in the system or a decrease in available beds brought about by the closure of a facility operated by a provider that is unable to be absorbed by current contracting providers located in the same general area. Before soliciting subcontracts without the competitive bid process, the program contractor shall receive approval from the director.

B. Hospitals that render care to members shall be paid by the program contractor as prescribed in section 36-2903.01, or such lower rate as may be negotiated by the program contractor.

C. The director may ensure through the subcontracts pursuant to subsection A of this section that at least ten per cent of the members are provided services pursuant to this article on a capitation basis.

D. A claim for an authorized service submitted by a licensed skilled nursing facility, an assisted living Arizona long-term care system provider or a home and community based Arizona long-term care system provider that renders care to members pursuant to this article shall be adjudicated within thirty calendar days after receipt by the program contractor. Any clean claim for an authorized service provided to a member that is not paid within thirty calendar days after the claim is received accrues interest at the rate of one per cent per month from the date the claim is submitted. The interest is prorated on a daily basis and must be paid by the program contractor at the time the clean claim is paid.

36-2944. Qualified plan health service contracts; proposals; administration; contract terms

A. For each county that has a population of four hundred thousand persons or less according to the most recent United States decennial census and that was not approved as a program contractor before January 1, 1994 or that officially states that it wishes to end its status as a program contractor, the director at least every five years shall prepare and issue a request for proposal and a proposed contract format to qualified group disability insurers, hospital and medical service corporations, health care services organizations and any other qualified public or private persons to be a program contractor and provide services pursuant to this article on a capitation rate basis to members who are enrolled with the program contractors by the system, who are not persons with developmental disabilities as defined in section 36-551 and who are residents of the county at the time of application for the system.

B. The director may adopt rules regarding the request for proposal process which provide:

1. For the award of contracts by categories of members or services in order to secure the most financially advantageous proposals for the system.

2. That each qualified proposal shall be entered with separate categories for the distinct groups of members or services to be covered by the proposed contracts, as set forth in the request for proposal.

3. For the procurement of reinsurance for expenses incurred by any program contractor, any member or the system in providing services in excess of amounts specified by the director in any contract year.

4. For second round competitive proposals to request voluntary price reduction of proposals from only those proposals that have been tentatively selected for award, before the final award or rejection of proposals.

C. Contracts shall be awarded as otherwise provided by law, except that in no event may a contract be awarded to any program contractor which will cause the system to lose any federal monies to which it is otherwise entitled.

D. After contracts are awarded pursuant to this section, the director may negotiate with any successful proposal respondent for the expansion or contraction of services or service areas if there are unnecessary gaps or duplications in services or service areas.

E. Payments to program contractors pursuant to this section shall be made monthly or quarterly and may be subject to contract provisions requiring the retention of a specified percentage of the payment by the director, a reserve fund or other contract provisions by which adjustments to the payments are made based on utilization efficiency, including incentives for maintaining quality care and minimizing unnecessary inpatient services. Reserve funds withheld from contracts shall be distributed to program contractors who meet performance standards established by the director. Any reserve fund established pursuant to this subsection shall be established as a separate account within the Arizona long-term care system fund.

F. Payments made pursuant to this section shall begin after a member is enrolled in the system.

G. Each program contractor pursuant to this section shall submit an annual audited financial and programmatic report for the preceding fiscal year as required by the administration. The report shall include beginning and ending fund balances, revenues and expenditures including specific identification of administrative costs. The report shall include the number of members served by the program contractor and the cost incurred for various types of services provided to members in a format prescribed by the director.

H. The director shall require contract terms necessary to ensure adequate performance by the program contractor of the provisions of each contract executed pursuant to this section. Contract provisions required by the director shall include the maintenance of deposits, performance bonds, financial reserves or other financial security.



36-2959. Reimbursement rates; capitation rates; annual review

A. The department shall contract with an independent consulting firm for an annual study of the adequacy and appropriateness of title XIX reimbursement rates to service providers for the persons with developmental disabilities program of both the Arizona long-term care system and the state only program. The consultant shall also include a recommendation for annual inflationary costs. Unless modified in response to federal or state law, the independent consulting firm shall include, in its recommendation, costs arising from amendments to existing contracts. The department may require, and the department's contracted providers shall provide, financial data to the department in the format prescribed by the department to assist in the study. A complete study of reimbursement rates shall be completed no less than once every five years.

B. Capitation rate adjustments shall be limited to utilization of existing services and inflation unless policy changes, including creation or expansion of programs, have been approved by the legislature or are specifically required by federal law or court mandate.

C. The administration shall contract with an independent consulting firm for an annual study of the adequacy and appropriateness of title XIX reimbursement rates to service providers for the elderly and physical disability program of the Arizona long-term care system. The administration may require, and the administration's contracted providers shall provide, financial data to the administration in the format prescribed by the administration to assist in the study. A complete study of reimbursement rates shall be completed no less than once every five years. In determining the adequacy of the rates in the five year study, the consulting firm shall examine in detail the costs associated with the delivery of services, including programmatic, administrative and indirect costs in providing services in rural and urban Arizona.

D. The department and the administration shall provide each of their reports to the joint legislative budget committee and the administration by October 1 of each year.

E. The department shall include the results of the study in its yearly capitation rate request to the administration.

F. If results of the study are not completely incorporated into the capitation rate, the administration shall provide a report to the joint legislative budget committee within thirty days of setting the final capitation rate, including reasons for differences between the rate and the study.

# AHCCCS Non-Emergency Medical Transportation

Contract language: Scope of Services

Transportation: These services include emergency and non-emergency medically necessary transportation. Emergency transportation, including transportation initiated by an emergency response system such as 911, may be provided by ground, air, or water ambulance to manage an AHCCCS member's emergency medical condition at an emergency scene and transport the member to the nearest appropriate medical facility. Non-emergency transportation shall be provided for members who are unable to provide or secure their own transportation for medically necessary services using the appropriate mode based on the needs of the member. Refer to AHCCCS Medical Policy Manual ([AMPM Policy 310-BB](#)). The Contractor shall ensure that members have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.

Contract language: Appointment Availability, Transportation Timeliness, Monitoring, and Reporting

The Contractor shall actively monitor and track provider compliance with appointment availability, transportation timeliness, monitoring, and reporting standards as specified in AHCCCS Contractor Operations Manual (ACOM) Policy 417 [42 CFR 438.206(c)(1)].

The Contractor shall ensure that populations with ongoing medical needs, including but not limited to dialysis, radiation, and chemotherapy, have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.

The Contractor shall ensure members have timely access to medically necessary non-emergent transportation for routine appointments. Additionally, the Contractor shall have a process in place for members to request and receive medically necessary transportation for urgent appointments. The Contractor shall schedule transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment. The Contractor shall develop and implement performance auditing protocol to evaluate compliance with the standards above for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.

<p><a href="#">Contract language:</a> Subcontracts (<i>NEMT Brokers are Administrative Services Subcontractors</i>)</p>	<p>The Contractor shall be held fully liable for the performance of all Contract requirements. Subject to limitations as specified in this Contract, any function required to be provided by the Contractor pursuant to this Contract may be subcontracted to a qualified individual or organization [42 CFR 438.6]. Notwithstanding any relationship(s) the Contractor may have with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract [42 CFR 438.230(b)(1); 42 CFR 438.3(k)].</p> <p>In order to determine adequate performance, the Contractor shall monitor the Administrative Services Subcontractor's performance on an ongoing basis and subject it to formal review at least annually or more frequently if requested by AHCCCS. As a result of the performance review, any deficiencies shall be communicated to the Administrative Services Subcontractor in order to establish a corrective action plan [42 CFR 438.230(b)]. The results of the performance review and the corrective action plan shall be communicated to AHCCCS upon completion as specified in <a href="#">ACOM Policy 438</a> and Section F, Attachment F3, <a href="#">Contractor Chart of Deliverables</a>.</p>
<p>ACOM <a href="#">Policy 417</a>, Appointment Availability, Transportation Timeliness, Monitoring, and Reporting</p>	<p>TRANSPORTATION TIMELINESS REVIEW</p> <p>For medically necessary non-emergent transportation, the Contractor shall ensure that a member arrives on time for an appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home.</p> <p>The Contractor shall evaluate compliance with the above standards on a quarterly basis for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.</p>
<p>ACOM <a href="#">Policy 417</a>, <a href="#">Transportation Timeliness Deliverable format</a></p>	<p>Total Drop Offs, Timely Drop Offs, % of Timely Drop Offs Total Pickups, Timely Pickups, % of Timely Pickups</p>
<p>Deliverable Data</p>	<p>For Contract Year ending 2022, Quarter 1 (Oct-Dec 2021) and Quarter 2 (Jan-Mar 2022) data received on Timeliness of Transportation shows the following:</p> <ul style="list-style-type: none"> <li>● 92.50% of 638,948 total drop off trips were timely</li> <li>● 98.05% of 570,725 total pickup trips were timely</li> </ul>

	(This data is from more recent time periods than the data quoted in the meeting)
<p>Strategy to Resolve NEMT Concerns: AHCCCS NEMT Workgroup</p>	<p>AHCCCS created an Internal NEMT workgroup which meets every six weeks.</p> <p>This cross-divisional team includes staff from the Office of Inspector General, Office of General Counsel, Division of Community Advocacy and Intergovernmental Relations, Division of Member and Provider Services, Division of Health Care Management, Division of Fee For Service Management, and Office of the Director (Legislative Liaison).</p> <p>The Workgroup discusses concerns around NEMT services in general, as well as policy and other regulatory changes aimed at improving access to NEMT services. Recent examples include: helping to resolve transportation issues for members residing at the bottom of the Grand Canyon by implementing Equine and Helicopter NEMT options, and new policy language around coverage of public transportation for members.</p>
<p>Strategy to Resolve NEMT Concerns: MCO Oversight of NEMT Brokers</p>	<p>MCOs meet with NEMT Brokers on a regular basis to review performance, address any gaps in services, and resolve any escalated issues. Additional information reviewed in these meetings include call center statistics, member grievances, complaint resolution reports and timeliness reports.</p> <p>One recent example regarding MCO work to address gaps in services relates to increasing capacity for specialty transportation (including wheelchair vans). One such idea looked to increase payment rates for providers that service specialty transports. Another looked to give provider incentives to providers who accepted a minimum percentage of rides..</p>

# Member Grievances and Quality of Care Concerns

Contract language: Member Complaint/Grievance requirements

At a minimum, the Contractor shall comply with the following Grievance and Appeal System Standards and incorporate these requirements into its policies and/or procedures:

The Contractor shall track and trend Grievance and Appeal System information as a source of information for quality improvement and in accordance with the AHCCCS Grievance and Appeal System Reporting Guide.

The Contractor shall address identified issues as expeditiously as the member's condition requires and shall resolve each grievance within 10 business days of receipt, absent extraordinary circumstances. However, no grievances shall exceed 90 days for resolution. Contractor decisions on member grievances cannot be appealed [42 CFR 438.408(a), 42 CFR 438.408(b)(1) and (3)].

Contract Language: Quality Management and Quality of Care requirements

The Contractor shall undergo annual, external independent reviews of the quality of, timeliness of, and access to services covered under the Contract [42 CFR 438.320, 42 CFR 438.350]. AHCCCS will utilize an External Quality Review Organization (EQRO) for purposes of independent review of its Contractors and related AHCCCS oversight. External quality reviews will be conducted by an EQRO [42 CFR 438.358]. Direct engagement at the Contractor level may occur, at the discretion or invitation of AHCCCS.

The Contractor shall establish and implement mechanisms to assess the quality and appropriateness of care provided to members, including members with special health care needs, [42 CFR 438.208(c)(4), 42 CFR 438.330(a)(1), 42 CFR 438.330(b)(4)].

The Contractor shall develop and implement policies and procedures that analyze quality of care issues through identifying the issue, initial assessment of the severity of the issue, and prioritization of action(s) needed to resolve immediate care needs when appropriate. The Contractor shall establish a process to ensure that all staff and providers are trained on how to refer suspected quality of care issues to quality management. This training shall be provided during new employee orientation (within 30 days of hire) and annually, thereafter.

	<p>The Contractor shall monitor contracted providers for compliance with Quality Management metrics, as well as member health and safety; Quality Management staff shall lead all monitoring and investigative efforts. The Contractor shall establish mechanisms to track and trend member and provider issues. The Contractor shall comply with requirements, as specified in Contract and <a href="#">AMPM Policy 960</a>.</p>
<p><a href="#">AMPM Policy 960</a>, Quality of Care Concerns</p>	<p>The Contractor shall develop and implement policies and procedures to review, report, evaluate, and resolve Quality of Care (QOC) concerns and service concerns raised by members/Health Care Decision Makers (HCDM)s, contracted providers, and stakeholders. Concerns may be received from anywhere within the organization or externally from anywhere in the community including provider incident, accident, and death reports entered directly into the AHCCCS Quality Management (QM) Portal as specified in <a href="#">AMPM Policy 961</a>. All concerns shall be addressed regardless of source (external or internal). QOC concerns involving both physical and behavioral health providers or services shall be addressed in the same manner.</p> <p>...</p> <p>The Contractor shall develop and implement a system to document, track, trend, and evaluate complaints and allegations received from members and providers or as directed by AHCCCS, inclusive of QOC concerns, quality of service, and immediate care needs.</p> <ol style="list-style-type: none"> <li>a. The data from the tracking and trending system shall be analyzed and evaluated to identify and address any trends related to members, providers, the QOC process or services in the Contractor's service delivery system or provider network. The Contractor is responsible for incorporating trending of QOC concerns in determining systemic interventions for quality improvement,</li> <li>b. The Contractor shall ensure that tracking and trending information is submitted, reviewed, and considered for action by the Contractor's local QM Committee and local Medical Director, as Chairman of the QM Committee,</li> <li>c. If significant negative trends are noted, the Contractor should consider developing performance improvement activities focused on the topic area to improve the concern resolution process itself, and to make improvements that address other system issues raised during the resolution process,</li> <li>d. The Contractor shall ensure that tracking and trending information related to provider education, training, and staff credentialing is shared with the workforce development operation as specified in ACOM Policy 407, ...</li> </ol>

<p>AHCCCS Review of Quality of Care (QOC) cases</p>	<p>The majority of the QOC investigative work is completed by the MCOs with oversight, monitoring, and auditing of cases completed by AHCCCS. QOCs can be submitted to either an MCO directly or to AHCCCS. If submitted directly to AHCCCS, staff review the concern, research the MCO that the member is enrolled with (for member-specific concerns) and/or the network status of the provider (for systemic provider-related concerns), and then forward all relevant information to the appropriate MCO(s) for review/investigation. A general outline of how concerns are reviewed can be found at the following location:  <a href="https://www.azahcccs.gov/AHCCCS/Downloads/AHCCCS_IncidentFlowChart_200911.pdf">https://www.azahcccs.gov/AHCCCS/Downloads/AHCCCS_IncidentFlowChart_200911.pdf</a></p> <p>MCOs document QOC information, including findings and corrective actions, in the AHCCCS Quality Management Portal. AHCCCS selects random samples of completed cases from each MCO and audits the case files (from initial triage through resolution). Additionally, AHCCCS runs data queries on selected procedure codes and assesses for correlating quality of care concern cases; if no case is found, a notification is sent to the MCO for follow up. AHCCCS also monitors timeliness of case review against timelines outlined in <a href="#">AMPM Policy 960</a>; MCOs receive reports on any QOCs that are overdue or at risk of becoming overdue and provide feedback on case status, rationale for extended time frames, and/or corrective action plans for addressing noted issues. If any of the above-mentioned oversight activities show concerning trends or under-performance, findings may result in corrective action, ranging from directed technical assistance, increased monitoring, more detailed audits, Notice to Cure, and/or financial sanctions.</p>
<p>AHCCCS Access to Care Committee</p>	<p>AHCCCS has an Access to Care Committee which meets quarterly.</p> <p>This cross-divisional committee reviews individual and systemic Access to Care issues for AHCCCS members to inform Medicaid health care delivery decisions, as well as development of rates and reimbursement to ensure availability of AHCCCS-covered services.</p> <p>This Committee reviews member and/or provider complaints, grievances and/or Quality of Care concerns that impact the accessibility and availability of an adequate AHCCCS registered provider network across Arizona.</p>

# Additional Relevant Requirements

Contract Language: Periodic Reporting Requirements

Under the terms and conditions of its CMS grant award, AHCCCS requires periodic reports, encounter data and other information from the Contractor. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions specified in Section D, Paragraph 74, Administrative Actions.

Standards applied for determining adequacy of required reports are as follows:

1. Timeliness: Reports or other required data shall be received on or before scheduled due dates.
2. Accuracy: Reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and/or AHCCCS defined standards.
3. Completeness: All required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions

Contract Language: Administrative Actions

Sanctions: In accordance with applicable Federal and State regulations, A.A.C. R9-28-606, [ACOM Policy 408](#), [ACOM Policy 440](#), Section 1932 of the Social Security Act or any implementing regulation, and the terms of this Contract, AHCCCS may impose sanctions for failure to comply with any provision of this Contract, including but not limited to: temporary management of the Contractor; monetary penalties; suspension of enrollment; withholding of payments; granting members the right to terminate enrollment without cause; suspension of new enrollments, suspension of payment for new enrollments, refusal to renew, or termination of the Contract, or any related subcontracts [45 CFR 74.48, 42 CFR Part 455, 42 CFR Part 438, Sections 1903 and 1932 of the Social Security Act]. See also Section E, Paragraph 45, Temporary Management/Operation of a Contractor and Paragraphs 47 through 50 regarding Termination of the Contract.



## **Non-Emergency Medical Transportation (NEMT): Oversight & Monitoring**

### **For the Governor's Regulatory Review Council (GRRC)**

#### **Background:**

In the August 2, 2022 meeting of the Governor's Regulatory Review Council (GRRC), in the discussion of AHCCCS's 5 Year Review Report for rules in Title 9, Chapter 28, Articles 6 & 7, the Council requested further information be provided regarding AHCCCS's oversight, monitoring, and sanctions with regards to provision of Non-Emergency Medical Transportation (NEMT) service. This document is to provide the Council with an update on the agency's next steps in addressing the Council's concerns, following internal workgroups and discussions with AHCCCS's Managed Care Organizations (MCOs). Additionally, the attached document contains further information regarding AHCCCS's existing contract and policy requirements that govern provision of NEMT services relevant to this request.

Due to the complicated nature of providing NEMT services that meet their members' needs appropriately, State Medicaid Agencies often approach management and delivery of the NEMT benefit differently and with varying levels of success. States and other entities that administer NEMT benefits, including Medicaid MCOs and third-party transportation brokers, are engaged in a number of efforts to improve NEMT program administration, program integrity, and beneficiary experience. Arizona was recently highlighted in a Medicaid and CHIP Payment and Access Commission (MACPAC) [June 2021 Report to Congress](#) that covered some of these recurring issues with the provision of NEMT services, which highlighted AHCCCS's efforts to be adaptive to member needs. AHCCCS maintains a standing internal NEMT workgroup to address concerns and be responsive to members', MCOs', and providers' potential NEMT issues.

#### **Updates:**

The August 2, 2022 Council concerns and requests include the following:

- Raised specific concerns about how member grievances regarding NEMT are handled and how AHCCCS communicates the available options for grievances to members.
  - Information regarding member grievances is included in the attachment.
- Requested that AHCCCS share MCO contract requirements regarding NEMT, as well as information regarding how NEMT concerns are resolved.
  - AHCCCS MCO contract requirements for the provision of NEMT, and information regarding how NEMT concerns are resolved, are attached.
- Requested AHCCCS provide MCO contract requirements regarding quality assurance and quality of care concerns.
  - MCO quality assurance and quality of care contract requirements are detailed in the attachment.
- Requested information regarding how AHCCCS communicates NEMT services, and the different level or mobility issues covered by those services, to members.
  - AHCCCS MCO contract requirements relative to meeting the transportation needs of the member, and how AHCCCS communicates to members how they access NEMT, are attached.

AHCCCS is working with its NEMT Workgroup, and has reached out to its MCOs, to investigate and address the concerns raised by the Council. Thus far, the following actions have been taken:

- AHCCCS requested and received information from its MCOs regarding how the timeliness statistics for NEMT drop offs and pick-ups are calculated:
  - Numerator = Number of timely trips completed, where timely is defined as:
    - Drop-offs: No more than one hour before the medical appointment
    - Pick-ups: Member waiting no more than one hour after the end of treatment
    - These one hour limits are in accordance with AHCCCS Policy
  - Denominator = Total number of completed trips
- AHCCCS additionally requested information from its MCOs regarding the collection of canceled or rescheduled trips (not currently required by AHCCCS), to have the most complete picture possible of the member experience. The collection of this information is still in process.
- AHCCCS has communicated with MCOs to determine if they have a special designation/process for NEMT access to care for members with high health care needs (not currently required by AHCCCS). All MCOs confirmed that they do offer special assistance for high need members. AHCCCS learned that communication regarding how this service is handled is inconsistent among MCOs. For example, some MCOs put this information in their member handbooks, and some train case managers how to make this determination.

AHCCCS is examining the following strategies to address concerns surrounding NEMT:

- AHCCCS will add NEMT timeliness statistics to the Health Plan Report Card on the AHCCCS website so it is available to the public.
- AHCCCS is developing contract and policy language regarding MCOs tracking of provider cancellations/rescheduled trips and reporting the data to AHCCCS.
  - This data will be added to the Health Plan Report Card upon future receipt of the new deliverable.
- Based on the MCO feedback regarding the special assistance for members with high health care needs, AHCCCS intends to work with MCOs to standardize the high-need member designation across plans; and to develop, and consistently deliver, member communication regarding qualifications for, and how to request, such a designation from their MCO.
- AHCCCS has announced a grants program using funds generated by the American Rescue Plan (ARP) Act to expand, enhance and strengthen home and community based services (HCBS). This grant program should be available in mid-2023. It is AHCCCS' hope that interested HCBS providers (including but not limited to assisted living facilities) would consider applying for grants to acquire vehicles to transport wheelchair utilizing and scooter-dependent resident members. Such activity would expand access to transportation services to the benefit of all members. When a qualified HCBS provider successfully applies to AHCCCS to add a transportation service to their provider profile, that provider would be paid for the provision of qualifying NEMT services. (Read more about the grants program in the [AHCCCS ARPA HCBS Spending Plan](#) on page 11.)

Finally, AHCCCS believes it is important to point out the significant number of NEMT services offered annually in order to offer some context around the NEMT statistics. In the attachment, AHCCCS reports six months of NEMT timeliness data for completed trips in contract year ending (CYE) 2022, from October 1, 2021 through March 31, 2022:

- 92.50% of 638,948 total drop off trips were timely
- 98.05% of 570,725 total pick up trips were timely

It is important to note that, on an annualized basis, over 1.2 million drop offs will occur over the 12 months of CYE 2022, and over 1 million pickups. In total that is more than 2 million completed NEMT services in CYE 2022. While a 92% timeliness rate for drop off trips, and a 98% timeliness rate for pick ups, do convey high timeliness adherence, we will still expect to see approximately 120,000 member trips, and possibly an equal number of members impacted. These high numbers (despite the low percentages) can and do result in numerous complaints, and should not equate to an assumption of inaccuracy of the data.

#### **Attachment Information:**

The attachment contains relevant excerpts from AHCCCS CYE 2022 MCO contracts, the AHCCCS Medical Policy Manual (AMPM), and the AHCCCS Contractor Operation Manual (ACOM).

## Non-Emergency Medical Transportation: AHCCCS Contract & Policy Requirements

AHCCCS Non-Emergency Medical Transportation Contract Language	
<p><u>Contract language:</u> Scope of Services</p>	<p>“Transportation: These services include emergency and non-emergency medically necessary transportation. Emergency transportation, including transportation initiated by an emergency response system such as 911, may be provided by ground, air, or water ambulance to manage an AHCCCS member’s emergency medical condition at an emergency scene and transport the member to the nearest appropriate medical facility. Non-emergency transportation shall be provided for members who are unable to provide or secure their own transportation for medically necessary services using the appropriate mode based on the needs of the member. Refer to AHCCCS Medical Policy Manual (<a href="#">AMPM</a>) <a href="#">Policy 310-BB</a>. The Contractor shall ensure that members have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.”</p>
<p><u>Contract language:</u> Appointment Availability, Transportation Timeliness, Monitoring, and Reporting</p>	<p>“The Contractor shall actively monitor and track provider compliance with appointment availability, transportation timeliness, monitoring, and reporting standards as specified in AHCCCS Contractor Operations Manual (<a href="#">ACOM</a>) <a href="#">Policy 417</a> [42 CFR 438.206(c)(1)].</p> <p>The Contractor shall ensure that populations with ongoing medical needs, including but not limited to dialysis, radiation, and chemotherapy, have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment...</p> <p>The Contractor shall ensure members have timely access to medically necessary non-emergent transportation for routine appointments. Additionally, the Contractor shall have a process in place for members to request and receive medically necessary transportation for urgent appointments. The Contractor shall schedule transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment. The Contractor shall develop and implement performance auditing protocol to evaluate compliance with the standards above for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.”</p>
<p><u>Contract language:</u> Subcontracts (<i>NEMT Brokers are Administrative Services Subcontractors</i>)</p>	<p>“The Contractor shall be held fully liable for the performance of all Contract requirements. Subject to limitations as specified in this Contract, any function required to be provided by the Contractor pursuant to this Contract may be subcontracted to a qualified individual or organization [42 CFR 438.6]. Notwithstanding any relationship(s) the Contractor may have with any</p>

	<p>subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract [42 CFR 438.230(b)(1); 42 CFR 438.3(k)].</p> <p>In order to determine adequate performance, the Contractor shall monitor the Administrative Services Subcontractor’s performance on an ongoing basis and subject it to formal review at least annually or more frequently if requested by AHCCCS. As a result of the performance review, any deficiencies shall be communicated to the Administrative Services Subcontractor in order to establish a corrective action plan [42 CFR 438.230(b)]. The results of the performance review and the corrective action plan shall be communicated to AHCCCS upon completion as specified in <a href="#">ACOM Policy 438</a> and Section F, Attachment F3, <a href="#">Contractor Chart of Deliverables</a>.”</p>
<p><a href="#">ACOM 406</a>, Member Handbook and Provider Directory</p>	<p>Requires that MCOs produce an annually updated member handbook, including language for members about how to obtain NEMT. The MCO must include in its handbook all information in ACOM 406, Attachment A.</p> <p>Attachment A includes: “How to Obtain Medically Necessary Transportation”</p>
<p><a href="#">ACOM Policy 417</a>, Appointment Availability, Transportation Timeliness, Monitoring, and Reporting</p>	<p>“G. Transportation Timeliness Review</p> <p>For medically necessary non-emergent transportation, the Contractor shall ensure that a member arrives on time for an appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home.</p> <p>The Contractor shall evaluate compliance with the above standards on a quarterly basis for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.”</p>
<p><a href="#">ACOM Policy 417</a>, <a href="#">Transportation Timeliness Deliverable Format</a></p>	<p>Transportation Timeliness Deliverable Format:</p> <ul style="list-style-type: none"> <li>● Total Drop Offs, Timely Drop Offs, % of Timely Drop Offs</li> <li>● Total Pickups, Timely Pickups, % of Timely Pickups</li> </ul>
<p>Deliverable Data <i>(Most recently available)</i></p>	<p>For Contract Year ending 2022, Quarter 1 (Oct-Dec 2021) and Quarter 2 (Jan-Mar 2022) data received on Timeliness of Transportation shows the following:</p> <ul style="list-style-type: none"> <li>● 92.50% of 638,948 total drop off trips were timely</li> <li>● 98.05% of 570,725 total pickup trips were timely</li> </ul>

Member Grievances and Quality of Care Concerns	
<p><u>Contract language:</u> Member Complaint/Grievance requirements</p>	<p>“At a minimum, the Contractor shall comply with the following Grievance and Appeal System Standards and incorporate these requirements into its policies and/or procedures:</p> <p>The Contractor shall track and trend Grievance and Appeal System information as a source of information for quality improvement and in accordance with the AHCCCS Grievance and Appeal System Reporting Guide.</p> <p>The Contractor shall address identified issues as expeditiously as the member’s condition requires and shall resolve each grievance within 10 business days of receipt, absent extraordinary circumstances. However, no grievances shall exceed 90 days for resolution. Contractor decisions on member grievances cannot be appealed [42 CFR 438.408(a), 42 CFR 438.408(b)(1) and (3)].”</p>
<p><u>Contract Language:</u> Quality Management and Quality of Care requirements</p>	<p>The Contractor shall undergo annual, external independent reviews of the quality of, timeliness of, and access to services covered under the Contract [42 CFR 438.320, 42 CFR 438.350]. AHCCCS will utilize an External Quality Review Organization (EQRO) for purposes of independent review of its Contractors and related AHCCCS oversight. External quality reviews will be conducted by an EQRO [42 CFR 438.358]. Direct engagement at the Contractor level may occur, at the discretion or invitation of AHCCCS.</p> <p>The Contractor shall establish and implement mechanisms to assess the quality and appropriateness of care provided to members, including members with special health care needs, [42 CFR 438.208(c)(4), 42 CFR 438.330(a)(1), 42 CFR 438.330(b)(4)].</p> <p>The Contractor shall develop and implement policies and procedures that analyze quality of care issues through identifying the issue, initial assessment of the severity of the issue, and prioritization of action(s) needed to resolve immediate care needs when appropriate. The Contractor shall establish a process to ensure that all staff and providers are trained on how to refer suspected quality of care issues to quality management. This training shall be provided during new employee orientation (within 30 days of hire) and annually, thereafter.</p> <p>The Contractor shall monitor contracted providers for compliance with Quality Management metrics, as well as member health and safety; Quality</p>

	<p>Management staff shall lead all monitoring and investigative efforts. The Contractor shall establish mechanisms to track and trend member and provider issues. The Contractor shall comply with requirements, as specified in Contract and <a href="#">AMPM Policy 960</a>.</p>
<p><a href="#">AMPM Policy 960</a>, Quality of Care Concerns</p>	<p>The Contractor shall develop and implement policies and procedures to review, report, evaluate, and resolve Quality of Care (QOC) concerns and service concerns raised by members/Health Care Decision Makers (HCDM)s, contracted providers, and stakeholders. Concerns may be received from anywhere within the organization or externally from anywhere in the community including provider incident, accident, and death reports entered directly into the AHCCCS Quality Management (QM) Portal as specified in <a href="#">AMPM Policy 961</a>. All concerns shall be addressed regardless of source (external or internal). QOC concerns involving both physical and behavioral health providers or services shall be addressed in the same manner.</p> <p>The Contractor shall develop and implement a system to document, track, trend, and evaluate complaints and allegations received from members and providers or as directed by AHCCCS, inclusive of QOC concerns, quality of service, and immediate care needs.</p> <ol style="list-style-type: none"> <li>a. The data from the tracking and trending system shall be analyzed and evaluated to identify and address any trends related to members, providers, the QOC process or services in the Contractor’s service delivery system or provider network. The Contractor is responsible for incorporating trending of QOC concerns in determining systemic interventions for quality improvement,</li> <li>b. The Contractor shall ensure that tracking and trending information is submitted, reviewed, and considered for action by the Contractor’s local QM Committee and local Medical Director, as Chairman of the QM Committee,</li> <li>c. If significant negative trends are noted, the Contractor should consider developing performance improvement activities focused on the topic area to improve the concern resolution process itself, and to make improvements that address other system issues raised during the resolution process,</li> <li>d. The Contractor shall ensure that tracking and trending information related to provider education, training, and staff credentialing is shared with the workforce development operation as specified in <a href="#">ACOM Policy 407...</a>”</li> </ol>
<p>AHCCCS Review of Quality of Care (QOC) Cases</p>	<p>The majority of the QOC investigative work is completed by the MCOs with oversight, monitoring, and auditing of cases completed by AHCCCS. QOCs can be submitted to either an MCO directly or to AHCCCS. If submitted directly to AHCCCS, staff review the concern, research the MCO that the member is</p>

	<p>enrolled with (for member-specific concerns) and/or the network status of the provider (for systemic provider-related concerns), and then forward all relevant information to the appropriate MCO(s) for review/investigation. A general outline of how concerns are reviewed can be found at the following location: <a href="https://www.azahcccs.gov/AHCCCS/Downloads/AHCCCS_IncidentFlowChart_200911.pdf">https://www.azahcccs.gov/AHCCCS/Downloads/AHCCCS_IncidentFlowChart_200911.pdf</a></p> <p>MCOs document QOC information, including findings and corrective actions, in the AHCCCS Quality Management Portal. AHCCCS selects random samples of completed cases from each MCO and audits the case files (from initial triage through resolution). Additionally, AHCCCS runs data queries on selected procedure codes and assesses for correlating quality of care concern cases; if no case is found, a notification is sent to the MCO for follow up. AHCCCS also monitors timeliness of case review against timelines outlined in <a href="#">AMPM Policy 960</a>; MCOs receive reports on any QOCs that are overdue or at risk of becoming overdue and provide feedback on case status, rationale for extended time frames, and/or corrective action plans for addressing noted issues. If any of the above-mentioned oversight activities show concerning trends or under-performance, findings may result in corrective action, ranging from directed technical assistance, increased monitoring, more detailed audits, Notice to Cure, and/or financial sanctions.</p>
<p>AHCCCS Access to Care Committee</p>	<p>AHCCCS has an Access to Care Committee which meets quarterly. This cross-divisional committee reviews individual and systemic Access to Care issues for AHCCCS members to inform Medicaid health care delivery decisions, as well as development of rates and reimbursement to ensure availability of AHCCCS-covered services.</p> <p>This Committee reviews member and/or provider complaints, grievances and/or Quality of Care concerns that impact the accessibility and availability of an adequate AHCCCS registered provider network across Arizona.</p>

Additional Relevant Requirements/Information	
<p><u>Contract Language:</u> Periodic Reporting Requirements</p>	<p>Under the terms and conditions of its CMS grant award, AHCCCS requires periodic reports, encounter data and other information from the Contractor. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions specified in Section D, Paragraph 74, Administrative Actions.</p> <p>Standards applied for determining adequacy of required reports are as follows:</p> <ol style="list-style-type: none"> <li>1. Timeliness: Reports or other required data shall be received on or before scheduled due dates.</li> <li>2. Accuracy: Reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and/or AHCCCS defined standards.</li> <li>3. Completeness: All required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions</li> </ol>
<p><u>Contract Language:</u> Administrative Actions</p>	<p>Sanctions: In accordance with applicable Federal and State regulations, A.A.C. R9-28-606, <a href="#">ACOM Policy 408</a>, <a href="#">ACOM Policy 440</a>, Section 1932 of the Social Security Act or any implementing regulation, and the terms of this Contract, AHCCCS may impose sanctions for failure to comply with any provision of this Contract, including but not limited to: temporary management of the Contractor; monetary penalties; suspension of enrollment; withholding of payments; granting members the right to terminate enrollment without cause; suspension of new enrollments, suspension of payment for new enrollments, refusal to renew, or termination of the Contract, or any related subcontracts [45 CFR 74.48, 42 CFR Part 455, 42 CFR Part 438, Sections 1903 and 1932 of the Social Security Act]. See also Section E, Paragraph 45, Temporary Management/Operation of a Contractor and Paragraphs 47 through 50 regarding Termination of the Contract.</p>
<p><i>Strategy to Resolve NEMT Concerns:</i> AHCCCS NEMT Workgroup</p>	<p>AHCCCS created an Internal NEMT workgroup which meets every six weeks. This cross-divisional team includes staff from the Office of Inspector General, Office of General Counsel, Division of Community Advocacy and Intergovernmental Relations, Division of Member and Provider Services, Division of Health Care Management, Division of Fee For Service Management, and Office of the Director (Legislative Liaison).</p> <p>The Workgroup discusses concerns around NEMT services in general, as well as</p>

	<p>policy and other regulatory changes aimed at improving access to NEMT services. Recent examples include: helping to resolve transportation issues for members residing at the bottom of the Grand Canyon by implementing Equine and Helicopter NEMT options, and new policy language around coverage of public transportation for members.</p>
<p><i>Strategy to Resolve NEMT Concerns:</i> MCO Oversight of NEMT Brokers</p>	<p>MCOs meet with NEMT Brokers on a regular basis to review performance, address any gaps in services, and resolve any escalated issues. Additional information reviewed in these meetings include call center statistics, member grievances, complaint resolution reports and timeliness reports.</p> <p>One recent example regarding MCO work to address gaps in services relates to increasing capacity for specialty transportation (including wheelchair vans). One such idea looked to increase payment rates for providers that service specialty transports. Another looked to give provider incentives to providers who accepted a minimum percentage of rides.</p>

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)**

Title 9, Chapter 22, Article 6



# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

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**MEETING DATE:** June 1, 2022; July 6, 2022; August 2, 2022; September 7, 2022; March 7, 2023

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** February 13, 2023

**SUBJECT:** ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)  
Title 9, Chapter 22, Articles 6

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### Summary

This Five-Year Review Report (5YRR) from the Arizona Health Care Cost Containment System (AHCCCS) relate to six (6) rules in Title 9, Chapter 22, Article 6 (RFP and Contract Process).

The rules in Article 6 relate to Request for Proposal (RFP) and contract process generally. Pursuant to A.R.S. § 36-2906, the director shall prepare and issue a request for proposal, including a proposed contract format, in each of the counties of this state, at least once every five years, to qualified group disability insurers, hospital and medical service corporations, health care services organizations and any other qualified public or private persons, including county-owned and operated health care facilities. The director shall adopt rules regarding the request for proposal process, which was done in Title 9, Chapter 22, Article 6.

As a reminder, this 5YRR was previously considered over several meeting cycles. Specifically, the Council had raised concerns regarding AHCCCS's oversight, monitoring, and sanctions with regards to provision of Non-Emergency Medical Transportation (NEMT) services. At the September 7, 2022 Council Meeting, the Council voted to return the report related to Title 9, Chapter 22, Article 6 and directed AHCCCS to submit a revised report for the current meeting cycle. Specifically, AHCCCS indicated it was working with its NEMT

Workgroup, and had reached out to its Managed Care Organizations (MCOs), to investigate and address the concerns raised by the Council and the Council indicated it would like to see a revised report outlining any proposed changes to the rules to address the issues that resulted from those discussions.

AHCCCS has indicated to Council staff they will be submitting the updated 5YRR to be responsive to the program updates that have occurred in the last six (6) months prior to the February 28, 2023 Study Session. Council staff will circulate the revised 5YRR to the Council when it is received.

February 21, 2023

Nicole Sornsin, Chair  
Governor's Regulatory Review Council  
100 North 15th Avenue, Suite 305  
Phoenix, Arizona 85007

RE: AHCCCS Title 9, Chapter 22, Article 6, and Chapter 28, Article 6 -  
Returned Five Year Review Reports

Ms. Sornsin:

This letter is submitted under A.A.C. Title 1, Chapter 6, Article 305, with the submission of a revised five-year review report. Per GRRC's comment regarding a lack of AHCCCS regulatory mechanisms to track and compile data regarding the timeliness of Non-Emergency Medical Transportation (NEMT) services, AHCCCS has made changes to the Five Year Review Reports' courses of action. Following GRRC's approval of the reports, AHCCCS will request approval from the Governor's Office to initiate a regular rulemaking to make those changes identified in rule and laid out in the report. Those changes identified in the five year review reports meet the requirements in A.R.S. 41-1056(A).

AHCCCS has taken GRRC's concerns regarding timeliness of NEMT services and began by speaking with each of the managed care health plans to determine what regulation of such services currently looked like. It was identified that the reason a trip might not be completed, and who cancelled a trip (a member or a provider) was not being captured in the information the health plans captured on a monthly basis and reported to AHCCCS. Therefore, AHCCCS has updated policy language to make it clear to providers the reasons that this additional level of granularity is required, and has updated contract language to make it clear this is also an additional reporting requirement of the health plan to report to AHCCCS. In this way, both the front line providers of these services, and the health plans as case managers of members' care will be monitoring and reporting NEMT services; and AHCCCS will also receive all of this data on a monthly basis and be able to identify systemic issues or concerning patterns much more quickly to prevent undue burdens on AHCCCS members. This reporting requirement can most clearly be seen in the chart that each health plan is required to use. The amendments to policy and contract language, as well as this deliverable chart can all be found in Attachment A submitted with the revised Five-year review reports.

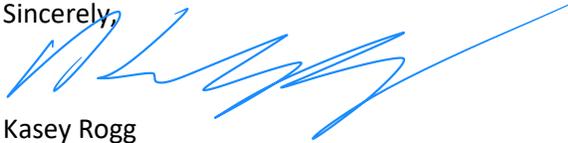
Additionally, although this was not part of GRRC's concerns when they returned the five-year review report to AHCCCS, the Administration wanted to update the council that additional information has been sent out to members and posted on AHCCCS's website regarding the level of services members may request when taking an NEMT trip. Either due to the current condition of the member, or as an ongoing status, members may request with their health plans a higher level of assistance on NEMT trips;

for example, instead of curb-to-curb drop off, they can request hand-to-hand that would take them directly from the assistance of one provider to the assistance of the other provider.

Through these changes in policy, rule, and outreach directly to members, AHCCCS believes we have addressed GRRC's concerns with the NEMT services. We also feel confident that this will prevent a temporary improvement due to the ongoing reporting, the monthly capturing of data, and members' abilities to request the care level they need at any time in NEMT services. Policy and contract language is also where the health plans and providers would expect to find additional data reporting required of them, instead of in administrative rule.

Please let me know if there are any questions about these changes.

Sincerely,



Kasey Rogg  
General Counsel

Attachments: Five Year Review Report R9-22-Art 6  
Five Year Review Report R9-28-Art 6  
Attachment A

**Arizona Health Care Cost Containment System (AHCCCS)**

**5 YEAR REVIEW REPORT**

**A.A.C. Title 9, Chapter 22, Articles 6**

**February 2023**

**1. Authorization of the rule by existing statutes**

General Statutory Authority: A.R.S. § 36-2903.01(F)

Implementing statute: A.R.S. § 36-2906

**2. The objective of each rule:**

Rule	Objective
R9-22-601	The objective of this rule is to list the authority for the Request for Proposal (RFP) and describe the applicability of Article 6.
R9-22-602	The objective of this rule is to prescribe the contents of the RFP and the proposal process.
R9-22-603	The objective of this rule is to prescribe the process the Administration follows when awarding contracts.
R9-22-604	The objective of these rules is to prescribe the means of protesting an RFP or award including the administrative appeal process.
R9-22-605	The objective of this rule is to prescribe means by which an offeror or contractor may request from the Director a waiver of the requirement for hospital subcontracts.
R9-22-606	The objective of this rule is to prescribe sanctions the Director may impose on contractors for noncompliance and the factors considered when doing so.

**3. Are the rules effective in achieving their objectives?**

Yes **X**

No   

Except;

Rule	Objective
R9-22-601	Replace bids/offers with submitted proposals

**4. Are the rules consistent with other rules and statutes?**

Yes **X**

No   

**5. Are the rules enforced as written?**

Yes **X**

No   

Except;

Rule	Objective
R9-22-602	Remove “The Administration shall not request best and final offers more than once unless the Administration determines that it is advantageous to the state to request additional best and final offers.” from subsection B(8) because ADOA (Arizona Department of Administration) has removed this language from their rules and AHCCCS would like to align with state best practices for procurement. Add “or other scope of work as applicable,” to subsection A(2). Add “or post such information publicly with the solicitation” to subsection B(1). Change and in subsection B(3) to and/or. Change proposal to RFP in subsection D
R9-22-603	Update references to contract file to procurement file.

R9-22-604	<p>Add “to an RFP” to subsection C.  Remove “or contract” from subsection C(2).  Add “3. The protest must be submitted to the procurement office by email unless otherwise allowed for in the RFP Instructions to Offerors.” to subsection C.  Change D to “Time for filing a RFP protest”.  Add “4. A protest is due by 5:00pm Arizona time on the due date. If the due date does not fall on a business day, the protest is due on the next business day.” to subsection D.  Add “Unless extended by a time period not to exceed 30 days under G(3)” to subsection G(1).  Add “electronic mail” to subsection G(2).  Change G(3) to read “The Administration may extend, for good cause, the time-limit for a decision in subsection (G)(1) by an additional time frame not to exceed 30 days. The procurement officer shall notify the protester in writing that the time for the issuance of a decision has been extended and the date by which a decision shall be issued.”</p>
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6. **Are the rules clear, concise, and understandable?** Yes  No

7. **Has the agency received written criticisms of the rules within the last five years?** Yes  No

8. **Economic, small business, and consumer impact comparison:**

There has been no noticeable change in economic impact on small businesses or consumers of these regulations, in this case the offerors to the agency’s RFPs (Request for Proposal). This is because the prior rulemaking in 2012 enacted changes to streamline the RFP process for offerors. Since then, the rules have continued to operate as they were intended, are clear, concise, and understandable. The changes recommended in this Five-Year Review Report have the same intention of streamlining the RFP process by updating the time for submissions and allowing correspondence, explicitly by e-mail, a practice already enacted by the agency. Therefore, the changes recommended in this report will have no economic impact on the agency or participants in the agency’s RFP process.

9. **Has the agency received any business competitiveness analyses of the rules?** Yes  No

10. **Has the agency completed the course of action indicated in the agency’s previous five-year-review report?**

There was no proposed course of action in the prior 5YRR.

11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

The Administration believes the rules as written impose the least burden and cost when meeting their objectives.

12. **Are the rules more stringent than corresponding federal laws?** Yes  No

13. **For rules adopted after July 29, 2010, that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

Not applicable.

**14. Proposed course of action:**

Following GRRC approval of this Five-Year Review Report, AHCCCS plans to undertake a workgroup with internal stakeholders in the RFP process, which will include the health plans and managed care contractors, to determine whether larger changes should be made to the RFP process. Since any substantive changes to the RFP process could implicate the eligibility of contractors' proposals, AHCCCS plans to undertake a regular rulemaking that allows for the full-length rulemaking process to ensure all stakeholders have an opportunity to be heard.

In addition, AHCCCS recently added new contract terms and policy language requiring contractors to report additional level of detail for each Non-Emergency Medical Transportation trip provided to a member on their health plan. Please see **Attachment A** for a detailed review of this new contract and policy language.

## **Attachment A: Updates to AHCCCS Policy & Contract Language for NEMT tracking**

### ***Changes to Policy Language***

The AHCCCS Contractor Operations Manual (ACOM) Policies are incorporated by reference in the Medicaid Managed Care Organization (MCO) Contracts. The purpose of the ACOM is to consolidate and provide ease of access to the Administrative, Claims, Financial, and Operational Policies of AHCCCS. The ACOM Manual provides information to Contractors and subcontractors who have delegated responsibilities under a contract. The ACOM should be referenced in conjunction with State and Federal regulations, other Agency manuals, and applicable contracts.

The Contractor is responsible for complying with the requirements set forth within the ACOM and is responsible for ensuring that its subcontractors are notified when modifications are made to policies therein. Upon adoption by AHCCCS, updates to the ACOM notifications are distributed to any stakeholder or tribal member that has signed up for AHCCCS Policy Update Notifications and are also made available on the AHCCCS website.

All substantive policy changes go through a rigorous policy review process internally, including approval by AHCCCS Policy Committee, made up of agency leadership. Then the policy goes through public notice & comment, as well as being presented at a quarterly tribal consultation and a subsequent 45-day tribal notice and comment. These processes allow all contractors, providers, and stakeholders to be included in the policy revision process, as well as meeting requirements placed by the Centers for Medicare & Medicaid Services upon all State Medicaid Agencies.

ACOM 417 establishes appointment accessibility and availability standards and establishes a common process for Contractors to monitor and report appointment accessibility and availability. The Contractor is responsible for adhering to all requirements as specified in Contract, Policy, 42 CFR Part 457 and 42 CFR Part 438.

**G. Transportation Timeliness Review** is amended as follows:

For medically necessary non-emergent transportation, the Contractor shall ensure that a member arrives on time for an appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home.

The Contractor shall meet the following performance target: 95% of all completed pickups and drop off trips in a quarter must be timely. The Contractor shall evaluate compliance with these standards on a quarterly basis for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.

The Contractor shall also track scheduled trips that were not completed for any reason.

**H. Tracking and Reporting** is amended as follows:

1. The Contractor shall track provider compliance with appointment availability and transportation timeliness as specified in Contract and outlined below.

A cover letter shall be included with Attachment A including, at a minimum, the following:

- a. A description of the methods used to collect the information,
- b. An explanation of whether the Contractor is surveying all providers in their network or a sample. If the Contractor is selecting a sample, the explanation shall include the methodology for how the sample size meets a 95% statistically significant confidence level, including the calculations used to confirm the confidence level,
- c. A summary of the findings and an explanation of trends in either direction (positive or negative),
- d. An analysis of the potential causes for these findings and trends, and
- e. A description of any interventions applied to areas of concern including, any corrective actions taken.

2. The Contractor shall submit Attachment B for each line of business, with a cover letter for each submission including, at a minimum, the following:

- a. A summary of the findings and any identified positive or negative trends ~~in either direction (positive or negative)~~ for timeliness, and incomplete scheduled trips and their reasons for each submission,
- b. An analysis of the potential causes for these findings and trends, and
- c. A description of any interventions applied to areas of concern including, any corrective actions taken.

The Contractor shall provide additional corrective action steps for any reporting quarter where the average percent of all timely completed trips for that quarter falls below the performance target of 95%. These steps shall include a timeline of when the contractor expects to again achieve the performance target of 95% of trips being completed timely.

3. DDD and CHP shall also submit a copy of Attachment A and B, for each of their Subcontracted Health Plans. DDD and CHP shall also submit a cover letter containing the information as specified above related to their Subcontracted Health Plans.

4. Annually, as a component of the NDMP, the Contractor shall:

- a. Conduct a review of its network sufficiency when there has been a significant decrease in appointment availability performance over the previous year, and
- b. For each standard specified within this Policy under the General Appointment Standards, General Behavioral Health Standards and Additional Behavioral Health Standards compare its annual average performance to the previous Contract year's average performance. For any standard that decreased by more than five percentage points, conduct a review of the sufficiency of its provider network.

ACOM 417 also contains two attachments, and Attachment B is a tracking spreadsheet they are required to complete on a monthly basis. Previously, ACOM 417B tracked the percentage of timely pick ups and drop offs. However, due to workgroup and data gathering that came out of GRRC’s prior questions on this topic, it was identified that this did not capture all possible scenarios where trips were not completed. Therefore, the Attachment B language is amended as follows: (Red text is new language)

<b>TRANSPORTATION TIMELINESS REPORT FOR COMPLETED TRIPS - ROLLING QUARTERS</b>	<b>MM/YY</b>	<b>MM/YY</b>	<b>MM/Y Y</b>	<b>Qtr Total</b>
<b>TOTAL AMBULATORY DROP OFFS</b>				0
<b>TOTAL NON-AMBULATORY DROP OFFS</b>				0
<b>TOTAL DROP OFFS</b>	0	0	0	0
<b>TIMELY AMBULATORY DROP OFFS</b>				0
<b>TIMELY NON-AMBULATORY DROP OFFS</b>				0
<b>TOTAL TIMELY DROP OFFS</b>	0	0	0	0
<b>% TOTAL DROP OFFS TIMELY</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
<b>TOTAL AMBULATORY PICKUPS</b>				0
<b>TOTAL NON-AMBULATORY PICKUPS</b>				0
<b>TOTAL PICKUPS</b>	0	0	0	0
<b>TIMELY AMBULATORY PICKUPS</b>				0
<b>TIMELY NON-AMBULATORY PICKUPS</b>				0
<b>TOTAL TIMELY PICKUPS</b>	0	0	0	0
<b>% TOTAL PICKUPS TIMELY</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
<b>TOTAL COMPLETED TRIPS</b>	0	0	0	0
<b>TOTAL COMPLETED TIMELY TRIPS</b>	0	0	0	0
<b>% TOTAL COMPLETED TRIPS TIMELY</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

<b>TRANSPORTATION REPORT FOR INCOMPLETE TRIPS - ROLLING QUARTERS [INCOMPLETE DUE TO:]</b>	<b>MM/Y Y</b>	<b>MM/YY</b>	<b>MM/YY</b>	<b>Qtr Total</b>
<b>PROVIDER/DRIVER</b>				0
<b>MEMBER</b>				0
<b>OTHER*</b>				0
<b>TOTAL INCOMPLETE</b>	0	0	0	0

\*Report the top five 'other' reasons for incomplete trips:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

These changes will allow AHCCCS to monitor incomplete trips or delayed trips for many more reasons, as well as if any patterns arise in completed or incomplete NEMT trips, allows a more rapid intervention by AHCCCS to improve care for members should an issue pattern arise.

The instructions for this attachment provide a greater level of detail:

<b>TRANSPORTATION TIMELINESS REPORT FOR COMPLETED TRIPS - ROLLING QUARTERS</b>	
<b>TOTAL AMBULATORY DROP OFFS</b>	The number of completed ambulatory drop off trips transporting a member to a medically necessary appointment.
<b>TOTAL NON-AMBULATORY DROP OFFS</b>	The number of completed non-ambulatory drop off trips transporting a member to a medically necessary appointment.
<b>TOTAL DROP OFFS</b>	Auto filled formula.
<b>TIMELY AMBULATORY DROP OFFS</b>	The number of completed ambulatory drop off trips where a member arrived on time, but no sooner than one hour before their appointment.
<b>TIMELY NON-AMBULATORY DROP OFFS</b>	The number of completed non-ambulatory drop off trips where a member arrived on time, but no sooner than one hour before their appointment.
<b>TOTAL TIMELY DROP OFFS</b>	Auto filled formula.
<b>% TOTAL DROP OFFS TIMELY</b>	Auto filled formula.
<b>TOTAL AMBULATORY PICKUPS</b>	The number of completed ambulatory pickup trips transporting from member to a medically necessary appointment.
<b>TOTAL NON-AMBULATORY PICKUPS</b>	The number of completed non-ambulatory pickup trips transporting from member to a medically necessary appointment.
<b>TOTAL PICKUPS</b>	Auto filled formula.
<b>TIMELY AMBULATORY PICKUPS</b>	The number of completed ambulatory pickups from a member's appointment that occurred no later than one hour from the conclusion of their appointment.
<b>TIMELY NON-AMBULATORY PICKUPS</b>	The number of completed non-ambulatory pickups from a member's appointment that occurred no later than one hour from the conclusion of their appointment.
<b>TOTAL TIMELY PICKUPS</b>	Auto filled formula.
<b>% TOTAL PICKUPS TIMELY</b>	Auto filled formula.

TRANSPORTATION REPORT FOR INCOMPLETE TRIPS - ROLLING QUARTERS	
<b>INCOMPLETE:</b>	<i>Defined as a trip that was scheduled but not completed for any reason. Incomplete trips do not include those trips rescheduled and completed.</i>
<b>INCOMPLETE DUE TO: PROVIDER/DRIVER</b>	The number of trips scheduled but not completed due to provider/driver issues, such as lack of available driver.
<b>INCOMPLETE DUE TO: MEMBER</b>	The number of trips scheduled but not completed due to member issues, such as members not available for pick up.
<b>INCOMPLETE DUE TO: OTHER</b>	The number of trips scheduled but not completed for any other reason. The top five reasons must be included.

### **Changes to Contract Language**

In addition, AHCCCS Complete Care is the name AHCCCS uses to refer to the contracted managed care integrated health plans that administer services for the majority of AHCCCS members. Therefore, the language of AHCCCS MCO contracts has also been updated, in addition to policy language. Amending the contract language is an important additional step to implementing this 95% of trips target because performance (or non-performance) under the terms of the contract is how AHCCCS documents whether a health plan has successfully executed their contract with AHCCCS during the five years that they hold a managed care contract. It also informs the Request for Proposal process when the managed care contracts are re-opened and re-negotiated.

### **The contract language is amended as follows:**

The Contractor shall ensure members have timely access to medically necessary non-emergent transportation for routine appointments. Additionally, the Contractor shall have a process in place for members to request and receive medically necessary transportation for urgent appointments. The Contractor shall schedule transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment. The Contractor shall meet a performance target of 95% of all completed pickups and drop off trips in a quarter completed timely. The Contractor shall develop and implement performance auditing protocol to evaluate compliance with the standards above for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.



# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

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**MEETING DATE:** June 1, 2022; July 6, 2022; August 2, 2022; September 7, 2022

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** May 11, 2022

**SUBJECT:** ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)  
Title 9, Chapter 22, Articles 6, 7

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### Summary

This Five-Year Review Report (5YRR) from the Arizona Health Care Cost Containment System (AHCCCS) relate to six (6) rules in Title 9, Chapter 22, Article 6 (RFP and Contract Process) and fifty-three (53) rules in Article 7 (Standards for Payments).

The rules in Article 6 relate to Request for Proposal (RFP) and contract process generally. Pursuant to A.R.S. § 36-2906, the director shall prepare and issue a request for proposal, including a proposed contract format, in each of the counties of this state, at least once every five years, to qualified group disability insurers, hospital and medical service corporations, health care services organizations and any other qualified public or private persons, including county-owned and operated health care facilities. The director shall adopt rules regarding the request for proposal process, which was done in Title 9, Chapter 22, Article 6. The rules in Article 7 relate to general standards for payments.

In the previous 5YRR for these rules, approved by the Council in November 2017, with regards to the rules in Article 7, AHCCCS indicated that it was "currently in the process of amending the [Diagnosis Related Group] rules to rebase the components of the DRG system using updated claims and encounter data" and would also "update the version of the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health

Information Systems for dates of discharge beginning January 1, 2018." AHCCCS indicates it completed this proposed course of action by rulemaking subsequent to the prior 5YRR..

### **Proposed Action**

As indicated in more detail below, AHCCCS intends to complete a rulemaking to address rules in Article 6 related to the RFP process that it believes are not currently effective in achieving their regulatory objectives and not enforced as written. AHCCCS indicates the proposed amendments are intended to: 1) Clarify the current RFP process wherein there are ambiguities, and 2) align AHCCCS's process to best practice and other state procurement laws. AHCCCS indicates it will request a rulemaking exemption to make these changes within a month of this 5YRR being approved by the Council.

#### **1. Has the agency analyzed whether the rules are authorized by statute?**

AHCCCS cites both general and specific authority for these rules.

#### **2. Summary of the agency's economic impact comparison and identification of stakeholders:**

In the prior economic impact statement, AHCCCS stated that the amendments are primarily made to make the rules more clear, concise, and understandable. Minimal impact was anticipated. The small business community as a whole was not impacted by the clarifications. All affected entities benefit from the additional clarity and conciseness of the rule language. AHCCCS and contractors are also directly affected by and benefit from the clarifications.

AHCCCS indicates there has been no noticeable change in the economic impact on small businesses or consumers of these regulations, in this case the offerors to the agency's RFPs. This is because the prior rulemaking in 2012 enacted changes to streamline the RFP process for offerors. Since then, the rules have continued to operate as they were intended, are clear, concise, and understandable.

The rule changes represent the most cost-effective and efficient method of fulfilling the agency's responsibilities and impose only those requirements that are necessary to comply with federal law and state statute.

#### **3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

For Article 6, AHCCCS believes the rules as written impose the least burden and cost when meeting their objectives. For Article 7, AHCCCS did not consider other alternatives because the changes are the most cost effective and efficient method of complying with federal law and state statute.

#### **4. Has the agency received any written criticisms of the rules over the last five years?**

AHCCCS indicates it has not received written criticisms of the rules in the last five years.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability?**

AHCCCS indicates the rules are clear, concise, and understandable.

**6. Has the agency analyzed the rules' consistency with other rules and statutes?**

AHCCCS indicates the rules are consistent with other rules and statutes.

**7. Has the agency analyzed the rules' effectiveness in achieving its objectives?**

AHCCCS indicates the rules are generally effective in achieving their objectives. However, AHCCCS indicates rule R9-22-601 could be made more effective by amending the rule to remove the term "bids/offers" with "submitted proposals."

**8. Has the agency analyzed the current enforcement status of the rules?**

AHCCCS indicates the rules are generally enforced as written except for the following rules:

- R9-22-602
- R9-22-603
- R9-22-604

The amendments AHCCCS proposes to make regarding these rules are outlined in Section 5 of the 5YRR.

**9. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

AHCCCS indicates the rules are not more stringent than corresponding federal law.

**10. For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

Not applicable. The rules do not require a permit, license, or agency authorization.

**11. Conclusion**

This 5YRR relates to six (6) rules in Title 9, Chapter 22, Article 6 (RFP and Contract Process) and fifty-three (53) rules in Article 7 (Standards for Payments). AHCCCS indicates the rules are generally clear, concise, understandable, consistent, effective, and enforced as written, except for rules R9-22-601 through 604. For those rules AHCCCS intends to amend to clarify the current RFP process wherein there are ambiguities and align AHCCCS's process to best

practice and other state procurement laws. AHCCCS indicates it intends to request a rulemaking exemption to make these changes within a month of this 5YRR being approved by the Council.

Council staff recommends approval of this report.

January 28, 2022

**VIA EMAIL: [grrc@azdoa.gov](mailto:grrc@azdoa.gov)**

Nicole Sornsins, Chair  
Governor's Regulatory Review Council  
100 North 15th Avenue, Suite 305  
Phoenix, Arizona 85007

RE: AHCCCS Title 9, Chapter 22, Article 6, Five Year Review Report

Dear Ms. Sornsins:

Please find enclosed the Five-Year Review Report of AHCCCS for Title 9, Chapter 22, Article 6 which is due on January 31, 2022.

AHCCCS hereby certifies compliance with A.R.S. 41-1091.

For questions about this report, please contact Nicole Fries at 602-417-4232 or [nicole.fries@azahcccs.gov](mailto:nicole.fries@azahcccs.gov).

Sincerely,



Kasey Rogg  
Assistant Director

Attachments

**Arizona Health Care Cost Containment System (AHCCCS)**

**5 YEAR REVIEW REPORT**

**A.A.C. Title 9, Chapter 22, Articles 6**

**January 2022**

**1. Authorization of the rule by existing statutes**

General Statutory Authority: A.R.S. § 36-2903.01(F)

Implementing statute: A.R.S. § 36-2906

**2. The objective of each rule:**

Rule	Objective
R9-22-601	The objective of this rule is to list the authority for the Request for Proposal (RFP) and describe the applicability of Article 6.
R9-22-602	The objective of this rule is to prescribe the contents of the RFP and the proposal process.
R9-22-603	The objective of this rule is to prescribe the process the Administration follows when awarding contracts.
R9-22-604	The objective of these rules is to prescribe the means of protesting an RFP or award including the administrative appeal process.
R9-22-605	The objective of this rule is to prescribe means by which an offeror or contractor may request from the Director a waiver of the requirement for hospital subcontracts.
R9-22-606	The objective of this rule is to prescribe sanctions the Director may impose on contractors for noncompliance and the factors considered when doing so.

**3. Are the rules effective in achieving their objectives?**

Yes **X**

No   

Except;

Rule	Objective
R9-22-601	Replace bids/offers with submitted proposals

**4. Are the rules consistent with other rules and statutes?**

Yes **X**

No   

**5. Are the rules enforced as written?**

Yes **X**

No   

Except;

Rule	Objective
R9-22-602	Remove “The Administration shall not request best and final offers more than once unless the Administration determines that it is advantageous to the state to request additional best and final offers.” from subsection B(8) because ADOA (Arizona Department of Administration) has removed this language from their rules and AHCCCS would like to align with state best practices for procurement. Add “or other scope of work as applicable,” to subsection A(2). Add “or post such information publicly with the solicitation” to subsection B(1). Change and in subsection B(3) to and/or. Change proposal to RFP in subsection D
R9-22-603	Update references to contract file to procurement file.

R9-22-604	<p>Add “to an RFP” to subsection C.  Remove “or contract” from subsection C(2).  Add “3. The protest must be submitted to the procurement office by email unless otherwise allowed for in the RFP Instructions to Offerors.” to subsection C.  Change D to “Time for filing a RFP protest”.  Add “4. A protest is due by 5:00pm Arizona time on the due date. If the due date does not fall on a business day, the protest is due on the next business day.” to subsection D.  Add “Unless extended by a time period not to exceed 30 days under G(3)” to subsection G(1).  Add “electronic mail” to subsection G(2).  Change G(3) to read “The Administration may extend, for good cause, the time-limit for a decision in subsection (G)(1) by an additional time frame not to exceed 30 days. The procurement officer shall notify the protester in writing that the time for the issuance of a decision has been extended and the date by which a decision shall be issued.”</p>
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6. **Are the rules clear, concise, and understandable?** Yes X No   

7. **Has the agency received written criticisms of the rules within the last five years?** Yes    No X

8. **Economic, small business, and consumer impact comparison:**

There has been no noticeable change in economic impact on small businesses or consumers of these regulations, in this case the offerors to the agency’s RFPs (Request for Proposal). This is because the prior rulemaking in 2012 enacted changes to streamline the RFP process for offerors. Since then, the rules have continued to operate as they were intended, are clear, concise, and understandable. The changes recommended in this Five-Year Review Report have the same intention of streamlining the RFP process by updating the time for submissions and allowing correspondence, explicitly by e-mail, a practice already enacted by the agency. Therefore, the changes recommended in this report will have no economic impact on the agency or participants in the agency’s RFP process.

9. **Has the agency received any business competitiveness analyses of the rules?** Yes    No X

10. **Has the agency completed the course of action indicated in the agency’s previous five-year-review report?**

11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

The Administration believes the rules as written impose the least burden and cost when meeting their objectives.

12. **Are the rules more stringent than corresponding federal laws?** Yes    No X

13. **For rules adopted after July 29, 2010, that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

Not applicable.

**14. Proposed course of action:**

Following GRRC approval of this Five-Year Review Report, AHCCCS plans to undertake a workgroup with internal stakeholders in the RFP process to determine whether larger changes are made to the RFP process. Since any substantive changes to the RFP process could implicate the eligibility of contractors' proposals, AHCCCS plans to undertake a regular rulemaking that allows for full participation by the public.

## CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

4). Former Section R9-22-524 repealed, new Section R9-22-524 adopted effective October 1, 1985 (Supp. 85-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-525. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-525 adopted as an emergency adopted, amended and renumbered as Section R9-22-523, former Section R9-22-527 adopted as an emergency now adopted, amended and renumbered as Section R9-22-525 as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1985 (Supp. 85-5).

**R9-22-526. Renumbered****Historical Note**

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of the permanent rule identical to the emergency (Supp. 83-3). Former Section R9-22-526 repealed, new Section R9-22-526 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-1).

**R9-22-527. Renumbered****Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5).

**R9-22-528. Renumbered****Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-528 renumbered and amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5).

**R9-22-529. Renumbered****Historical Note**

Adopted as Section R9-22-529 effective October 1, 1985, then renumbered as Section R9-22-1002 effective October 1, 1985 (Supp. 85-5).

**ARTICLE 6. RFP AND CONTRACT PROCESS****R9-22-601. General Provisions**

- A. The Director has full operational authority to adopt rules for the RFP process and the award of contracts under A.R.S. § 36-2906.
- B. This Article applies to the award of contracts under A.R.S. §§ 36-2904 and 36-2906 to provide services under A.R.S. § 36-2907 and the expenditure of public monies by the Administration pertaining to covered services when the procurement so states. The Administration shall establish conflict-of-interest safeguards for officers and employees of this state with responsibilities relating to contracts that comply with 42 U.S.C. 1396u-2(d)(3).
- C. The Administration is exempt from the procurement code under A.R.S. § 41-2501.
- D. The Administration and contractors shall retain all contract records for five years under A.R.S. § 36-2903 and dispose of the records under A.R.S. § 41-2550.
- E. The following terms are defined as related to this Article:

“Procurement file” means the official records file of the Director whether located in the Office of the Director or at the public procurement unit. The procurement file shall include in electronic or paper form a list of notified vendors, final solicitation, solicitation amendments, bids/offers, final proposal revisions, clarifications, and final evaluation report.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-601 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

**R9-22-602. RFP**

- A. RFP content. The Administration shall include the following items in any RFP under this Article:
  1. Instructions and information to an offeror concerning the proposal submission including:
    - a. The deadline for submitting a proposal,
    - b. The address of the office at which a proposal is to be received,
    - c. The period during which the RFP remains open, and
    - d. Any special instructions and information;
  2. The scope of covered services under Article 2 of this Chapter and A.R.S. §§ 36-2906 and 36-2907, covered populations, geographic coverage, service and performance requirements, and a delivery or performance schedule;
  3. The contract terms and conditions, including bonding or other security requirements, if applicable;
  4. The factors used to evaluate a proposal;
  5. The location and method of obtaining documents that are incorporated by reference in the RFP;
  6. A requirement that the offeror acknowledge receipt of all RFP amendments issued by the Administration;
  7. The type of contract to be used and a copy of a proposed contract form or provisions;
  8. The length of the contract service;
  9. A requirement for cost or pricing data;
  10. The minimum RFP requirements; and
  11. A provision requiring an offeror to certify that a submitted proposal does not involve collusion or other anti-competitive practices.
- B. Proposal process.
  1. After the deadline for submitting proposals, the Administration may open a proposal publicly and announce and record the name of the offeror. The Administration shall keep all other information contained in a proposal confidential. The Administration shall open a proposal for public inspection after contract award unless the Administration determines that disclosure is not in the best interest of the state.
  2. The Administration shall evaluate a proposal based on the GSA and the evaluation factors listed in the RFP.
  3. The Administration may initiate discussions with a responsive and responsible offeror to clarify and assure full understanding of an offeror's proposal. The Administration shall provide an offeror fair treatment with respect

## CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

to discussion and revision of a proposal. The Administration shall not disclose information derived from a proposal submitted by a competing offeror.

4. The Administration shall allow for the adjustment of covered services by expansion, deletion, segregation, or combination in order to secure the most financially advantageous proposals for the state.
  5. The Administration may conduct an investigation of a person or organization who has ownership or management interests in corporate offerors or affiliated corporate organizations of an offeror.
  6. The Administration may issue a written request for best and final offers. The Administration shall state in the request the date, time, and place for the submission of best and final offers.
  7. The Administration shall not request best and final offers more than once unless the Administration determines that it is advantageous to the state to request additional best and final offers. The Administration shall state in the written request for best and final offers that if the offeror does not submit a notice of withdrawal or a best and final offer, the Administration shall take the most recent offer as the offeror's best and final offer.
- C. Proposal rejection.
1. The Administration may reject an offeror's proposal if the offeror fails to supply the information requested by the Administration.
  2. The offeror shall not disclose information pertaining to its proposal to any other offeror prior to contract award. The offeror may disclose proposal information to a person other than another offeror if the recipient agrees to keep the information confidential until contract award. Disclosure in violation of this subsection may be grounds for rejecting a proposal.
  3. The Administration shall provide written notification to an offeror whose proposal is rejected. The rejection notice shall be part of the contract file and a public record.
  4. If the Administration determines that it is in the best interest of the state, the Administration may reject any and all proposals, in whole or in part, under the RFP. The reasons for rejection shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if a proposal is rejected in whole or in part.
- D. Proposal cancellation. If the Administration determines that it is in the best interest of the state, the Administration may cancel a RFP. The reasons for cancellation shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if a RFP is cancelled.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-602 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-603. Contract Award**

The Administration shall award a contract to the responsible and responsive offeror whose proposal is determined most advantageous to the state under A.R.S. § 36-2906. If the Administration determines that multiple contracts are in the best interest of the state, the Administration may award multiple contracts. The contract file shall contain the basis on which the award is made.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-603 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-604. Contract or Proposal Protests; Appeals**

- A. Disputes related to contract performance. This Section does not apply to a dispute related to contract performance. A contract performance dispute is governed by 9 A.A.C. 34.
- B. Resolution of a proposal protest. The procurement officer issuing a RFP shall have the authority to resolve proposal protests. An appeal from the decision of the procurement officer shall be made to the Director.
- C. Filing of a protest.
1. A person may file a protest with the procurement officer regarding:
    - a. A RFP issued by the Administration,
    - b. A proposed award, or
    - c. An award of a contract.
  2. A protester shall submit a written protest and include the following information:
    - a. The name, address, and telephone number of the protester;
    - b. The signature of the protester or protester's representative;
    - c. Identification of a RFP or contract number;
    - d. A detailed statement of the legal and factual grounds of the protest including copies of any relevant documents; and
    - e. The relief requested.
- D. Time for filing a protest.
1. A protester filing a protest alleging improprieties in an RFP or an amendment to an RFP shall file the protest at least 14 days before the due date of receipt of proposals.
  2. Any protest alleging improprieties in an amendment issued 14 or fewer days before the due date of the proposal shall be filed before the due date for receipt of proposals.
  3. In cases other than those covered in subsections (D)(1) and (2), a protester shall file a protest no later than 10 days after the procurement officer makes the procurement file available for public inspection.
- E. Stay of procurement during the protest. If a protester files a protest before the contract award, the procurement officer may issue a written stay of the contract award. In considering whether to issue a written stay of contract, the procurement officer shall consider but is not limited to considering whether:
1. A reasonable probability exists that the protest will be sustained, and
  2. The stay of the contract award is in the best interest of the state.

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- F. Stay of contract award during an appeal to the Director. The Director shall automatically continue the stay of a contract award if:
1. An appeal is filed before a contract award, and
  2. The procurement officer issues a stay of the contract award under subsection (E), unless
  3. The Director issues a written determination that the contract award is necessary to protect the best interest of the state.
- G. Decision by the procurement officer.
1. The procurement officer shall issue a written decision no later than 14 days after a protest has been filed. The decision shall contain an explanation of the basis of the decision.
  2. The procurement officer shall furnish a copy of the decision to the protester by:
    - a. Certified mail, return receipt requested; or
    - b. Any other method that provides evidence of receipt.
  3. The Administration may extend, for good cause, the time-limit for decisions in subsection (G)(1) for a time not to exceed 30 days. The procurement officer shall notify the protester in writing that the time for the issuance of a decision has been extended and the date by which a decision shall be issued.
  4. If the procurement officer fails to issue a decision within the time-limits in subsection (G)(1) or (G)(3), the protester may proceed as if the procurement officer issued an adverse decision.
- H. Remedies.
1. If the procurement officer sustains the protest in whole or in part and determines that the RFP, proposed contract award, or contract award does not comply with applicable statutes and rules, the procurement officer shall order an appropriate remedy.
  2. In determining an appropriate remedy, the procurement officer shall consider all the circumstances of the procurement or proposed procurement, including:
    - a. Seriousness of the procurement deficiency,
    - b. Degree of prejudice to other interested parties or to the integrity of the RFP process,
    - c. Good faith of the parties,
    - d. Extent of performance,
    - e. Costs to the state, and
    - f. Urgency of the procurement.
  3. An appropriate remedy may include one or more of the following:
    - a. Terminating the contract;
    - b. Reissuing the RFP;
    - c. Issuing a new RFP;
    - d. Awarding a contract consistent with statutes, rules, and the terms of the RFP; or
    - e. Any relief determined necessary to ensure compliance with applicable statutes and rules.
- I. Appeals to the Director.
1. A person may file an appeal of a procurement officer's decision with both the Director and the procurement officer no later than five days from the date the decision is received. The date the decision is received shall be determined under subsection (G)(2).
  2. The appeal shall contain:
    - a. The information required in subsection (C)(2),
    - b. A copy of the procurement officer's decision,
    - c. The alleged factual or legal error in the decision of the procurement officer on which the appeal to the Director is based, and
      - d. A request for hearing unless the person requests that the Director's decision be based solely upon the procurement file.
- J. Dismissal. The Director shall not schedule a hearing and shall dismiss an appeal with a written determination if:
1. The appeal does not state a basis for protest,
  2. The appeal is untimely under subsection (I)(1), or
  3. The appeal is moot.
- K. Hearing. Hearings under this Section shall be conducted using the Arizona Administrative Procedure Act under A.R.S. Title 41, Ch. 6.
- Historical Note**
- Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).
- R9-22-605. Waiver of Contractor's Subcontract with Hospitals**
- If a contractor is unable to obtain a subcontract with a hospital as contractually required, the contractor may request in writing a waiver from the Administration as allowed by A.R.S. § 36-2906. The contractor shall state in the request the reasons a waiver is believed to be necessary and all efforts the contractor has made to secure a subcontract.
- Historical Note**
- Adopted effective January 31, 1986 (Supp. 86-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).
- R9-22-606. Contract Compliance Sanction**
- A. The Director may impose sanctions upon a contractor for violation of any provision of this Chapter or of a contract. Sanctions include but are not limited to:
1. Suspension of any or all further member enrollment, by choice and/or assignment for a period of time.
  2. Imposition of a monetary sanction.
- B. The Director shall consider the nature, severity, and length of the violation when determining a sanction.
- C. The Director shall provide a contractor with written notice specifying grounds and terms for the sanction.
- D. Nothing contained in this Section shall be construed to prevent the Administration from imposing sanctions as provided in contract under A.R.S. § 36-2903.
- Historical Note**
- New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).
- ARTICLE 7. STANDARDS FOR PAYMENTS**
- R9-22-701. Standard for Payments Related Definitions**
- In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Article have the following meanings unless the context explicitly requires another meaning:
- "Accommodation" means room and board services provided to a patient during an inpatient hospital stay and includes all staffing, supplies, and equipment. The accommodation is

### 36-2903.01. Additional powers and duties; report; definition

A. The director of the Arizona health care cost containment system administration may adopt rules that provide that the system may withhold or forfeit payments to be made to a noncontracting provider by the system if the noncontracting provider fails to comply with this article, the provider agreement or rules that are adopted pursuant to this article and that relate to the specific services rendered for which a claim for payment is made.

B. The director shall:

1. Prescribe uniform forms to be used by all contractors. The rules shall require a written and signed application by the applicant or an applicant's authorized representative, or, if the person is incompetent or incapacitated, a family member or a person acting responsibly for the applicant may obtain a signature or a reasonable facsimile and file the application as prescribed by the administration.

2. Enter into an interagency agreement with the department to establish a streamlined eligibility process to determine the eligibility of all persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). At the administration's option, the interagency agreement may allow the administration to determine the eligibility of certain persons, including those defined pursuant to section 36-2901, paragraph 6, subdivision (a).

3. Enter into an intergovernmental agreement with the department to:

(a) Establish an expedited eligibility and enrollment process for all persons who are hospitalized at the time of application.

(b) Establish performance measures and incentives for the department.

(c) Establish the process for management evaluation reviews that the administration shall perform to evaluate the eligibility determination functions performed by the department.

(d) Establish eligibility quality control reviews by the administration.

(e) Require the department to adopt rules, consistent with the rules adopted by the administration for a hearing process, that applicants or members may use for appeals of eligibility determinations or redeterminations.

(f) Establish the department's responsibility to place sufficient eligibility workers at federally qualified health centers to screen for eligibility and at hospital sites and level one trauma centers to ensure that persons seeking hospital services are screened on a timely basis for eligibility for the system, including a process to ensure that applications for the system can be accepted on a twenty-four hour basis, seven days a week.

(g) Withhold payments based on the allowable sanctions for errors in eligibility determinations or redeterminations or failure to meet performance measures required by the intergovernmental agreement.

(h) Recoup from the department all federal fiscal sanctions that result from the department's inaccurate eligibility determinations. The director may offset all or part of a sanction if the department submits a corrective action plan and a strategy to remedy the error.

4. By rule establish a procedure and time frames for the intake of grievances and requests for hearings, for the continuation of benefits and services during the appeal process and for a grievance process at the contractor level. Notwithstanding sections 41-1092.02, 41-1092.03 and 41-1092.05, the administration shall develop rules to establish the procedure and time frame for the informal resolution of grievances and appeals. A grievance that is not related to a claim for payment of system covered services shall be filed in writing with and received by the administration or the prepaid capitated provider or program contractor not later than sixty days after the date of the adverse action, decision or policy implementation being grieved. A grievance that is related to a claim for payment of system covered services must be filed in writing and received by the administration or the prepaid capitated provider or program contractor within twelve months after the date of service, within twelve months

after the date that eligibility is posted or within sixty days after the date of the denial of a timely claim submission, whichever is later. A grievance for the denial of a claim for reimbursement of services may contest the validity of any adverse action, decision, policy implementation or rule that related to or resulted in the full or partial denial of the claim. A policy implementation may be subject to a grievance procedure, but it may not be appealed for a hearing. The administration is not required to participate in a mandatory settlement conference if it is not a real party in interest. In any proceeding before the administration, including a grievance or hearing, persons may represent themselves or be represented by a duly authorized agent who is not charging a fee. A legal entity may be represented by an officer, partner or employee who is specifically authorized by the legal entity to represent it in the particular proceeding.

5. Apply for and accept federal funds available under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) in support of the system. The application made by the director pursuant to this paragraph shall be designed to qualify for federal funding primarily on a prepaid capitated basis. Such funds may be used only for the support of persons defined as eligible pursuant to title XIX of the social security act or the approved section 1115 waiver.

6. At least thirty days before the implementation of a policy or a change to an existing policy relating to reimbursement, provide notice to interested parties. Parties interested in receiving notification of policy changes shall submit a written request for notification to the administration.

7. In addition to the cost sharing requirements specified in subsection D, paragraph 4 of this section:

(a) Charge monthly premiums up to the maximum amount allowed by federal law to all populations of eligible persons who may be charged.

(b) Implement this paragraph to the extent permitted under the federal deficit reduction act of 2005 and other federal laws, subject to the approval of federal waiver authority and to the extent that any changes in the cost sharing requirements under this paragraph would permit this state to receive any enhanced federal matching rate.

C. The director is authorized to apply for any federal funds available for the support of programs to investigate and prosecute violations arising from the administration and operation of the system. Available state funds appropriated for the administration and operation of the system may be used as matching funds to secure federal funds pursuant to this subsection.

D. The director may adopt rules or procedures to do the following:

1. Authorize advance payments based on estimated liability to a contractor or a noncontracting provider after the contractor or noncontracting provider has submitted a claim for services and before the claim is ultimately resolved. The rules shall specify that any advance payment shall be conditioned on the execution before payment of a contract with the contractor or noncontracting provider that requires the administration to retain a specified percentage, which shall be at least twenty percent, of the claimed amount as security and that requires repayment to the administration if the administration makes any overpayment.

2. Defer liability, in whole or in part, of contractors for care provided to members who are hospitalized on the date of enrollment or under other circumstances. Payment shall be on a capped fee-for-service basis for services other than hospital services and at the rate established pursuant to subsection G of this section for hospital services or at the rate paid by the health plan, whichever is less.

3. Deputize, in writing, any qualified officer or employee in the administration to perform any act that the director by law is empowered to do or charged with the responsibility of doing, including the authority to issue final administrative decisions pursuant to section 41-1092.08.

4. Notwithstanding any other law, require persons eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section 36-2981, paragraph 6 to be financially responsible for any cost sharing requirements established in a state plan or a section 1115 waiver and approved by the centers for medicare and

medicaid services. Cost sharing requirements may include copayments, coinsurance, deductibles, enrollment fees and monthly premiums for enrolled members, including households with children enrolled in the Arizona long-term care system.

E. The director shall adopt rules that further specify the medical care and hospital services that are covered by the system pursuant to section 36-2907.

F. In addition to the rules otherwise specified in this article, the director may adopt necessary rules pursuant to title 41, chapter 6 to carry out this article. Rules adopted by the director pursuant to this subsection shall consider the differences between rural and urban conditions on the delivery of hospitalization and medical care.

G. For inpatient hospital admissions and outpatient hospital services on and after March 1, 1993, the administration shall adopt rules for the reimbursement of hospitals according to the following procedures:

1. For inpatient hospital stays from March 1, 1993 through September 30, 2014, the administration shall use a prospective tiered per diem methodology, using hospital peer groups if analysis shows that cost differences can be attributed to independently definable features that hospitals within a peer group share. In peer grouping the administration may consider such factors as length of stay differences and labor market variations. If there are no cost differences, the administration shall implement a stop loss-stop gain or similar mechanism. Any stop loss-stop gain or similar mechanism shall ensure that the tiered per diem rates assigned to a hospital do not represent less than ninety percent of its 1990 base year costs or more than one hundred ten percent of its 1990 base year costs, adjusted by an audit factor, during the period of March 1, 1993 through September 30, 1994. The tiered per diem rates set for hospitals shall represent no less than eighty-seven and one-half percent or more than one hundred twelve and one-half percent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1994 through September 30, 1995 and no less than eighty-five percent or more than one hundred fifteen percent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1995 through September 30, 1996. For the periods after September 30, 1996 no stop loss-stop gain or similar mechanisms shall be in effect. An adjustment in the stop loss-stop gain percentage may be made to ensure that total payments do not increase as a result of this provision. If peer groups are used, the administration shall establish initial peer group designations for each hospital before implementation of the per diem system. The administration may also use a negotiated rate methodology. The tiered per diem methodology may include separate consideration for specialty hospitals that limit their provision of services to specific patient populations, such as rehabilitative patients or children. The initial per diem rates shall be based on hospital claims and encounter data for dates of service November 1, 1990 through October 31, 1991 and processed through May of 1992. The administration may also establish a separate reimbursement methodology for claims with extraordinarily high costs per day that exceed thresholds established by the administration.

2. For rates effective on October 1, 1994, and annually through September 30, 2011, the administration shall adjust tiered per diem payments for inpatient hospital care by the data resources incorporated market basket index for prospective payment system hospitals. For rates effective beginning on October 1, 1999, the administration shall adjust payments to reflect changes in length of stay for the maternity and nursery tiers.

3. Through June 30, 2004, for outpatient hospital services, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to the covered charges. Beginning on July 1, 2004 through June 30, 2005, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to covered charges. If the hospital increases its charges for outpatient services filed with the Arizona department of health services pursuant to chapter 4, article 3 of this title, by more than 4.7 percent for dates of service effective on or after July 1, 2004, the hospital specific cost-to-charge ratio will be reduced by the amount that it exceeds 4.7 percent. If charges exceed 4.7 percent, the effective date of the increased charges will be the effective date of the adjusted Arizona health care cost containment system cost-to-charge ratio. The administration shall develop the methodology for a capped fee-for-service schedule and a statewide cost-to-charge ratio. Any covered outpatient service not included in the capped fee-for-service schedule shall be reimbursed by applying the statewide cost-to-charge ratio that is based on the services not included in the capped fee-for-service schedule. Beginning on July 1, 2005, the administration shall reimburse clean claims with dates of service on or after July 1, 2005, based on the capped fee-for-service schedule or the statewide cost-to-charge

ratio established pursuant to this paragraph. The administration may make additional adjustments to the outpatient hospital rates established pursuant to this section based on other factors, including the number of beds in the hospital, specialty services available to patients and the geographic location of the hospital.

4. Except if submitted under an electronic claims submission system, a hospital bill is considered received for purposes of this paragraph on initial receipt of the legible, error-free claim form by the administration if the claim includes the following error-free documentation in legible form:

- (a) An admission face sheet.
- (b) An itemized statement.
- (c) An admission history and physical.
- (d) A discharge summary or an interim summary if the claim is split.
- (e) An emergency record, if admission was through the emergency room.
- (f) Operative reports, if applicable.
- (g) A labor and delivery room report, if applicable.

Payment received by a hospital from the administration pursuant to this subsection or from a contractor either by contract or pursuant to section 36-2904, subsection I is considered payment by the administration or the contractor of the administration's or contractor's liability for the hospital bill. A hospital may collect any unpaid portion of its bill from other third-party payors or in situations covered by title 33, chapter 7, article 3.

5. For services rendered on and after October 1, 1997, the administration shall pay a hospital's rate established according to this section subject to the following:

- (a) If the hospital's bill is paid within thirty days of the date the bill was received, the administration shall pay ninety-nine percent of the rate.
- (b) If the hospital's bill is paid after thirty days but within sixty days of the date the bill was received, the administration shall pay one hundred percent of the rate.
- (c) If the hospital's bill is paid any time after sixty days of the date the bill was received, the administration shall pay one hundred percent of the rate plus a fee of one percent per month for each month or portion of a month following the sixtieth day of receipt of the bill until the date of payment.

6. In developing the reimbursement methodology, if a review of the reports filed by a hospital pursuant to section 36-125.04 indicates that further investigation is considered necessary to verify the accuracy of the information in the reports, the administration may examine the hospital's records and accounts related to the reporting requirements of section 36-125.04. The administration shall bear the cost incurred in connection with this examination unless the administration finds that the records examined are significantly deficient or incorrect, in which case the administration may charge the cost of the investigation to the hospital examined.

7. Except for privileged medical information, the administration shall make available for public inspection the cost and charge data and the calculations used by the administration to determine payments under the tiered per diem system, provided that individual hospitals are not identified by name. The administration shall make the data and calculations available for public inspection during regular business hours and shall provide copies of the data and calculations to individuals requesting such copies within thirty days of receipt of a written request. The administration may charge a reasonable fee for the provision of the data or information.

8. The prospective tiered per diem payment methodology for inpatient hospital services shall include a mechanism for the prospective payment of inpatient hospital capital related costs. The capital payment shall

include hospital specific and statewide average amounts. For tiered per diem rates beginning on October 1, 1999, the capital related cost component is frozen at the blended rate of forty percent of the hospital specific capital cost and sixty percent of the statewide average capital cost in effect as of January 1, 1999 and as further adjusted by the calculation of tier rates for maternity and nursery as prescribed by law. Through September 30, 2011, the administration shall adjust the capital related cost component by the data resources incorporated market basket index for prospective payment system hospitals.

9. For graduate medical education programs:

(a) Beginning September 30, 1997, the administration shall establish a separate graduate medical education program to reimburse hospitals that had graduate medical education programs that were approved by the administration as of October 1, 1999. The administration shall separately account for monies for the graduate medical education program based on the total reimbursement for graduate medical education reimbursed to hospitals by the system in federal fiscal year 1995-1996 pursuant to the tiered per diem methodology specified in this section. The graduate medical education program reimbursement shall be adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement. Subject to legislative appropriation, on an annual basis, each qualified hospital shall receive a single payment from the graduate medical education program that is equal to the same percentage of graduate medical education reimbursement that was paid by the system in federal fiscal year 1995-1996. Any reimbursement for graduate medical education made by the administration shall not be subject to future settlements or appeals by the hospitals to the administration. The monies available under this subdivision shall not exceed the fiscal year 2005-2006 appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement, except for monies distributed for expansions pursuant to subdivision (b) of this paragraph.

(b) The monies available for graduate medical education programs pursuant to this subdivision shall not exceed the fiscal year 2006-2007 appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement. Graduate medical education programs eligible for such reimbursement are not precluded from receiving reimbursement for funding under subdivision (c) of this paragraph. Beginning July 1, 2006, the administration shall distribute any monies appropriated for graduate medical education above the amount prescribed in subdivision (a) of this paragraph in the following order or priority:

(i) For the direct costs to support the expansion of graduate medical education programs established before July 1, 2006 at hospitals that do not receive payments pursuant to subdivision (a) of this paragraph. These programs must be approved by the administration.

(ii) For the direct costs to support the expansion of graduate medical education programs established on or before October 1, 1999. These programs must be approved by the administration.

(c) The administration shall distribute to hospitals any monies appropriated for graduate medical education above the amount prescribed in subdivisions (a) and (b) of this paragraph for the following purposes:

(i) For the direct costs of graduate medical education programs established or expanded on or after July 1, 2006. These programs must be approved by the administration.

(ii) For a portion of additional indirect graduate medical education costs for programs that are located in a county with a population of less than five hundred thousand persons at the time the residency position was created or for a residency position that includes a rotation in a county with a population of less than five hundred thousand persons at the time the residency position was established. These programs must be approved by the administration.

(d) The administration shall develop, by rule, the formula by which the monies are distributed.

(e) Each graduate medical education program that receives funding pursuant to subdivision (b) or (c) of this paragraph shall identify and report to the administration the number of new residency positions created by the funding provided in this paragraph, including positions in rural areas. The program shall also report information related to the number of funded residency positions that resulted in physicians locating their practices in this state. The administration shall report to the joint legislative budget committee by February 1 of each year on the number of new residency positions as reported by the graduate medical education programs.

(f) Local, county and tribal governments and any university under the jurisdiction of the Arizona board of regents may provide monies in addition to any state general fund monies appropriated for graduate medical education in order to qualify for additional matching federal monies for providers, programs or positions in a specific locality and costs incurred pursuant to a specific contract between the administration and providers or other entities to provide graduate medical education services as an administrative activity. Payments by the administration pursuant to this subdivision may be limited to those providers designated by the funding entity and may be based on any methodology deemed appropriate by the administration, including replacing any payments that might otherwise have been paid pursuant to subdivision (a), (b) or (c) of this paragraph had sufficient state general fund monies or other monies been appropriated to fully fund those payments. These programs, positions, payment methodologies and administrative graduate medical education services must be approved by the administration and the centers for medicare and medicaid services. The administration shall report to the president of the senate, the speaker of the house of representatives and the director of the joint legislative budget committee on or before July 1 of each year on the amount of money contributed and number of residency positions funded by local, county and tribal governments, including the amount of federal matching monies used.

(g) Any funds appropriated but not allocated by the administration for subdivision (b) or (c) of this paragraph may be reallocated if funding for either subdivision is insufficient to cover appropriate graduate medical education costs.

10. Notwithstanding section 41-1005, subsection A, paragraph 9, the administration shall adopt rules pursuant to title 41, chapter 6 establishing the methodology for determining the prospective tiered per diem payments that are in effect through September 30, 2014.

11. For inpatient hospital services rendered on or after October 1, 2011, the prospective tiered per diem payment rates are permanently reset to the amounts payable for those services as of October 1, 2011 pursuant to this subsection.

12. The administration shall adopt a diagnosis-related group based hospital reimbursement methodology consistent with title XIX of the social security act for inpatient dates of service on and after October 1, 2014. The administration may make additional adjustments to the inpatient hospital rates established pursuant to this section for hospitals that are publicly operated or based on other factors, including the number of beds in the hospital, the specialty services available to patients, the geographic location and diagnosis-related group codes that are made publicly available by the hospital pursuant to section 36-437. The administration may also provide additional reimbursement for extraordinarily high cost cases that exceed a threshold above the standard payment. The administration may also establish a separate payment methodology for specific services or hospitals serving unique populations.

H. The director may adopt rules that specify enrollment procedures, including notice to contractors of enrollment. The rules may provide for varying time limits for enrollment in different situations. The administration shall specify in contract when a person who has been determined eligible will be enrolled with that contractor and the date on which the contractor will be financially responsible for health and medical services to the person.

I. The administration may make direct payments to hospitals for hospitalization and medical care provided to a member in accordance with this article and rules. The director may adopt rules to establish the procedures by which the administration shall pay hospitals pursuant to this subsection if a contractor fails to make timely payment to a hospital. Such payment shall be at a level determined pursuant to section 36-2904, subsection H

or I. The director may withhold payment due to a contractor in the amount of any payment made directly to a hospital by the administration on behalf of a contractor pursuant to this subsection.

J. The director shall establish a special unit within the administration for the purpose of monitoring the third-party payment collections required by contractors and noncontracting providers pursuant to section 36-2903, subsection B, paragraph 10 and subsection F and section 36-2915, subsection E. The director shall determine by rule:

1. The type of third-party payments to be monitored pursuant to this subsection.
2. The percentage of third-party payments that is collected by a contractor or noncontracting provider and that the contractor or noncontracting provider may keep and the percentage of such payments that the contractor or noncontracting provider may be required to pay to the administration. Contractors and noncontracting providers must pay to the administration one hundred percent of all third-party payments that are collected and that duplicate administration fee-for-service payments. A contractor that contracts with the administration pursuant to section 36-2904, subsection A may be entitled to retain a percentage of third-party payments if the payments collected and retained by a contractor are reflected in reduced capitation rates. A contractor may be required to pay the administration a percentage of third-party payments that are collected by a contractor and that are not reflected in reduced capitation rates.

K. The administration shall establish procedures to apply to the following if a provider that has a contract with a contractor or noncontracting provider seeks to collect from an individual or financially responsible relative or representative a claim that exceeds the amount that is reimbursed or should be reimbursed by the system:

1. On written notice from the administration or oral or written notice from a member that a claim for covered services may be in violation of this section, the provider that has a contract with a contractor or noncontracting provider shall investigate the inquiry and verify whether the person was eligible for services at the time that covered services were provided. If the claim was paid or should have been paid by the system, the provider that has a contract with a contractor or noncontracting provider shall not continue billing the member.

2. If the claim was paid or should have been paid by the system and the disputed claim has been referred for collection to a collection agency or referred to a credit reporting bureau, the provider that has a contract with a contractor or noncontracting provider shall:

- (a) Notify the collection agency and request that all attempts to collect this specific charge be terminated immediately.

- (b) Advise all credit reporting bureaus that the reported delinquency was in error and request that the affected credit report be corrected to remove any notation about this specific delinquency.

- (c) Notify the administration and the member that the request for payment was in error and that the collection agency and credit reporting bureaus have been notified.

3. If the administration determines that a provider that has a contract with a contractor or noncontracting provider has billed a member for charges that were paid or should have been paid by the administration, the administration shall send written notification by certified mail or other service with proof of delivery to the provider that has a contract with a contractor or noncontracting provider stating that this billing is in violation of federal and state law. If, twenty-one days or more after receiving the notification, a provider that has a contract with a contractor or noncontracting provider knowingly continues billing a member for charges that were paid or should have been paid by the system, the administration may assess a civil penalty in an amount equal to three times the amount of the billing and reduce payment to the provider that has a contract with a contractor or noncontracting provider accordingly. Receipt of delivery signed by the addressee or the addressee's employee is prima facie evidence of knowledge. Civil penalties collected pursuant to this subsection shall be deposited in the state general fund. Section 36-2918, subsections C, D and F, relating to the imposition, collection and enforcement of civil penalties, apply to civil penalties imposed pursuant to this paragraph.

L. The administration may conduct postpayment review of all claims paid by the administration and may recoup any monies erroneously paid. The director may adopt rules that specify procedures for conducting postpayment review. A contractor may conduct a postpayment review of all claims paid by the contractor and may recoup monies that are erroneously paid.

M. Subject to title 41, chapter 4, article 4, the director or the director's designee may employ and supervise personnel necessary to assist the director in performing the functions of the administration.

N. The administration may contract with contractors for obstetrical care who are eligible to provide services under title XIX of the social security act.

O. Notwithstanding any other law, on federal approval the administration may make disproportionate share payments to private hospitals, county operated hospitals, including hospitals owned or leased by a special health care district, and state operated institutions for mental disease beginning October 1, 1991 in accordance with federal law and subject to legislative appropriation. If at any time the administration receives written notification from federal authorities of any change or difference in the actual or estimated amount of federal funds available for disproportionate share payments from the amount reflected in the legislative appropriation for such purposes, the administration shall provide written notification of such change or difference to the president and the minority leader of the senate, the speaker and the minority leader of the house of representatives, the director of the joint legislative budget committee, the legislative committee of reference and any hospital trade association within this state, within three working days not including weekends after receipt of the notice of the change or difference. In calculating disproportionate share payments as prescribed in this section, the administration may use either a methodology based on claims and encounter data that is submitted to the administration from contractors or a methodology based on data that is reported to the administration by private hospitals and state operated institutions for mental disease. The selected methodology applies to all private hospitals and state operated institutions for mental disease qualifying for disproportionate share payments.

P. Disproportionate share payments made pursuant to subsection O of this section include amounts for disproportionate share hospitals designated by political subdivisions of this state, tribal governments and universities under the jurisdiction of the Arizona board of regents. Subject to the approval of the centers for medicare and medicaid services, any amount of federal funding allotted to this state pursuant to section 1923(f) of the social security act and not otherwise spent under subsection O of this section shall be made available for distribution pursuant to this subsection. Political subdivisions of this state, tribal governments and universities under the jurisdiction of the Arizona board of regents may designate hospitals eligible to receive disproportionate share payments in an amount up to the limit prescribed in section 1923(g) of the social security act if those political subdivisions, tribal governments or universities provide sufficient monies to qualify for the matching federal monies for the disproportionate share payments.

Q. Notwithstanding any law to the contrary, the administration may receive confidential adoption information to determine whether an adopted child should be terminated from the system.

R. The adoption agency or the adoption attorney shall notify the administration within thirty days after an eligible person receiving services has placed that person's child for adoption.

S. If the administration implements an electronic claims submission system, it may adopt procedures pursuant to subsection G of this section requiring documentation different than prescribed under subsection G, paragraph 4 of this section.

T. In addition to any requirements adopted pursuant to subsection D, paragraph 4 of this section, notwithstanding any other law, subject to approval by the centers for medicare and medicaid services, beginning July 1, 2011, members eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section 36-2981, paragraph 6 shall pay the following:

1. A monthly premium of fifteen dollars, except that the total monthly premium for an entire household shall not exceed sixty dollars.

2. A copayment of five dollars for each physician office visit.
3. A copayment of ten dollars for each urgent care visit.
4. A copayment of thirty dollars for each emergency department visit.

U. Subject to the approval of the centers for medicare and medicaid services, political subdivisions of this state, tribal governments and any university under the jurisdiction of the Arizona board of regents may provide to the Arizona health care cost containment system administration monies in addition to any state general fund monies appropriated for critical access hospitals in order to qualify for additional federal monies. Any amount of federal monies received by this state pursuant to this subsection shall be distributed as supplemental payments to critical access hospitals.

V. For the purposes of this section, "disproportionate share payment" means a payment to a hospital that serves a disproportionate share of low-income patients as described by 42 United States Code section 1396r-4.

36-2906. Qualified plan health services contracts; proposals; administration

A. The administration shall:

1. Supervise the administrator.
2. Review the proposals.
3. Award contracts.

B. The director shall prepare and issue a request for proposal, including a proposed contract format, in each of the counties of this state, at least once every five years, to qualified group disability insurers, hospital and medical service corporations, health care services organizations and any other qualified public or private persons, including county-owned and operated health care facilities. The contracts shall specify the administrative requirements, the delivery of medically necessary services and the subcontracting requirements.

C. The director shall adopt rules regarding the request for proposal process that provide:

1. For definition of proposals in the following categories subject to the following conditions:

(a) Inpatient hospital services.

(b) Outpatient services, including emergency dental care, and early and periodic health screening and diagnostic services for children.

(c) Pharmacy services.

(d) Laboratory, x-ray and related diagnostic medical services and appliances.

2. Allowance for the adjustment of such categories by expansion, deletion, segregation or combination in order to secure the most financially advantageous proposals for the system.

3. An allowance for limitations on the number of high risk persons that must be included in any proposal.

4. For analysis of the proposals for each geographic service area as defined by the director to ensure the provision of health and medical services that are required to be provided throughout the geographic service area pursuant to section 36-2907.

5. For the submittal of proposals by a group disability insurer, a hospital and medical service corporation, a health care services organization or any other qualified public or private person intending to submit a proposal pursuant to this section. Each qualified proposal shall be entered with separate categories for the distinct groups of persons to be covered by the proposed contracts, as set forth in the request for proposal.

6. For the procurement of reinsurance for expenses incurred by any contractor or member or the system in providing services in excess of amounts specified by the director in any contract year. The director shall adopt rules to provide that the administrator may specify guidelines on a case by case basis for the types of care and services that may be provided to a person whose care is covered by reinsurance. The rules shall provide that if a contractor does not follow specified guidelines for care or services and if the care or services could be provided pursuant to the guidelines at a lower cost the contractor is entitled to reimbursement as if the care or services specified in the guidelines had been provided.

7. For the awarding of contracts to contractors with qualified proposals determined to be the most advantageous to the state for each of the counties in this state. A contract may be awarded that provides services only to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e). The director may provide by rule a second round competitive proposal procedure for the director to request voluntary price

reduction of proposals from only those that have been tentatively selected for award, before the final award or rejection of proposals.

8. For the requirement that any proposal in a geographic service area provide for the full range of system covered services.

9. For the option of the administration to waive the requirement in any request for proposal or in any contract awarded pursuant to a request for proposal for a subcontract with a hospital for good cause in a county or area including but not limited to situations when such hospital is the only hospital in the health service area. In any situation where the subcontract requirement is waived, no hospital may refuse to treat members of the system admitted by primary care physicians or primary care practitioners with hospital privileges in that hospital. In the absence of a subcontract, the reimbursement level shall be at the levels specified in section 36-2904, subsection H or I.

D. Reinsurance may be obtained against expenses in excess of a specified amount on behalf of any individual for system covered emergency or inpatient services either through the purchase of a reinsurance policy or through a system self-insurance program as determined by the director. Reinsurance, subject to the approval of the director, may be obtained against expenses in excess of a specified amount on behalf of any individual for outpatient services either through the purchase of a reinsurance policy or through a system self-insurance program as determined by the director.

E. Notwithstanding the other provisions of this section, the administration may procure, provide or coordinate system covered services by interagency agreement with authorized agencies of this state or with a federal agency for distinct groups of eligible persons, including persons eligible for children's rehabilitative services through the department of economic security and persons eligible for comprehensive medical and dental program services through the department of child safety.

F. Contracts shall be awarded as otherwise provided by law, except that in no event may a contract be awarded to any respondent that will cause the system to lose any federal monies to which it is otherwise entitled.

G. After contracts are awarded pursuant to this section, the director may negotiate with any successful proposal respondent for the expansion or contraction of services or service areas if there are unnecessary gaps or duplications in services or service areas.

# AHCCCS Non-Emergency Medical Transportation

Contract language: Scope of Services

Transportation: These services include emergency and non-emergency medically necessary transportation. Emergency transportation, including transportation initiated by an emergency response system such as 911, may be provided by ground, air, or water ambulance to manage an AHCCCS member's emergency medical condition at an emergency scene and transport the member to the nearest appropriate medical facility. Non-emergency transportation shall be provided for members who are unable to provide or secure their own transportation for medically necessary services using the appropriate mode based on the needs of the member. Refer to AHCCCS Medical Policy Manual ([AMPM Policy 310-BB](#)). The Contractor shall ensure that members have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.

Contract language: Appointment Availability, Transportation Timeliness, Monitoring, and Reporting

The Contractor shall actively monitor and track provider compliance with appointment availability, transportation timeliness, monitoring, and reporting standards as specified in AHCCCS Contractor Operations Manual (ACOM) Policy 417 [42 CFR 438.206(c)(1)].

The Contractor shall ensure that populations with ongoing medical needs, including but not limited to dialysis, radiation, and chemotherapy, have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.

The Contractor shall ensure members have timely access to medically necessary non-emergent transportation for routine appointments. Additionally, the Contractor shall have a process in place for members to request and receive medically necessary transportation for urgent appointments. The Contractor shall schedule transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment. The Contractor shall develop and implement performance auditing protocol to evaluate compliance with the standards above for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.

<p><a href="#">Contract language:</a> Subcontracts (<i>NEMT Brokers are Administrative Services Subcontractors</i>)</p>	<p>The Contractor shall be held fully liable for the performance of all Contract requirements. Subject to limitations as specified in this Contract, any function required to be provided by the Contractor pursuant to this Contract may be subcontracted to a qualified individual or organization [42 CFR 438.6]. Notwithstanding any relationship(s) the Contractor may have with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract [42 CFR 438.230(b)(1); 42 CFR 438.3(k)].</p> <p>In order to determine adequate performance, the Contractor shall monitor the Administrative Services Subcontractor's performance on an ongoing basis and subject it to formal review at least annually or more frequently if requested by AHCCCS. As a result of the performance review, any deficiencies shall be communicated to the Administrative Services Subcontractor in order to establish a corrective action plan [42 CFR 438.230(b)]. The results of the performance review and the corrective action plan shall be communicated to AHCCCS upon completion as specified in <a href="#">ACOM Policy 438</a> and Section F, Attachment F3, <a href="#">Contractor Chart of Deliverables</a>.</p>
<p>ACOM <a href="#">Policy 417</a>, Appointment Availability, Transportation Timeliness, Monitoring, and Reporting</p>	<p>TRANSPORTATION TIMELINESS REVIEW</p> <p>For medically necessary non-emergent transportation, the Contractor shall ensure that a member arrives on time for an appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home.</p> <p>The Contractor shall evaluate compliance with the above standards on a quarterly basis for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.</p>
<p>ACOM <a href="#">Policy 417</a>, <a href="#">Transportation Timeliness Deliverable format</a></p>	<p>Total Drop Offs, Timely Drop Offs, % of Timely Drop Offs Total Pickups, Timely Pickups, % of Timely Pickups</p>
<p>Deliverable Data</p>	<p>For Contract Year ending 2022, Quarter 1 (Oct-Dec 2021) and Quarter 2 (Jan-Mar 2022) data received on Timeliness of Transportation shows the following:</p> <ul style="list-style-type: none"> <li>● 92.50% of 638,948 total drop off trips were timely</li> <li>● 98.05% of 570,725 total pickup trips were timely</li> </ul>

	(This data is from more recent time periods than the data quoted in the meeting)
<p>Strategy to Resolve NEMT Concerns: AHCCCS NEMT Workgroup</p>	<p>AHCCCS created an Internal NEMT workgroup which meets every six weeks.</p> <p>This cross-divisional team includes staff from the Office of Inspector General, Office of General Counsel, Division of Community Advocacy and Intergovernmental Relations, Division of Member and Provider Services, Division of Health Care Management, Division of Fee For Service Management, and Office of the Director (Legislative Liaison).</p> <p>The Workgroup discusses concerns around NEMT services in general, as well as policy and other regulatory changes aimed at improving access to NEMT services. Recent examples include: helping to resolve transportation issues for members residing at the bottom of the Grand Canyon by implementing Equine and Helicopter NEMT options, and new policy language around coverage of public transportation for members.</p>
<p>Strategy to Resolve NEMT Concerns: MCO Oversight of NEMT Brokers</p>	<p>MCOs meet with NEMT Brokers on a regular basis to review performance, address any gaps in services, and resolve any escalated issues. Additional information reviewed in these meetings include call center statistics, member grievances, complaint resolution reports and timeliness reports.</p> <p>One recent example regarding MCO work to address gaps in services relates to increasing capacity for specialty transportation (including wheelchair vans). One such idea looked to increase payment rates for providers that service specialty transports. Another looked to give provider incentives to providers who accepted a minimum percentage of rides..</p>

# Member Grievances and Quality of Care Concerns

Contract language: Member Complaint/Grievance requirements

At a minimum, the Contractor shall comply with the following Grievance and Appeal System Standards and incorporate these requirements into its policies and/or procedures:

The Contractor shall track and trend Grievance and Appeal System information as a source of information for quality improvement and in accordance with the AHCCCS Grievance and Appeal System Reporting Guide.

The Contractor shall address identified issues as expeditiously as the member's condition requires and shall resolve each grievance within 10 business days of receipt, absent extraordinary circumstances. However, no grievances shall exceed 90 days for resolution. Contractor decisions on member grievances cannot be appealed [42 CFR 438.408(a), 42 CFR 438.408(b)(1) and (3)].

Contract Language: Quality Management and Quality of Care requirements

The Contractor shall undergo annual, external independent reviews of the quality of, timeliness of, and access to services covered under the Contract [42 CFR 438.320, 42 CFR 438.350]. AHCCCS will utilize an External Quality Review Organization (EQRO) for purposes of independent review of its Contractors and related AHCCCS oversight. External quality reviews will be conducted by an EQRO [42 CFR 438.358]. Direct engagement at the Contractor level may occur, at the discretion or invitation of AHCCCS.

The Contractor shall establish and implement mechanisms to assess the quality and appropriateness of care provided to members, including members with special health care needs, [42 CFR 438.208(c)(4), 42 CFR 438.330(a)(1), 42 CFR 438.330(b)(4)].

The Contractor shall develop and implement policies and procedures that analyze quality of care issues through identifying the issue, initial assessment of the severity of the issue, and prioritization of action(s) needed to resolve immediate care needs when appropriate. The Contractor shall establish a process to ensure that all staff and providers are trained on how to refer suspected quality of care issues to quality management. This training shall be provided during new employee orientation (within 30 days of hire) and annually, thereafter.

	<p>The Contractor shall monitor contracted providers for compliance with Quality Management metrics, as well as member health and safety; Quality Management staff shall lead all monitoring and investigative efforts. The Contractor shall establish mechanisms to track and trend member and provider issues. The Contractor shall comply with requirements, as specified in Contract and <a href="#">AMPM Policy 960</a>.</p>
<p><a href="#">AMPM Policy 960</a>, Quality of Care Concerns</p>	<p>The Contractor shall develop and implement policies and procedures to review, report, evaluate, and resolve Quality of Care (QOC) concerns and service concerns raised by members/Health Care Decision Makers (HCDM)s, contracted providers, and stakeholders. Concerns may be received from anywhere within the organization or externally from anywhere in the community including provider incident, accident, and death reports entered directly into the AHCCCS Quality Management (QM) Portal as specified in <a href="#">AMPM Policy 961</a>. All concerns shall be addressed regardless of source (external or internal). QOC concerns involving both physical and behavioral health providers or services shall be addressed in the same manner.</p> <p>...</p> <p>The Contractor shall develop and implement a system to document, track, trend, and evaluate complaints and allegations received from members and providers or as directed by AHCCCS, inclusive of QOC concerns, quality of service, and immediate care needs.</p> <ol style="list-style-type: none"> <li>a. The data from the tracking and trending system shall be analyzed and evaluated to identify and address any trends related to members, providers, the QOC process or services in the Contractor's service delivery system or provider network. The Contractor is responsible for incorporating trending of QOC concerns in determining systemic interventions for quality improvement,</li> <li>b. The Contractor shall ensure that tracking and trending information is submitted, reviewed, and considered for action by the Contractor's local QM Committee and local Medical Director, as Chairman of the QM Committee,</li> <li>c. If significant negative trends are noted, the Contractor should consider developing performance improvement activities focused on the topic area to improve the concern resolution process itself, and to make improvements that address other system issues raised during the resolution process,</li> <li>d. The Contractor shall ensure that tracking and trending information related to provider education, training, and staff credentialing is shared with the workforce development operation as specified in ACOM Policy 407, ...</li> </ol>

<p>AHCCCS Review of Quality of Care (QOC) cases</p>	<p>The majority of the QOC investigative work is completed by the MCOs with oversight, monitoring, and auditing of cases completed by AHCCCS. QOCs can be submitted to either an MCO directly or to AHCCCS. If submitted directly to AHCCCS, staff review the concern, research the MCO that the member is enrolled with (for member-specific concerns) and/or the network status of the provider (for systemic provider-related concerns), and then forward all relevant information to the appropriate MCO(s) for review/investigation. A general outline of how concerns are reviewed can be found at the following location:  <a href="https://www.azahcccs.gov/AHCCCS/Downloads/AHCCCS_IncidentFlowChart_200911.pdf">https://www.azahcccs.gov/AHCCCS/Downloads/AHCCCS_IncidentFlowChart_200911.pdf</a></p> <p>MCOs document QOC information, including findings and corrective actions, in the AHCCCS Quality Management Portal. AHCCCS selects random samples of completed cases from each MCO and audits the case files (from initial triage through resolution). Additionally, AHCCCS runs data queries on selected procedure codes and assesses for correlating quality of care concern cases; if no case is found, a notification is sent to the MCO for follow up. AHCCCS also monitors timeliness of case review against timelines outlined in <a href="#">AMPM Policy 960</a>; MCOs receive reports on any QOCs that are overdue or at risk of becoming overdue and provide feedback on case status, rationale for extended time frames, and/or corrective action plans for addressing noted issues. If any of the above-mentioned oversight activities show concerning trends or under-performance, findings may result in corrective action, ranging from directed technical assistance, increased monitoring, more detailed audits, Notice to Cure, and/or financial sanctions.</p>
<p>AHCCCS Access to Care Committee</p>	<p>AHCCCS has an Access to Care Committee which meets quarterly.</p> <p>This cross-divisional committee reviews individual and systemic Access to Care issues for AHCCCS members to inform Medicaid health care delivery decisions, as well as development of rates and reimbursement to ensure availability of AHCCCS-covered services.</p> <p>This Committee reviews member and/or provider complaints, grievances and/or Quality of Care concerns that impact the accessibility and availability of an adequate AHCCCS registered provider network across Arizona.</p>

# Additional Relevant Requirements

Contract Language: Periodic Reporting Requirements

Under the terms and conditions of its CMS grant award, AHCCCS requires periodic reports, encounter data and other information from the Contractor. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions specified in Section D, Paragraph 74, Administrative Actions.

Standards applied for determining adequacy of required reports are as follows:

1. Timeliness: Reports or other required data shall be received on or before scheduled due dates.
2. Accuracy: Reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and/or AHCCCS defined standards.
3. Completeness: All required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions

Contract Language: Administrative Actions

Sanctions: In accordance with applicable Federal and State regulations, A.A.C. R9-28-606, [ACOM Policy 408](#), [ACOM Policy 440](#), Section 1932 of the Social Security Act or any implementing regulation, and the terms of this Contract, AHCCCS may impose sanctions for failure to comply with any provision of this Contract, including but not limited to: temporary management of the Contractor; monetary penalties; suspension of enrollment; withholding of payments; granting members the right to terminate enrollment without cause; suspension of new enrollments, suspension of payment for new enrollments, refusal to renew, or termination of the Contract, or any related subcontracts [45 CFR 74.48, 42 CFR Part 455, 42 CFR Part 438, Sections 1903 and 1932 of the Social Security Act]. See also Section E, Paragraph 45, Temporary Management/Operation of a Contractor and Paragraphs 47 through 50 regarding Termination of the Contract.



## **Non-Emergency Medical Transportation (NEMT): Oversight & Monitoring**

### **For the Governor's Regulatory Review Council (GRRC)**

#### **Background:**

In the August 2, 2022 meeting of the Governor's Regulatory Review Council (GRRC), in the discussion of AHCCCS's 5 Year Review Report for rules in Title 9, Chapter 28, Articles 6 & 7, the Council requested further information be provided regarding AHCCCS's oversight, monitoring, and sanctions with regards to provision of Non-Emergency Medical Transportation (NEMT) service. This document is to provide the Council with an update on the agency's next steps in addressing the Council's concerns, following internal workgroups and discussions with AHCCCS's Managed Care Organizations (MCOs). Additionally, the attached document contains further information regarding AHCCCS's existing contract and policy requirements that govern provision of NEMT services relevant to this request.

Due to the complicated nature of providing NEMT services that meet their members' needs appropriately, State Medicaid Agencies often approach management and delivery of the NEMT benefit differently and with varying levels of success. States and other entities that administer NEMT benefits, including Medicaid MCOs and third-party transportation brokers, are engaged in a number of efforts to improve NEMT program administration, program integrity, and beneficiary experience. Arizona was recently highlighted in a Medicaid and CHIP Payment and Access Commission (MACPAC) [June 2021 Report to Congress](#) that covered some of these recurring issues with the provision of NEMT services, which highlighted AHCCCS's efforts to be adaptive to member needs. AHCCCS maintains a standing internal NEMT workgroup to address concerns and be responsive to members', MCOs', and providers' potential NEMT issues.

#### **Updates:**

The August 2, 2022 Council concerns and requests include the following:

- Raised specific concerns about how member grievances regarding NEMT are handled and how AHCCCS communicates the available options for grievances to members.
  - Information regarding member grievances is included in the attachment.
- Requested that AHCCCS share MCO contract requirements regarding NEMT, as well as information regarding how NEMT concerns are resolved.
  - AHCCCS MCO contract requirements for the provision of NEMT, and information regarding how NEMT concerns are resolved, are attached.
- Requested AHCCCS provide MCO contract requirements regarding quality assurance and quality of care concerns.
  - MCO quality assurance and quality of care contract requirements are detailed in the attachment.
- Requested information regarding how AHCCCS communicates NEMT services, and the different level or mobility issues covered by those services, to members.
  - AHCCCS MCO contract requirements relative to meeting the transportation needs of the member, and how AHCCCS communicates to members how they access NEMT, are attached.

AHCCCS is working with its NEMT Workgroup, and has reached out to its MCOs, to investigate and address the concerns raised by the Council. Thus far, the following actions have been taken:

- AHCCCS requested and received information from its MCOs regarding how the timeliness statistics for NEMT drop offs and pick-ups are calculated:
  - Numerator = Number of timely trips completed, where timely is defined as:
    - Drop-offs: No more than one hour before the medical appointment
    - Pick-ups: Member waiting no more than one hour after the end of treatment
    - These one hour limits are in accordance with AHCCCS Policy
  - Denominator = Total number of completed trips
- AHCCCS additionally requested information from its MCOs regarding the collection of canceled or rescheduled trips (not currently required by AHCCCS), to have the most complete picture possible of the member experience. The collection of this information is still in process.
- AHCCCS has communicated with MCOs to determine if they have a special designation/process for NEMT access to care for members with high health care needs (not currently required by AHCCCS). All MCOs confirmed that they do offer special assistance for high need members. AHCCCS learned that communication regarding how this service is handled is inconsistent among MCOs. For example, some MCOs put this information in their member handbooks, and some train case managers how to make this determination.

AHCCCS is examining the following strategies to address concerns surrounding NEMT:

- AHCCCS will add NEMT timeliness statistics to the Health Plan Report Card on the AHCCCS website so it is available to the public.
- AHCCCS is developing contract and policy language regarding MCOs tracking of provider cancellations/rescheduled trips and reporting the data to AHCCCS.
  - This data will be added to the Health Plan Report Card upon future receipt of the new deliverable.
- Based on the MCO feedback regarding the special assistance for members with high health care needs, AHCCCS intends to work with MCOs to standardize the high-need member designation across plans; and to develop, and consistently deliver, member communication regarding qualifications for, and how to request, such a designation from their MCO.
- AHCCCS has announced a grants program using funds generated by the American Rescue Plan (ARP) Act to expand, enhance and strengthen home and community based services (HCBS). This grant program should be available in mid-2023. It is AHCCCS' hope that interested HCBS providers (including but not limited to assisted living facilities) would consider applying for grants to acquire vehicles to transport wheelchair utilizing and scooter-dependent resident members. Such activity would expand access to transportation services to the benefit of all members. When a qualified HCBS provider successfully applies to AHCCCS to add a transportation service to their provider profile, that provider would be paid for the provision of qualifying NEMT services. (Read more about the grants program in the [AHCCCS ARPA HCBS Spending Plan](#) on page 11.)

Finally, AHCCCS believes it is important to point out the significant number of NEMT services offered annually in order to offer some context around the NEMT statistics. In the attachment, AHCCCS reports six months of NEMT timeliness data for completed trips in contract year ending (CYE) 2022, from October 1, 2021 through March 31, 2022:

- 92.50% of 638,948 total drop off trips were timely
- 98.05% of 570,725 total pick up trips were timely

It is important to note that, on an annualized basis, over 1.2 million drop offs will occur over the 12 months of CYE 2022, and over 1 million pickups. In total that is more than 2 million completed NEMT services in CYE 2022. While a 92% timeliness rate for drop off trips, and a 98% timeliness rate for pick ups, do convey high timeliness adherence, we will still expect to see approximately 120,000 member trips, and possibly an equal number of members impacted. These high numbers (despite the low percentages) can and do result in numerous complaints, and should not equate to an assumption of inaccuracy of the data.

#### **Attachment Information:**

The attachment contains relevant excerpts from AHCCCS CYE 2022 MCO contracts, the AHCCCS Medical Policy Manual (AMPM), and the AHCCCS Contractor Operation Manual (ACOM).

## Non-Emergency Medical Transportation: AHCCCS Contract & Policy Requirements

AHCCCS Non-Emergency Medical Transportation Contract Language	
<p><u>Contract language:</u> Scope of Services</p>	<p>“Transportation: These services include emergency and non-emergency medically necessary transportation. Emergency transportation, including transportation initiated by an emergency response system such as 911, may be provided by ground, air, or water ambulance to manage an AHCCCS member’s emergency medical condition at an emergency scene and transport the member to the nearest appropriate medical facility. Non-emergency transportation shall be provided for members who are unable to provide or secure their own transportation for medically necessary services using the appropriate mode based on the needs of the member. Refer to AHCCCS Medical Policy Manual (<a href="#">AMPM</a>) <a href="#">Policy 310-BB</a>. The Contractor shall ensure that members have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.”</p>
<p><u>Contract language:</u> Appointment Availability, Transportation Timeliness, Monitoring, and Reporting</p>	<p>“The Contractor shall actively monitor and track provider compliance with appointment availability, transportation timeliness, monitoring, and reporting standards as specified in AHCCCS Contractor Operations Manual (<a href="#">ACOM</a>) <a href="#">Policy 417</a> [42 CFR 438.206(c)(1)].</p> <p>The Contractor shall ensure that populations with ongoing medical needs, including but not limited to dialysis, radiation, and chemotherapy, have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment...</p> <p>The Contractor shall ensure members have timely access to medically necessary non-emergent transportation for routine appointments. Additionally, the Contractor shall have a process in place for members to request and receive medically necessary transportation for urgent appointments. The Contractor shall schedule transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment. The Contractor shall develop and implement performance auditing protocol to evaluate compliance with the standards above for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.”</p>
<p><u>Contract language:</u> Subcontracts <i>(NEMT Brokers are Administrative Services Subcontractors)</i></p>	<p>“The Contractor shall be held fully liable for the performance of all Contract requirements. Subject to limitations as specified in this Contract, any function required to be provided by the Contractor pursuant to this Contract may be subcontracted to a qualified individual or organization [42 CFR 438.6]. Notwithstanding any relationship(s) the Contractor may have with any</p>

	<p>subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract [42 CFR 438.230(b)(1); 42 CFR 438.3(k)].</p> <p>In order to determine adequate performance, the Contractor shall monitor the Administrative Services Subcontractor’s performance on an ongoing basis and subject it to formal review at least annually or more frequently if requested by AHCCCS. As a result of the performance review, any deficiencies shall be communicated to the Administrative Services Subcontractor in order to establish a corrective action plan [42 CFR 438.230(b)]. The results of the performance review and the corrective action plan shall be communicated to AHCCCS upon completion as specified in <a href="#">ACOM Policy 438</a> and Section F, Attachment F3, <a href="#">Contractor Chart of Deliverables</a>.”</p>
<p><a href="#">ACOM 406</a>, Member Handbook and Provider Directory</p>	<p>Requires that MCOs produce an annually updated member handbook, including language for members about how to obtain NEMT. The MCO must include in its handbook all information in ACOM 406, Attachment A.</p> <p>Attachment A includes: “How to Obtain Medically Necessary Transportation”</p>
<p><a href="#">ACOM Policy 417</a>, Appointment Availability, Transportation Timeliness, Monitoring, and Reporting</p>	<p>“G. Transportation Timeliness Review</p> <p>For medically necessary non-emergent transportation, the Contractor shall ensure that a member arrives on time for an appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home.</p> <p>The Contractor shall evaluate compliance with the above standards on a quarterly basis for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.”</p>
<p><a href="#">ACOM Policy 417</a>, <a href="#">Transportation Timeliness Deliverable Format</a></p>	<p>Transportation Timeliness Deliverable Format:</p> <ul style="list-style-type: none"> <li>● Total Drop Offs, Timely Drop Offs, % of Timely Drop Offs</li> <li>● Total Pickups, Timely Pickups, % of Timely Pickups</li> </ul>
<p>Deliverable Data <i>(Most recently available)</i></p>	<p>For Contract Year ending 2022, Quarter 1 (Oct-Dec 2021) and Quarter 2 (Jan-Mar 2022) data received on Timeliness of Transportation shows the following:</p> <ul style="list-style-type: none"> <li>● 92.50% of 638,948 total drop off trips were timely</li> <li>● 98.05% of 570,725 total pickup trips were timely</li> </ul>

Member Grievances and Quality of Care Concerns	
<p><u>Contract language:</u> Member Complaint/Grievance requirements</p>	<p>“At a minimum, the Contractor shall comply with the following Grievance and Appeal System Standards and incorporate these requirements into its policies and/or procedures:</p> <p>The Contractor shall track and trend Grievance and Appeal System information as a source of information for quality improvement and in accordance with the AHCCCS Grievance and Appeal System Reporting Guide.</p> <p>The Contractor shall address identified issues as expeditiously as the member’s condition requires and shall resolve each grievance within 10 business days of receipt, absent extraordinary circumstances. However, no grievances shall exceed 90 days for resolution. Contractor decisions on member grievances cannot be appealed [42 CFR 438.408(a), 42 CFR 438.408(b)(1) and (3)].”</p>
<p><u>Contract Language:</u> Quality Management and Quality of Care requirements</p>	<p>The Contractor shall undergo annual, external independent reviews of the quality of, timeliness of, and access to services covered under the Contract [42 CFR 438.320, 42 CFR 438.350]. AHCCCS will utilize an External Quality Review Organization (EQRO) for purposes of independent review of its Contractors and related AHCCCS oversight. External quality reviews will be conducted by an EQRO [42 CFR 438.358]. Direct engagement at the Contractor level may occur, at the discretion or invitation of AHCCCS.</p> <p>The Contractor shall establish and implement mechanisms to assess the quality and appropriateness of care provided to members, including members with special health care needs, [42 CFR 438.208(c)(4), 42 CFR 438.330(a)(1), 42 CFR 438.330(b)(4)].</p> <p>The Contractor shall develop and implement policies and procedures that analyze quality of care issues through identifying the issue, initial assessment of the severity of the issue, and prioritization of action(s) needed to resolve immediate care needs when appropriate. The Contractor shall establish a process to ensure that all staff and providers are trained on how to refer suspected quality of care issues to quality management. This training shall be provided during new employee orientation (within 30 days of hire) and annually, thereafter.</p> <p>The Contractor shall monitor contracted providers for compliance with Quality Management metrics, as well as member health and safety; Quality</p>

	<p>Management staff shall lead all monitoring and investigative efforts. The Contractor shall establish mechanisms to track and trend member and provider issues. The Contractor shall comply with requirements, as specified in Contract and <a href="#">AMPM Policy 960</a>.</p>
<p><a href="#">AMPM Policy 960</a>, Quality of Care Concerns</p>	<p>The Contractor shall develop and implement policies and procedures to review, report, evaluate, and resolve Quality of Care (QOC) concerns and service concerns raised by members/Health Care Decision Makers (HCDM)s, contracted providers, and stakeholders. Concerns may be received from anywhere within the organization or externally from anywhere in the community including provider incident, accident, and death reports entered directly into the AHCCCS Quality Management (QM) Portal as specified in <a href="#">AMPM Policy 961</a>. All concerns shall be addressed regardless of source (external or internal). QOC concerns involving both physical and behavioral health providers or services shall be addressed in the same manner.</p> <p>The Contractor shall develop and implement a system to document, track, trend, and evaluate complaints and allegations received from members and providers or as directed by AHCCCS, inclusive of QOC concerns, quality of service, and immediate care needs.</p> <ol style="list-style-type: none"> <li>a. The data from the tracking and trending system shall be analyzed and evaluated to identify and address any trends related to members, providers, the QOC process or services in the Contractor’s service delivery system or provider network. The Contractor is responsible for incorporating trending of QOC concerns in determining systemic interventions for quality improvement,</li> <li>b. The Contractor shall ensure that tracking and trending information is submitted, reviewed, and considered for action by the Contractor’s local QM Committee and local Medical Director, as Chairman of the QM Committee,</li> <li>c. If significant negative trends are noted, the Contractor should consider developing performance improvement activities focused on the topic area to improve the concern resolution process itself, and to make improvements that address other system issues raised during the resolution process,</li> <li>d. The Contractor shall ensure that tracking and trending information related to provider education, training, and staff credentialing is shared with the workforce development operation as specified in <a href="#">ACOM Policy 407...</a>”</li> </ol>
<p>AHCCCS Review of Quality of Care (QOC) Cases</p>	<p>The majority of the QOC investigative work is completed by the MCOs with oversight, monitoring, and auditing of cases completed by AHCCCS. QOCs can be submitted to either an MCO directly or to AHCCCS. If submitted directly to AHCCCS, staff review the concern, research the MCO that the member is</p>

	<p>enrolled with (for member-specific concerns) and/or the network status of the provider (for systemic provider-related concerns), and then forward all relevant information to the appropriate MCO(s) for review/investigation. A general outline of how concerns are reviewed can be found at the following location: <a href="https://www.azahcccs.gov/AHCCCS/Downloads/AHCCCS_IncidentFlowChart_200911.pdf">https://www.azahcccs.gov/AHCCCS/Downloads/AHCCCS_IncidentFlowChart_200911.pdf</a></p> <p>MCOs document QOC information, including findings and corrective actions, in the AHCCCS Quality Management Portal. AHCCCS selects random samples of completed cases from each MCO and audits the case files (from initial triage through resolution). Additionally, AHCCCS runs data queries on selected procedure codes and assesses for correlating quality of care concern cases; if no case is found, a notification is sent to the MCO for follow up. AHCCCS also monitors timeliness of case review against timelines outlined in <a href="#">AMPM Policy 960</a>; MCOs receive reports on any QOCs that are overdue or at risk of becoming overdue and provide feedback on case status, rationale for extended time frames, and/or corrective action plans for addressing noted issues. If any of the above-mentioned oversight activities show concerning trends or under-performance, findings may result in corrective action, ranging from directed technical assistance, increased monitoring, more detailed audits, Notice to Cure, and/or financial sanctions.</p>
<p>AHCCCS Access to Care Committee</p>	<p>AHCCCS has an Access to Care Committee which meets quarterly. This cross-divisional committee reviews individual and systemic Access to Care issues for AHCCCS members to inform Medicaid health care delivery decisions, as well as development of rates and reimbursement to ensure availability of AHCCCS-covered services.</p> <p>This Committee reviews member and/or provider complaints, grievances and/or Quality of Care concerns that impact the accessibility and availability of an adequate AHCCCS registered provider network across Arizona.</p>

Additional Relevant Requirements/Information	
<p><u>Contract Language:</u> Periodic Reporting Requirements</p>	<p>Under the terms and conditions of its CMS grant award, AHCCCS requires periodic reports, encounter data and other information from the Contractor. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions specified in Section D, Paragraph 74, Administrative Actions.</p> <p>Standards applied for determining adequacy of required reports are as follows:</p> <ol style="list-style-type: none"> <li>1. Timeliness: Reports or other required data shall be received on or before scheduled due dates.</li> <li>2. Accuracy: Reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and/or AHCCCS defined standards.</li> <li>3. Completeness: All required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions</li> </ol>
<p><u>Contract Language:</u> Administrative Actions</p>	<p>Sanctions: In accordance with applicable Federal and State regulations, A.A.C. R9-28-606, <a href="#">ACOM Policy 408</a>, <a href="#">ACOM Policy 440</a>, Section 1932 of the Social Security Act or any implementing regulation, and the terms of this Contract, AHCCCS may impose sanctions for failure to comply with any provision of this Contract, including but not limited to: temporary management of the Contractor; monetary penalties; suspension of enrollment; withholding of payments; granting members the right to terminate enrollment without cause; suspension of new enrollments, suspension of payment for new enrollments, refusal to renew, or termination of the Contract, or any related subcontracts [45 CFR 74.48, 42 CFR Part 455, 42 CFR Part 438, Sections 1903 and 1932 of the Social Security Act]. See also Section E, Paragraph 45, Temporary Management/Operation of a Contractor and Paragraphs 47 through 50 regarding Termination of the Contract.</p>
<p><i>Strategy to Resolve NEMT Concerns:</i> AHCCCS NEMT Workgroup</p>	<p>AHCCCS created an Internal NEMT workgroup which meets every six weeks. This cross-divisional team includes staff from the Office of Inspector General, Office of General Counsel, Division of Community Advocacy and Intergovernmental Relations, Division of Member and Provider Services, Division of Health Care Management, Division of Fee For Service Management, and Office of the Director (Legislative Liaison).</p> <p>The Workgroup discusses concerns around NEMT services in general, as well as</p>

	<p>policy and other regulatory changes aimed at improving access to NEMT services. Recent examples include: helping to resolve transportation issues for members residing at the bottom of the Grand Canyon by implementing Equine and Helicopter NEMT options, and new policy language around coverage of public transportation for members.</p>
<p><i>Strategy to Resolve NEMT Concerns:</i> MCO Oversight of NEMT Brokers</p>	<p>MCOs meet with NEMT Brokers on a regular basis to review performance, address any gaps in services, and resolve any escalated issues. Additional information reviewed in these meetings include call center statistics, member grievances, complaint resolution reports and timeliness reports.</p> <p>One recent example regarding MCO work to address gaps in services relates to increasing capacity for specialty transportation (including wheelchair vans). One such idea looked to increase payment rates for providers that service specialty transports. Another looked to give provider incentives to providers who accepted a minimum percentage of rides.</p>

**ARIZONA MEDICAL BOARD**

Title 4, Chapter 16



# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - ONE-YEAR REVIEW REPORT

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**MEETING DATE:** March 7, 2023

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** November 22, 2022

**SUBJECT:** ARIZONA MEDICAL BOARD  
Title 4, Chapter 16, Article 2

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### Summary

This One Year Review Report (1YRR) from the Arizona Medical Board (Board) was previously considered at the November 29, 2022 Study Session and tabled at the December 6, 2022 Council Meeting due to the questions surrounding the \$500 Telehealth Registration Fee. The Board has provided a fee analysis for the Council's review. This 1YRR from the Board relates to rules in Title 4, Chapter 16, Article 2 regarding fees and charges for licensure. These rules were amended under an exemption provided by Laws 2021, Ch. 320, § 24, an emergency measure that was created to expand the availability of telehealth services in order to meet the health care needs of Arizonans. In a rulemaking that went into effect on September 22, 2021, the Board established the fee for out-of-state health care providers to register to provide telehealth services in Arizona. In this rulemaking, the Board also amended the time frame table to include the applicable time frames for registration as an out-of-state health care provider of telehealth services.

The Board submitted this 1YRR pursuant to A.R.S. § 41-1095.

1. **Has the agency analyzed whether the rules are authorized by statute?**

Yes, the Board cites both general and specific statutory authority for these rules.

**2. Summary of the agency's economic impact comparison and identification of stakeholders:**

Because Laws 2021, Chapter 320, Sec. 24 exempted the Board from complying with A.R.S. Title 41, Chapter 6, the Board did not prepare an economic, small business, and consumer impact statement at the time that the rulemaking was completed. In the 11 months since the rule went into effect, the Board has received 25 applications to register as an out-of-state provider of telehealth services. The Board approved 22 of these applications. One application was not approved because the applicant did not have an active license in another jurisdiction. Two other applications were not approved due to pending receipt of required documentation.

Under R4-16-205(B), the 25 applicants each paid \$500 for registration. As a result, under A.R.S. § 32-1406, the Board deposited \$1,250 into the state's general fund and \$11,250 into the Arizona Medical Board fund.

For all applications received, the Board acted within the time frames specified in Table 1.

Stakeholders include the Board and out-of-state providers of telehealth that would like to provide their services in Arizona.

**3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Board indicates that when the Legislature enacted A.R.S. § 36-3606, the legislature determined that the benefits of allowing out-of-state providers to register to provide telehealth services outweighed the costs to the state.

The only authority provided to the Board under A.R.S. § 36-3606 is to establish a one-time-only registration fee. For this one-time fee, the Board is required to evaluate the information submitted by an out-of-state provider, supervise compliance for as long as the provider chooses to provide telehealth services to Arizona residents, and receive and evaluate annual updates from the provider. Based on the legislature's cost-benefit determination and the limited authority provided under A.R.S. § 36-3606, the Board concludes that the benefits of the rule outweigh the costs.

The time frames listed in Table 1 run against the Board. These time frames do not regulate out-of-state health care providers.

In the provided supplemental materials, the Board indicates that the fee amount is reasonable compared to the telehealth registration fees established by other states. Additionally, the Board indicates that the fee amount is comparable to the standard licensure fees. Council staff believes that the Board has adequately shown that the rules impose the least burden and costs to those regulated.

**4. Has the agency received any written criticisms of the rules since the rule was adopted?**

No, the Board has not received any written criticisms of the rules since the rule was adopted.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability?**

Yes, the Board indicates that the rules are clear, concise, and understandable.

**6. Has the agency analyzed the rules' consistency with other rules and statutes?**

Yes, the Board indicates that the rules are consistent with other rules and statutes.

**7. Has the agency analyzed the rules' effectiveness in achieving its objectives?**

Yes, the Board indicates that the rules are effective in achieving their objectives.

**8. Has the agency analyzed the current enforcement status of the rules?**

Yes, the Board states that the rules are enforced as written.

**9. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

No, the Board indicates that the rules are not more stringent than corresponding federal law.

**10. Has the agency completed any additional process required by law?**

Not applicable; no additional process is required.

**11. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

No, the rules do not require the issuance of a permit or license. R4-16-205 and Table 1 only specify the required fee.

**12. Conclusion**

Council staff finds that the Board submitted an adequate report pursuant to A.R.S. § 41-1095. Council staff recommends approval of this report.



## Arizona Medical Board

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Eileen M. Oswald, M.P.H.  
Public Member

### Executive Director

**Patricia E. McSorley**

August 30, 2022

**VIA EMAIL: [grrc@azdoa.gov](mailto:grrc@azdoa.gov)**

Nicole Sornsins, Chair  
Governor's Regulatory Review Council  
100 North 15th Avenue, Suite 305  
Phoenix, Arizona 85007

**RE: Arizona Medical Board  
One-year-review Report  
R4-16-205 and Table 1**

Dear Ms. Sornsins:

Please find enclosed the referenced one-year-review report. The report is due to be submitted by September 22, 2022.

The Board complies with A.R.S. § 41-1091.

For questions about this report, please contact the Board's executive director, Patricia McSorley, at 480-551-2791 or [patricia.mcsorley@azmd.gov](mailto:patricia.mcsorley@azmd.gov).

Sincerely,

Patricia McSorley  
Executive Director

**ONE-YEAR-REVIEW REPORT**  
**TITLE 4. PROFESSIONS AND OCCUPATIONS**  
**CHAPTER 16. ARIZONA MEDICAL BOARD**  
**Submitted for November 1, 2022**

INTRODUCTION

The legislature enacted Laws 2021, Chapter 320, as an emergency measure to expand use of telehealth in meeting the health-care needs of Arizonans. The statute (A.R.S. § 36-3606) included a provision allowing a health care provider not licensed in this state to provide telehealth services to individuals in Arizona if the out-of-state health care provider registered with Arizona’s applicable regulatory board and paid a fee specified by the regulatory board. The Board established the fee for an out-of-state health care provider to register to provide telehealth services in Arizona in a rulemaking that went into effect on September 22, 2021. The Board also amended the Board’s time frame table to include the new registration.

As required under A.R.S. § 41-1095(A), this report focuses on the Board’s review of R4-16-205 and Table 1, the two provisions amended under the exemption provided by Laws 2021, Chapter 320, Sec. 24.

Statute that generally authorizes the agency to make rules: A.R.S. § 32-1403(A)(8)

1. Specific statute authorizing the rule: A.R.S. §§ 36-3606(A)(3) and 41-1073

2. Objective of the rule:

R4-16-205. Fees and Charges: The objective of this rule is to establish the fees the Board charges for the licenses, certificates, and registrations it issues.

Table 1. Time Frames: The objective of this rule is to provide notice of the amount of time the Board requires to act on an application.

3. Is the rule effective in achieving its objective? Yes

4. Were there written criticisms of the rule, including written analyses questioning whether the rule is based on valid scientific or reliable principles or methods? No
5. Is the rule consistent with other rules and statutes? Yes
6. Is the rule enforced as written? Yes
7. Is the rule clear, concise, and understandable? Yes

8. Estimated economic, small business, and consumer impact of the rule:

Because Laws 2021, Chapter 320, Sec. 24, exempted the Board from complying with A.R.S. Title 41, Chapter 6, the Board did not prepare an economic, small business, and consumer impact statement when the rulemaking was done. In the 11 months since the rule went into effect, the Board has received 25 applications to register as an out-of-state provider of medical services by telehealth. The Board has approved 22 of the registrations. One application was not approved because the applicant did not have an active license in another jurisdiction. The remaining two applications are pending receipt of required documentation

Under R4-16-205(B), the 25 applicants paid \$500 each to register. This means that under A.R.S. § 32-1406, the Board deposited \$1,250 into the state’s general fund and \$11,250 into the Arizona Medical Board fund.

The Board acted within the time frames specified in Table 1 for all the applications.

9. Has the agency received any business competitiveness analyses of the rule? No
10. If applicable, whether the agency completed additional processes required by law: NA
11. A determination after analysis that the probable benefits of the rule outweigh within this state the probable costs of the rule and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective:

When the legislature enacted A.R.S. § 36-3606, the legislature determined the benefits from allowing registration of out-of-state providers to practice medicine by telehealth outweigh the costs to the state.

The legislature established the paperwork cost when it specified the content of an application that must be submitted and established multiple compliance requirements at A.R.S. § 36-3606(A)(2) through (A)(9), (B), and (C). In establishing these paperwork and compliance requirements, the legislature determined the requirements imposed the least burden and costs on out-of-state providers practicing medicine by telehealth necessary to achieve the underlying regulatory objective.

The only authority provided to the Board under A.R.S. § 36-3606 is to establish a one-time-only registration fee. The fee is the only compliance cost established by the Board in the reviewed rules. For this one-time fee, the Board is required to evaluate the application information submitted by the out-of-state provider, supervise compliance for as long as the out-of-state provider may choose to provide telehealth services to residents of Arizona, and receive and evaluate an annual update from the out-of-state provider. The legislature did not authorize the Board to establish a fee for the annual renewal of the registration by an out-of-state provider of telehealth services.

The rules reviewed for this report comply with the minimal authority the legislature provided to the Board. R4-16-205 establishes the fee the Board charges for an out-of-state health care provider to register to provide telehealth services in Arizona. In establishing the fee amount, the Board assumed registered out-of-state providers would maintain their telehealth registrations because the only cost to the out-of-state providers is to submit a renewal registration form. The Board is required to supervise compliance of the out-of-state providers and process the annual registration forms without authority to charge a renewal fee. Because this is the only authority provided to the Board and because the legislature determined there is benefit in allowing out-of-state providers of services by telehealth to register to provide the services in Arizona, the Board concludes the benefits of the rule outweigh the costs.

The time frames listed in Table 1 run against the Board. The time frames do not regulate out-of-state health care providers.

12. Is the rule more stringent than corresponding federal laws? No

13. For a rule that requires issuance of a regulatory permit, license, or agency authorization, whether the rule complies with A.R.S. § 41-1037:

Neither R4-16-205 nor Table 1 requires issuance of a permit, license, or other authorization. The requirements for registration are established in statute. The rule simply specifies the fee required.



## Arizona Medical Board

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February 16, 2023

Ms. Nicole Sornsins, Chair  
The Governor's Regulatory Review Council  
100 North 15th Avenue, Ste. 305  
Phoenix, AZ 85007

Re: One Year Rule Review of A.A.C. Title 4, Chapter 16,  
R4-16-205

Dear Ms. Sornsins:

This letter is follow-up by the Arizona Medical Board ("AMB") to the Governor's Regulatory Review Council ("GRRC") regarding the November 29, 2022, GRRC meeting that included the One-Year Review report of R4-16-205 created under emergency rulemaking.

Background: A comprehensive Arizona telehealth law was enacted in April 2021. The statute A.R.S § 36-3606 (HB2454) allowed for out-of-state healthcare providers to practice telehealth in Arizona by submitting a telehealth registration to the appropriate health regulatory board and complying with several other requirements. The AMB was granted a one-time rulemaking exemption for this new law. Per A.R.S § 41-1095, the One-Year Review Report was submitted in October 2022. It was submitted to obtain the council's approval of a written report summarizing the success of the new out-of-state telehealth care registration, annual reporting and monitoring.

At the November 2022 GRRC meeting, council members discussed the one-year report and inquired about the registration fee. The AMB was asked for additional information and metrics for the registration fee. This letter provides that response. The emergency rulemaking created this new registration fee. The one-time registration fee was recommended by AMB staff based on a time and materials cost analysis.

The fee analysis includes the staff time and systems costs for this new registration process, it includes: responding to applicant inquiries, review of initial application, downloading of submitted documents, verification of submitted documents, review of completed application, issuing a notice of application deficiency and follow-up, adding name to the review committee agenda and the file to the meeting folder, adding name to the Board meeting agenda and adding the file to the meeting review folder, having the meetings, notification of registration issuance or denial to applicant, IT resource estimated costs and the annual record updating and maintenance and ongoing annual review reporting set pursuant to the exempt rulemaking provisions of A.R.S. § 36- 3606(A)(3).

The AMB considered the reasonable time expended by staff and materials needs for system upload and maintenance. The AMB concluded that the registration fee to adequately cover the costs associated with the Telehealth Registration, that is the least financially burdensome to cover costs, is \$500. Please see attached matrix analysis – see Ex A.

In considering the appropriate registration fee for telehealth, the AMB also looked to other telehealth registration fees that GRRC approved. In particular, GRRC approved the Registrants of the AZ Board of Psychologist Examiners (“ABoPE”) \$600 fee under R4-26-108, pursuant to A.R.S. § 36-3606. ABoPE’s one-year-review was before GRRC at its August 7, 2022 meeting. Please see ABoPE’s attached matrix analysis – See Ex B.

The AMB respectfully requests approval of its written report summarizing the new AMB out-of-state Telehealth Registration. If and when additional legislative action is taken or the AMB seeks adjustments, submittals would be made to GRRC. In the meantime, out-of-state telehealth care registration and annual updating will continue as the process put in place by the legislature in 2021. Thank you for your time and attention.

Sincerely,



Patricia E. McSorley  
Executive Director

**Exhibit A**

Staff Hourly Rate (Inclusive of partial Employee Related Expenses)*	Hours to Process/Review Initial Application**	Hours to Process Annual Update (assumes 0.5 hour each year for 8 years)	Cost
\$53.00	3		\$159.00
\$53.00		4	\$212.00
Hourly Rate - JLRC Committee	Hours to Review Application	Hours to Process Annual Update (assumes 0.5 hour each year for 4 years)	Cost
\$250.00	0.25	4	\$250.00
Hourly Rate - 13 Board Members	Hours to Process/Review Application	Hours to Process Annual Update (assumes 0.5 hour each year for 4 years)	Cost
\$300.00	0.25	4	\$300.00
Cost to Maintain Record in Database (Assumes 20 Year Retention) ***			
\$1 x 12 months x 20 years			\$240

Total\*\*\*\* **\$1,161.00**

<p><i>* Includes blended rate for licensing, operations, and IT staff.</i></p>	<p><i>** Includes responding to applicant inquiries, review of initial application, downloading of submitted documents, verification of submitted documents, review of completed application, issuing a notice of application deficiency and follow-up, issuing a notice of administrative completeness, issuing a notice of approval, adding name to the application review committee agenda and the file to the meeting folder, adding name to the JLRC and Board meeting agendas and adding the file to the meeting review folder, having the meetings, and notification of license issuance or denial to applicant.</i></p>	<p><i>*** The AMB's cloud-based management system charges a subscription fee based on a per-record formula. This applies to both active and inactive records.</i></p>	<p><i>**** The fee assumes there are no investigative time or other costs incurred.</i></p>
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**Exhibit B**

GRRC approve the AZ Board of Psychologist Examiners \$600 fee under R4-26-108, pursuant to A.R.S. 36-3606 before GRRC at its August 7, 2022 meeting.

Staff Hourly Rate (Inclusive of Employee Related Expenses)	Hours to Process/Review Initial Application*	Hours to Process Annual Update (assumes 0.5 hour each year for 8 years)	Cost
\$41.00	2		\$82.00
\$41.00		4	\$164.00

Hourly Rate - 10 Board Members	Hours to Process/Review Application	Hours to Process Annual Update (assumes 0.5 hour each year for 8 years)	Cost
\$140.00	0.5	4	\$280.00

Cost to Maintain Record in Database (Assumes 20 Years) **	
\$0.29 x 12 months x 20 years	\$70

**\$596.00**

*The fee assumes there are to be no investigative costs incurred*

<p><i>* Includes responding to applicant inquiries; downloading submitted documents; issuing a notice of application deficiency; issuing a notice of administrative completeness; issuing a notice of approval; adding name to the application review committee agenda and the file to the meeting folder; adding name to the Board meeting agenda and adding the file to the meeting review folder.</i></p>	<p><i>** The Board's cloud-based management system charges a subscription fee based on a per-record formula. This applies to both active and inactive records.</i></p>
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32-1403. Powers and duties of the board; compensation; immunity; committee on executive director selection and retention

A. The primary duty of the board is to protect the public from unlawful, incompetent, unqualified, impaired or unprofessional practitioners of allopathic medicine through licensure, regulation and rehabilitation of the profession in this state. The powers and duties of the board include:

1. Ordering and evaluating physical, psychological, psychiatric and competency testing of licensed physicians and candidates for licensure as may be determined necessary by the board.
2. Initiating investigations and determining on its own motion whether a doctor of medicine has engaged in unprofessional conduct or provided incompetent medical care or is mentally or physically unable to engage in the practice of medicine.
3. Developing and recommending standards governing the profession.
4. Reviewing the credentials and the abilities of applicants whose professional records or physical or mental capabilities may not meet the requirements for licensure or registration as prescribed in article 2 of this chapter in order for the board to make a final determination whether the applicant meets the requirements for licensure pursuant to this chapter.
5. Disciplining and rehabilitating physicians.
6. Engaging in a full exchange of information with the licensing and disciplinary boards and medical associations of other states and jurisdictions of the United States and foreign countries and the Arizona medical association and its components.
7. Directing the preparation and circulation of educational material the board determines is helpful and proper for licensees.
8. Adopting rules regarding the regulation and the qualifications of doctors of medicine.
9. Establishing fees and penalties as provided pursuant to section 32-1436.
10. Delegating to the executive director the board's authority pursuant to section 32-1405 or 32-1451. The board shall adopt substantive policy statements pursuant to section 41-1091 for each specific licensing and regulatory authority the board delegates to the executive director.
11. Determining whether a prospective or current Arizona licensed physician has the training or experience to demonstrate the physician's ability to treat and manage opiate-dependent patients as a qualifying physician pursuant to 21 United States Code section 823(g)(2)(G)(ii).

B. The board may appoint one of its members to the jurisdiction arbitration panel pursuant to section 32-2907, subsection B.

C. There shall be no monetary liability on the part of and no cause of action shall arise against the executive director or such other permanent or temporary personnel or professional medical investigators for any act done or proceeding undertaken or performed in good faith and in furtherance of the purposes of this chapter.

D. In conducting its investigations pursuant to subsection A, paragraph 2 of this section, the board may receive and review staff reports relating to complaints and malpractice claims.

E. The board shall establish a program that is reasonable and necessary to educate doctors of medicine regarding the uses and advantages of autologous blood transfusions.

F. The board may make statistical information on doctors of medicine and applicants for licensure under this article available to academic and research organizations.

G. The committee on executive director selection and retention is established consisting of the Arizona medical board and the chairperson and vice chairperson of the Arizona regulatory board of physician assistants. The committee is a public body and is subject to the requirements of title 38, chapter 3, article 3.1. The committee is responsible for appointing the executive director pursuant to section 32-1405. All members of the committee are voting members of the committee. The committee shall elect a chairperson and a vice chairperson when the committee meets but no more frequently than once a year. The chairperson shall call meetings of the committee as necessary, and the vice chairperson may call meetings of the committee that are necessary if the chairperson is not available. The presence of eight members of the committee at a meeting constitutes a quorum. The committee meetings may be held using communications equipment that allows all members who are participating in the meeting to hear each other. If any discussions occur in an executive session of the committee, notwithstanding the requirement that discussions made at an executive session be kept confidential as specified in section 38-431.03, the chairperson and vice chairperson of the Arizona regulatory board of physician assistants may discuss this information with the Arizona regulatory board of physician assistants in executive session. This disclosure of executive session information to the Arizona regulatory board of physician assistants does not constitute a waiver of confidentiality or any privilege, including the attorney-client privilege.

H. The officers of the Arizona medical board and the Arizona regulatory board of physician assistants shall meet twice a year to discuss matters of mutual concern and interest.

I. The board may accept and expend grants, gifts, devises and other contributions from any public or private source, including the federal government. Monies received under this subsection do not revert to the state general fund at the end of a fiscal year.

### 36-3606. Interstate telehealth services; registration; requirements; venue; exceptions

A. A health care provider who is not licensed in this state may provide telehealth services to a person located in this state if the health care provider complies with all of the following:

1. Registers with this state's applicable health care provider regulatory board or agency that licenses comparable health care providers in this state on an application prescribed by the board or agency that contains all of the following:

(a) The health care provider's name.

(b) Proof of the health care provider's professional licensure, including all United States jurisdictions in which the provider is licensed and the license numbers. Verification of licensure in another state shall be made through information obtained from the applicable regulatory board's website.

(c) The health care provider's address, email address and telephone number, including information if the provider needs to be contacted urgently.

(d) Evidence of professional liability insurance coverage.

(e) Designation of a duly appointed statutory agent for service of process in this state.

2. Before prescribing a controlled substance to a patient in this state, registers with the controlled substances prescription monitoring program established pursuant to chapter 28 of this title.

3. Pays the registration fee as determined by the applicable health care provider regulatory board or agency.

4. Holds a current, valid and unrestricted license to practice in another state that is substantially similar to a license issued in this state to a comparable health care provider and is not subject to any past or pending disciplinary proceedings in any jurisdiction. The health care provider shall notify the applicable health care provider regulatory board or agency within five days after any restriction is placed on the health care provider's license or any disciplinary action is initiated or imposed. The health care provider regulatory board or agency registering the health care provider may use the national practitioner databank to verify the information submitted pursuant to this paragraph.

5. Acts in full compliance with all applicable laws and rules of this state, including scope of practice, laws and rules governing prescribing, dispensing and administering prescription drugs and devices, telehealth requirements and the best practice guidelines adopted by the telehealth advisory committee on telehealth best practices established by section 36-3607.

6. Complies with all existing requirements of this state and any other state in which the health care provider is licensed regarding maintaining professional liability insurance, including coverage for telehealth services provided in this state.

7. Consents to this state's jurisdiction for any disciplinary action or legal proceeding related to the health care provider's acts or omissions under this article.

8. Follows this state's standards of care for that particular licensed health profession.

9. Annually updates the health care provider's registration for accuracy and submits to the applicable health care provider regulatory board or agency a report with the number of patients the provider served in this state and the total number and type of encounters in this state for the preceding year.

B. A health care provider who is registered pursuant to this section may not:

1. Open an office in this state, except as part of a multistate provider group that includes at least one health care provider who is licensed in this state through the applicable health care provider regulatory board or agency.

2. Provide in-person health care services to persons located in this state without first obtaining a license through the applicable health care provider regulatory board or agency.

C. A health care provider who fails to comply with the applicable laws and rules of this state is subject to investigation and both nondisciplinary and disciplinary action by the applicable health care provider regulatory board or agency in this state. For the purposes of disciplinary action by the applicable health care provider regulatory board or agency in this state, all statutory authority regarding investigating,

rehabilitating and educating health care providers may be used. If a health care provider fails to comply with the applicable laws and rules of this state, the applicable health care provider regulatory board or agency in this state may revoke or prohibit the health care provider's privileges in this state, report the action to the national practitioner database and refer the matter to the licensing authority in the state or states where the health care provider possesses a professional license. In any matter or proceeding arising from such a referral, the applicable health care provider regulatory board or agency in this state may share any related disciplinary and investigative information in its possession with another state licensing board.

D. The venue for any civil or criminal action arising from a violation of this section is the patient's county of residence in this state.

E. A health care provider who is not licensed to provide health care services in this state but who holds an active license to provide health care services in another jurisdiction and who provides telehealth services to a person located in this state is not subject to the registration requirements of this section if either of the following applies:

1. The services are provided under one of the following circumstances:

(a) In response to an emergency medication condition.

(b) In consultation with a health care provider who is licensed in this state and who has the ultimate authority over the patient's diagnosis and treatment.

(c) To provide after-care specifically related to a medical procedure that was delivered in person in another state.

(d) To a person who is a resident of another state and the telehealth provider is the primary care provider or behavioral health provider located in the person's state of residence.

2. The health care provider provides fewer than ten telehealth encounters in a calendar year.

#### 41-1073. Time frames; exception

A. No later than December 31, 1998, an agency that issues licenses shall have in place final rules establishing an overall time frame during which the agency will either grant or deny each type of license that it issues. Agencies shall submit their overall time frame rules to the governor's regulatory review council pursuant to the schedule developed by the council. The council shall schedule each agency's rules so that final overall time frame rules are in place no later than December 31, 1998. The rule regarding the overall time frame for each type of license shall state separately the administrative completeness review time frame and the substantive review time frame.

B. If a statutory licensing time frame already exists for an agency but the statutory time frame does not specify separate time frames for the administrative completeness review and the substantive review, by rule the agency shall establish separate time frames for the administrative completeness review and the substantive review, which together shall not exceed the statutory overall time frame. An agency may establish different time frames for initial licenses, renewal licenses and revisions to existing licenses.

C. The submission by the department of environmental quality of a revised permit to the United States environmental protection agency in response to an objection by that agency shall be given the same effect

as a notice granting or denying a permit application for licensing time frame purposes. For the purposes of this subsection, "permit" means a permit required by title 49, chapter 2, article 3.1 or section 49-426.

D. In establishing time frames, agencies shall consider all of the following:

1. The complexity of the licensing subject matter.
2. The resources of the agency granting or denying the license.
3. The economic impact of delay on the regulated community.
4. The impact of the licensing decision on public health and safety.
5. The possible use of volunteers with expertise in the subject matter area.
6. The possible increased use of general licenses for similar types of licensed businesses or facilities.
7. The possible increased cooperation between the agency and the regulated community.
8. Increased agency flexibility in structuring the licensing process and personnel.

E. This article does not apply to licenses issued either:

1. Pursuant to tribal state gaming compacts.
2. Within seven days after receipt of initial application.
3. By a lottery method.

## TITLE 4. PROFESSIONS AND OCCUPATIONS

### CHAPTER 16. ARIZONA MEDICAL BOARD

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#### **R4-16-205. Fees and Charges**

- A.** As specifically authorized under A.R.S. § 32-1436(A), the Board establishes and shall collect the following fees:
1. Application for a license through endorsement, USMLE Step 3, or Endorsement with SPX Examination, \$500;
  2. Issuance of an initial license, \$500, prorated from date of issuance to date of license renewal;
  3. Renewal of license for two years, \$500;
  4. Application to reactivate an inactive license, \$500;
  5. Locum tenens registration, \$350;
  6. Annual registration of an approved internship, residency, clinical fellowship program, or short-term residency program, \$50;
  7. Annual teaching license at an approved school of medicine or at an approved hospital internship, residency, or clinical fellowship program, \$250;
  8. Five-day teaching permit at an approved school of medicine or at an approved hospital internship, residency, or clinical fellowship program, \$100;
  9. Initial registration to dispense drugs and devices, \$200;
  10. Annual renewal to dispense drugs and devices, \$150;
  11. Penalty fee for late renewal of an active license, \$350; and
  12. Application for temporary license, \$250.
- B.** Under the specific authority provided by A.R.S. § 36-3606(A)(3), the Board establishes and shall collect the following fee to register as an out-of-state health care provider of telehealth services: \$500.
- C.** The fees specified in subsections (A) and (B) are nonrefundable unless A.R.S. §§ 32-1436(C) or 41-1077 applies.
- D.** As specifically authorized under A.R.S. § 32-1436(B), the Board establishes the following charges for the services listed:
1. Processing fingerprints to conduct a criminal background check, \$50;
  2. Providing a duplicate license, \$50;
  3. Verifying a license, \$10 per request;
  4. Providing a copy of records, documents, letters, minutes, applications, and files, \$1 for the first three pages and 25¢ for each additional page;
  5. Providing a copy of annual allopathic medical directory, \$30; and
  6. Providing an electronic medium containing public information about licensed physicians, \$100.

**Table 1. Time Frames****Time Frames (in calendar days)**

<b>Type of License</b>	<b>Overall Time Frame</b>	<b>Administrative Review Time Frame</b>	<b>Time to Respond to Deficiency Notice</b>	<b>Substantive Review Time Frame</b>	<b>Time to Respond to Request for Additional Information</b>
Initial License by Examination or Endorsement	240	120	365	120	90
Biennial License Renewal	90	45	60	45	60
Locum Tenens or Pro Bono Registration	120	60	90	60	30
Teaching License	40	20	30	20	30
Educational Teaching Permit	20	10	30	10	10
Training Permit	40	20	30	20	30
Short-term Training Permit	40	20	30	20	30
One-year Training Permit	40	20	30	20	30
Annual Registration to Dispense Drugs and Devices	150	45	30	105	30
Registration as an Out-of-state Health Care Provider of Telehealth Services	40	20	30	20	30

**ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS**

Title 4, Chapter 17, Article 2



# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - ONE-YEAR REVIEW REPORT

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**MEETING DATE:** December 6, 2022; March 7, 2023

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** February 13, 2023

**SUBJECT:** ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS  
Title 4, Chapter 17, Article 2

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### Summary

This One-Year Review Report (1YRR) from the Arizona Regulatory Board of Physician Assistants (Board) relates to rules in Title 4, Chapter 17, Article 2 regarding fees and charges for licensure. These rules were amended under an exemption provided by Laws 2021, Chapter 320, Section 24, an emergency measure that was created to expand the availability of telehealth services in order to meet the health care needs of Arizonans. In a rulemaking that went into effect on September 22, 2021, the Board established a one-time \$200 fee for out-of-state health care providers to register to provide physician assistant services by telehealth in Arizona. In this rulemaking, the Board also amended the time frame table to include the applicable time frames for registration as an out-of-state provider of telehealth services.

The Board submitted this 1YRR pursuant to A.R.S. § 41-1095.

As a reminder, this 1YRR was previously considered at the November 29, 2022 Study Session and December 6, 2022 Council Meeting. At those meetings, the Council raised concerns regarding the Board's analysis determining the fee amount for out-of-state healthcare provider telehealth registration, particularly in relation to lower telehealth registration fees charged by other states. At the December 6, 2022 Council Meeting, the Council voted to table consideration of the 1YRR for Title 4, Chapter 17, Article 2, to allow the Board additional time to take the

Council's comments and suggestions regarding the telehealth registration fee back to the Board's Joint Legislative and Rules Committee (Committee).

The Board indicates it will meet on February 22, 2023 and a revised submission to the Council will follow in preparation for the February 28, 2023 Study Session. Council staff will circulate the revised submission when it is received.

Katie Hobbs  
Governor



Susan Reina, P.A.-C  
Chair

**Arizona Regulatory Board of  
Physician Assistants**

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February 24, 2023

Ms. Nicole Sornsin, Chair  
The Governor's Regulatory Review Council  
100 North 15th Avenue, Ste. 305  
Phoenix, AZ 85007

Re: One Year Rule Review of A.A.C. Title 4, Chapter 17,  
R4-17-204

Dear Ms. Sornsin:

This letter is follow-up by the Arizona Regulatory Board of Physician Assistants ("ARBoPA") to the Governor's Regulatory Review Council ("GRRC") regarding the November 29, 2022, GRRC meeting that included the One-Year Review report of R4-17-204 created under emergency rulemaking.

Background: A comprehensive Arizona telehealth law was enacted in April 2021. The statute A.R.S § 36-3606 (HB2454) allowed for out-of-state healthcare providers to practice telehealth in Arizona by submitting a telehealth registration to the appropriate health regulatory board and complying with several other requirements. The ARBoPA was granted a one-time rulemaking exemption for this new law. Per A.R.S § 41-1095, the One-Year Review Report was submitted in October 2022. It was submitted to obtain the council's approval of a written report summarizing the success of the new out-of-state telehealth care registration, annual reporting, and monitoring.

At the November 2022 GRRC meeting, council members discussed the one-year report and inquired about the registration fee. The ARBoPA was asked for additional information and metrics for the registration fee. This letter provides that response. The emergency rulemaking created this new registration fee. The one-time registration fee was recommended by ARBoPA staff based on a time and materials cost analysis.

The fee analysis includes the staff time and systems costs for this new registration process, it includes: responding to applicant inquiries, review of initial application, downloading of submitted documents, verification of submitted documents, review of completed application, issuing a notice of application deficiency and follow-up, adding name to the review committee agenda and the file to the meeting folder, adding name to the Board meeting agenda and adding the file to the meeting review folder, having the meetings, notification of registration issuance or denial to applicant, IT resource estimated costs and the annual record updating and maintenance and ongoing annual review reporting set pursuant to the exempt rulemaking provisions of A.R.S. § 36- 3606(A)(3).

The ARBoPA considered the reasonable time expended by staff and materials needs for system upload and maintenance. The ARBoPA concluded that the registration fee to adequately cover the costs associated with the Telehealth Registration, that is the least financially burdensome to cover costs, is \$500. Please see attached matrix analysis – see Ex A.

In considering the appropriate registration fee for telehealth, the ARBoPA also looked to other telehealth registration fees that GRRC approved. In particular, GRRC approved the Registrants of the AZ Board of Psychologist Examiners (“ABoPE”) \$600 fee under R4-26-108, pursuant to A.R.S. § 36-3606. ABoPE’s one-year-review was before GRRC at its August 7, 2022 meeting. Please see ABoPE’s attached matrix analysis – See Ex B.

The ARBoPA respectfully requests approval of its written report summarizing the new ARBoPA out-of-state Telehealth Registration. If and when additional legislative action is taken or the AMB seeks adjustments, submittals would be made to GRRC. In the meantime, out-of-state telehealth care registration and annual updating will continue as the process put in place by the legislature in 2021. Thank you for your time and attention.

Sincerely,

  
Patricia E. McSorley  
Executive Director

**Exhibit A**

Staff Hourly Rate (Inclusive of parital Employee Related Expenses)*	Hours to Process/Review Initial Application**	Hours to Process Annual Update (assumes 0.5 hour each year for 8 years)	Cost
\$53.00	3		\$159.00
\$53.00		4	\$212.00
Hourly Rate - JLRC Committee	Hours to Review Application	Hours to Process Annual Update (assumes 0.5 hour each year for 4 years)	Cost
\$50.00	0.25	4	\$50.00
Hourly Rate-11 Board Members	Hours to Process/Review Application	Hours to Process Annual Update (assumes 0.5 hour each year for 4 years)	Cost
\$200.00	0.25	4	\$200.00
Cost to Maintain Record in Database (Assumes 20 Year Retention) ***			
\$1 x 12 months x 20 years			\$240
		Total****	\$861.00
<i>* Includes blended rate for licensing, operations and IT staff. AMB and ARBoPA share Staff and Database. Boards have their own members and are reimbursed at different rates.</i>	<i>** Includes responding to applicant inquiries, review of initial application, downloading of submitted documents, verification of submitted documents, review of completed application, issuing a notice of application deficiency and follow-up, issuing a notice of administrative completedness, issuing a notice of approval, adding name to the application review committee agenda and the file to the meeting folder, adding name to the JLRC and Board meeting agendas and adding the file to the meeting review folder, having the meetings, and notification of license issuance or denial to applicant.</i>	<i>*** The AMB's cloud-based management system charges a subscription fee based on a per-record formula. This applies to both active and inactive records.</i>	<i>**** The fee assumes there are no investigative time or other costs incurred.</i>



**Exhibit B**

GRRC approve the AZ Board of Psychologist Examiners \$600 fee under R4-26-108, pursuant to A.R.S. 36-3606 before GRRC at its August 7, 2022 meeting.

Staff Hourly Rate (Inclusive of Employee Related Expenses)	Hours to Process/Review Initial Application*	Hours to Process Annual Update (assumes 0.5 hour each year for 8 years)	Cost
\$41.00	2		\$82.00
\$41.00		4	\$164.00

Hourly Rate - 10 Board Members	Hours to Process/Review Application	Hours to Process Annual Update (assumes 0.5 hour each year for 8 years)	Cost
\$140.00	0.5	4	\$280.00

Cost to Maintain Record in Database (Assumes 20 Years) **	
\$0.29 x 12 months x 20 years	\$70

**\$596.00**

*The fee assumes there are to be no investigative costs incurred*

<p><i>* Includes responding to applicant inquiries; downloading submitted documents; issuing a notice of application deficiency; issuing a notice of administrative completeness; issuing a notice of approval; adding name to the application review committee agenda and the file to the meeting folder; adding name to the Board meeting agenda and adding the file to the meeting review folder.</i></p>	<p><i>** The Board's cloud-based management system charges a subscription fee based on a per-record formula. This applies to both active and inactive records.</i></p>
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# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - ONE-YEAR REVIEW REPORT

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**MEETING DATE:** December 6, 2022

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** November 21, 2022

**SUBJECT:** ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS  
Title 4, Chapter 17, Article 2

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### Summary

This One-Year Review Report (1YRR) from the Arizona Regulatory Board of Physician Assistants (Board) relates to rules in Title 4, Chapter 17, Article 2 regarding fees and charges for licensure. These rules were amended under an exemption provided by Laws 2021, Chapter 320, Section 24, an emergency measure that was created to expand the availability of telehealth services in order to meet the health care needs of Arizonans. In a rulemaking that went into effect on September 22, 2021, the Board established the fee for out-of-state health care providers to register to provide physician assistant services by telehealth in Arizona. In this rulemaking, the Board also amended the time frame table to include the applicable time frames for registration as an out-of-state provider of telehealth services.

The Board submitted this 1YRR pursuant to A.R.S. § 41-1095.

1. **Has the agency analyzed whether the rules are authorized by statute?**

Yes, the Board cites both general and specific statutory authority for these rules.

2. **Summary of the agency's economic impact comparison and identification of stakeholders:**

Because Laws 2021, Chapter 320, Sec. 24 exempted the Board from complying with A.R.S. Title 41, Chapter 6, the Board did not prepare an economic, small business, and consumer impact statement at the time that the rulemaking was completed. In the 11 months since the rule went into effect, the Board has not received any applications to register as an out-of-state provider of physician assistant services by telehealth. As a result, the Board has received no registration fees.

**3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Board indicates that when the Legislature enacted A.R.S. § 36-3606, the legislature determined that the benefits of allowing out-of-state providers to register to provide telehealth services outweighed the costs to the state.

The only authority provided to the Board under A.R.S. § 36-3606 is to establish a one-time-only registration fee of \$200. For this one-time fee, the Board is required to evaluate the information submitted by an out-of-state provider, supervise compliance for as long as the provider chooses to provide telehealth services to Arizona residents, and receive and evaluate annual updates from the provider. Based on the legislature's cost-benefit determination and the limited authority provided under A.R.S. § 36-3606, the Board concludes that the benefits of the rule outweigh the costs.

The time frames listed in Table 1 run against the Board. These time frames do not regulate out-of-state health care providers.

The Board indicates that the fee amount is reasonable compared to the telehealth registration fees established by other states. Additionally, the Board indicates that the fee amount is comparable to the standard licensure fees. Council staff believes that the Board has adequately shown that the rules impose the least burden and costs to those regulated.

**4. Has the agency received any written criticisms of the rules since the rule was adopted?**

No, the Board has not received any written criticisms of the rules since the rule was adopted.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability?**

Yes, the Board indicates that the rules are clear, concise, and understandable.

**6. Has the agency analyzed the rules' consistency with other rules and statutes?**

Yes, the Board indicates that the rules are consistent with other rules and statutes.

**7. Has the agency analyzed the rules' effectiveness in achieving its objectives?**

Yes, the Board indicates that the rules are effective in achieving their objectives.

**8. Has the agency analyzed the current enforcement status of the rules?**

Yes, the Board states that the rules are enforced as written.

**9. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

No, the Board indicates that there is no corresponding federal law.

**10. Has the agency completed any additional process required by law?**

Not applicable; no additional process is required.

**11. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

No; the rules do not require the issuance of a permit or license. R4-17-204 and Table 1 only specify the required fee.

**12. Conclusion**

Council staff finds that the Board has submitted an adequate report pursuant to A.R.S. § 41-1095. Council staff recommends approval of this report.



Douglas A. Ducey  
Governor

**Arizona Regulatory Board of  
Physician Assistants**

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Susan Reina, PA-C  
Chair

August 30, 2022

**VIA EMAIL: [grrc@azdoa.gov](mailto:grrc@azdoa.gov)**

Nicole Sornsin, Chair  
Governor's Regulatory Review Council  
100 North 15th Avenue, Suite 305  
Phoenix, Arizona 85007

**RE: Arizona Regulatory Board of Physician Assistants  
One-year-review Report  
R4-17-204 and Table 1**

Dear Ms Sornsin:

Please find enclosed the referenced one-year-review report. The report is due to be submitted by September 22, 2022.

The Board complies with A.R.S. § 41-1091.

For questions about this report, please contact the Board's executive director, Patricia McSorley, at 480-551-2791 or [patricia.mcsorley@azmd.gov](mailto:patricia.mcsorley@azmd.gov).

Sincerely,

Patricia McSorley  
Executive Director

**ONE-YEAR-REVIEW REPORT**  
**TITLE 4. PROFESSIONS AND OCCUPATIONS**  
**CHAPTER 17. ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS**  
**Submitted for November 1, 2022**

INTRODUCTION

The legislature enacted Laws 2021, Chapter 320, as an emergency measure to expand use of telehealth in meeting the health-care needs of Arizonans. The statute (A.R.S. § 36-3606) included a provision allowing a health care provider not licensed in this state to provide telehealth services to individuals in Arizona if the out-of-state health care provider registered with Arizona’s applicable regulatory board and paid a fee specified by the regulatory board. The Board established the fee for an out-of-state health care provider to register to provide telehealth services in Arizona in a rulemaking that went into effect on September 22, 2021. The Board also amended the Board’s time frame table to include the new registration.

As required under A.R.S. § 41-1095(A), this report focuses on the Board’s review of Table 1 and R4-17-204, the two provisions amended under the exemption provided by Laws 2021, Chapter 320, Sec. 24.

Statute that generally authorizes the agency to make rules: A.R.S. § 32-2504(C)

1. Specific statute authorizing the rule: A.R.S. §§ 36-3606(A)(3) and 41-1073

2. Objective of the rule:

Table 1. Time Frames (in days): The objective of this rule is to provide notice of the amount of time the Board requires to act of an application.

R4-17-204. Fees and Charges: The objective of this rule is to establish the fees the Board charges for the licenses and registrations it issues.

3. Is the rule effective in achieving its objective? Yes

4. Were there written criticisms of the rule, including written analyses questioning whether the rule is based on valid scientific or reliable principles or methods? No
5. Is the rule consistent with other rules and statutes? Yes
6. Is the rule enforced as written? Yes
7. Is the rule clear, concise, and understandable? Yes

8. Estimated economic, small business, and consumer impact of the rule:

Because Laws 2021, Chapter 320, Sec. 24, exempted the Board from complying with A.R.S. Title 41, Chapter 6, the Board did not prepare an economic, small business, and consumer impact statement when the rulemaking was done. In the 11 months since the rule went into effect, the Board has received no applications to register as an out-of-state provider of physician assistant services by telehealth. As a result, the Board has received no registration fees and has deposited no monies in the state's general fund or the Arizona Medical Board fund.

The Board acts within the time frames specified in Table 1.

9. Has the agency received any business competitiveness analyses of the rule? No
10. If applicable, whether the agency completed additional processes required by law: NA
11. A determination after analysis that the probable benefits of the rule outweigh within this state the probable costs of the rule and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective:

When the legislature enacted A.R.S. § 36-3606, the legislature determined the benefits from allowing registration of out-of-state providers of physician assistant services by telehealth outweigh the costs to the state. The legislature established the paperwork cost when it specified the content of an application that must be submitted and established multiple compliance requirements at A.R.S. § 36-3606(A)(2) through (A)(9), (B), and (C). In establishing these paperwork and compliance requirements, the legislature determined the requirements imposed the least burden and costs on out-

of-state providers of physician assistant services by telehealth necessary to achieve the underlying regulatory objective.

The only authority provided to the Board under A.R.S. § 36-3606 is to establish a one-time-only registration fee. The fee is the only compliance cost established by the Board in the reviewed rules. For this one-time fee, the Board is required to evaluate the application information submitted by the out-of-state provider, supervise compliance for as long as the out-of-state provider may choose to provide telehealth services to residents of Arizona, and receive and evaluate an annual update from the out-of-state provider. The legislature did not authorize the Board to establish a fee for the annual renewal of the registration by an out-of-state provider of telehealth services.

The rules reviewed for this report comply with the minimal authority the legislature provided to the Board. R4-17-204 establishes the fee the Board charges for an out-of-state health care provider to register to provide telehealth services in Arizona. In establishing the fee amount, the Board assumed registered out-of-state providers would maintain their telehealth registrations because the only cost to the out-of-state providers is to submit a renewal registration form. The Board is required to supervise compliance of the out-of-state providers and process the annual registration forms without authority to charge a renewal fee. Because this is the only authority provided to the Board and because the legislature determined there is benefit in allowing out-of-state providers of services by telehealth to register to provide the services in Arizona, the Board concludes the benefits of the rule outweigh the costs.

The time frames listed in Table 1 run against the Board. The time frames do not regulate out-of-state health care providers.

Currently, there are only 6 other states, like Arizona, that offer an out-of-state physician/physician assistant the ability to practice via telehealth by way of a registration.

#### States with Telehealth Registration and Fees:

1. Florida No fee
2. West Virginia \$175 for an MD and PA \$100
3. Vermont MD- \$ and PA \$ 175
4. Indiana No fee
5. Minnesota \$75 Annually, plus an application fee of \$100
6. Kansas \$100

A majority of the states, and the standard at this time, is that a physician/physician assistant who wishes to practice telemedicine in the state where a patient is located, must be licensed in and pay the licensing fee associated with practice in that state

Both the AMB and the ARBoPA applied the “reasonable” standard approach when setting the telehealth registration fee, considering both the cost of the administration and the oversight of the telemedicine registration, including the lack of a renewal fee associated with the annual updating of the registration. The fees were not set to create a barrier or to limit out of state providers from practicing telemedicine within Arizona. The established fees for the telehealth registration are consistent with the fees currently charged for licensure. The MD licensure fee is \$ 500, with a renewal fee of \$500 every two years. The PA licensure fee for two years is \$370 prorated at time of licensure, with a renewal fee of \$370 every two-years.

Currently, the Agency has a licensing department consisting of 12 employees working continuously on the various license application types offered in the State of Arizona: initial license, licensure by endorsement, Compact license, Universal Recognition License Medical Graduate Training Permit, temporary license, and the telehealth training permit. The same staff also process license applications for physician assistants. The same licensing staff also process the renewals for the 28,352 physicians and the 4385 physician assistants.

Taking into consideration the range of fees set by the minority of states that have a telehealth registration, and after reviewing the one-time fees set by the AMB and the ARBoPA for the administration and oversight of the telehealth registration, it would be reasonable to conclude that the probable benefit outweighs to cost to those registering to provide telehealth services in Arizona.

12. Is the rule more stringent than corresponding federal laws?

The function of professional licensing and regulation is a state’s right and there are no federal laws giving or providing telehealth registration.

13. For a rule that requires issuance of a regulatory permit, license, or agency authorization, whether the rule complies with A.R.S. § 41-1037:

Neither R4-17-204 nor Table 1 requires issuance of a permit, license, or other authorization. The requirements for registration are established in statute. The rule simply specifies the fee required.

**TITLE 4. PROFESSIONS AND OCCUPATIONS**

**CHAPTER 17. ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS**

Table 1. Time Frames (in days)

Type of License	Overall Time Frame	Administrative Review Time Frame	Time to Respond to Deficiency Notice	Substantive Review Time Frame	Time to Respond to Request for Additional Information
Regular License including schedule II or schedule III controlled substances approval R4-17-203	120	30	365	90	90
License Renewal R4-17-206	75	30	60	45	60
Registration as an Out-of-state Health Care Provider of Telehealth Services A.R.S. § 36-3606(A)(3)	40	20	30	20	30

**R4-17-204. Fees and Charges**

- A.** As expressly authorized under A.R.S. § 32-2526(A)(1) through (4), the Board shall charge the following fees:
1. License application - \$125.00;
  2. Regular license - \$370.00, prorated for each month remaining in the biennial period;
  3. Regular license renewal - \$370.00 if the renewal application is postmarked no later than the applicant's birthdate; and
  4. Penalty for late renewal - \$100.00.
- B.** Under the specific authority provided by A.R.S. § 36-3606(A)(3), the Board establishes and shall collect the following fee to register as an out-of-state health care provider of telehealth services: \$200.
- C.** The fees specified in subsections (A) and (B) are nonrefundable unless A.R.S. §§ 32-2526(B) or 41-1077 applies.
- D.** As expressly authorized under A.R.S. § 32-2526(A)(5) through (9), the Board establishes the following charges for providing the services listed:
1. Duplicate license - \$25.00;
  2. Copies of Board documents - \$1.00 for first three pages, \$.25 for each additional page;
  3. Medical Directory (CD-ROM) - \$30.00;
  4. Data Disk - \$100.00; and

32-2504. Powers and duties; delegation of authority; rules; subcommittees; immunity

A. The board shall:

1. As its primary duty, protect the public from unlawful, incompetent, unqualified, impaired or unprofessional physician assistants.
  2. License and regulate physician assistants pursuant to this chapter.
  3. Order and evaluate physical, psychological, psychiatric and competency testing of licensees and applicants the board determines is necessary to enforce this chapter.
  4. Review the credentials and the abilities of applicants for licensure whose professional records or physical or mental capabilities may not meet the requirements of this chapter.
  5. Initiate investigations and determine on its own motion whether a licensee has engaged in unprofessional conduct or is or may be incompetent or mentally or physically unable to safely perform health care tasks.
  6. Establish fees and penalties pursuant to section 32-2526.
  7. Develop and recommend standards governing the profession.
  8. Engage in the full exchange of information with the licensing and disciplinary boards and professional associations of other states and jurisdictions of the United States and foreign countries and a statewide association for physician assistants.
  9. Direct the preparation and circulation of educational material the board determines is helpful and proper for its licensees.
  10. Discipline and rehabilitate physician assistants pursuant to this chapter.
  11. Certify physician assistants for thirty-day prescription privileges for schedule II, schedule III, schedule IV and schedule V controlled substances that are opioids or benzodiazepine and ninety-day prescription privileges for schedule II, schedule III, schedule IV and schedule V controlled substances that are not opioids or benzodiazepine if the physician assistant either:
    - (a) Within the preceding three years of application, completed forty-five hours in pharmacology or clinical management of drug therapy or at the time of application is certified by a national commission on the certification of physician assistants or its successor.
    - (b) Met any other requirement established by board rule.
- B. The board may delegate to the executive director the board's authority pursuant to this section or section 32-2551. The board shall adopt a substantive policy statement pursuant to section 41-1091 for each specific licensing and regulatory authority the board delegates to the executive director.
- C. The board may make and adopt rules necessary or proper for the administration of this chapter.

D. The chairperson may establish subcommittees consisting of board members and define their duties as the chairperson deems necessary to carry out the functions of the board.

E. Board employees, including the executive director, temporary personnel and professional medical investigators, are immune from civil liability for good faith actions they take to enforce this chapter.

F. In performing its duties pursuant to subsection A of this section, the board may receive and review staff reports on complaints, malpractice cases and all investigations.

G. The chairperson and vice chairperson of the Arizona regulatory board of physician assistants are members of the committee on executive director selection and retention established by section 32-1403, subsection G, which is responsible for the appointment of the executive director pursuant to section 32-1405.

### 36-3606. Interstate telehealth services; registration; requirements; venue; exceptions

A. A health care provider who is not licensed in this state may provide telehealth services to a person located in this state if the health care provider complies with all of the following:

1. Registers with this state's applicable health care provider regulatory board or agency that licenses comparable health care providers in this state on an application prescribed by the board or agency that contains all of the following:

(a) The health care provider's name.

(b) Proof of the health care provider's professional licensure, including all United States jurisdictions in which the provider is licensed and the license numbers. Verification of licensure in another state shall be made through information obtained from the applicable regulatory board's website.

(c) The health care provider's address, email address and telephone number, including information if the provider needs to be contacted urgently.

(d) Evidence of professional liability insurance coverage.

(e) Designation of a duly appointed statutory agent for service of process in this state.

2. Before prescribing a controlled substance to a patient in this state, registers with the controlled substances prescription monitoring program established pursuant to chapter 28 of this title.

3. Pays the registration fee as determined by the applicable health care provider regulatory board or agency.

4. Holds a current, valid and unrestricted license to practice in another state that is substantially similar to a license issued in this state to a comparable health care provider and is not subject to any past or pending disciplinary proceedings in any jurisdiction. The health care provider shall notify the applicable health care provider regulatory board or agency within five days after any restriction is placed on the health care provider's license or any disciplinary action is initiated or imposed. The health care provider regulatory

board or agency registering the health care provider may use the national practitioner databank to verify the information submitted pursuant to this paragraph.

5. Acts in full compliance with all applicable laws and rules of this state, including scope of practice, laws and rules governing prescribing, dispensing and administering prescription drugs and devices, telehealth requirements and the best practice guidelines adopted by the telehealth advisory committee on telehealth best practices established by section 36-3607.

6. Complies with all existing requirements of this state and any other state in which the health care provider is licensed regarding maintaining professional liability insurance, including coverage for telehealth services provided in this state.

7. Consents to this state's jurisdiction for any disciplinary action or legal proceeding related to the health care provider's acts or omissions under this article.

8. Follows this state's standards of care for that particular licensed health profession.

9. Annually updates the health care provider's registration for accuracy and submits to the applicable health care provider regulatory board or agency a report with the number of patients the provider served in this state and the total number and type of encounters in this state for the preceding year.

B. A health care provider who is registered pursuant to this section may not:

1. Open an office in this state, except as part of a multistate provider group that includes at least one health care provider who is licensed in this state through the applicable health care provider regulatory board or agency.

2. Provide in-person health care services to persons located in this state without first obtaining a license through the applicable health care provider regulatory board or agency.

C. A health care provider who fails to comply with the applicable laws and rules of this state is subject to investigation and both nondisciplinary and disciplinary action by the applicable health care provider regulatory board or agency in this state. For the purposes of disciplinary action by the applicable health care provider regulatory board or agency in this state, all statutory authority regarding investigating, rehabilitating and educating health care providers may be used. If a health care provider fails to comply with the applicable laws and rules of this state, the applicable health care provider regulatory board or agency in this state may revoke or prohibit the health care provider's privileges in this state, report the action to the national practitioner database and refer the matter to the licensing authority in the state or states where the health care provider possesses a professional license. In any matter or proceeding arising from such a referral, the applicable health care provider regulatory board or agency in this state may share any related disciplinary and investigative information in its possession with another state licensing board.

D. The venue for any civil or criminal action arising from a violation of this section is the patient's county of residence in this state.

E. A health care provider who is not licensed to provide health care services in this state but who holds an active license to provide health care services in another jurisdiction and who provides telehealth services to a person located in this state is not subject to the registration requirements of this section if either of the following applies:

1. The services are provided under one of the following circumstances:

(a) In response to an emergency medication condition.

(b) In consultation with a health care provider who is licensed in this state and who has the ultimate authority over the patient's diagnosis and treatment.

(c) To provide after-care specifically related to a medical procedure that was delivered in person in another state.

(d) To a person who is a resident of another state and the telehealth provider is the primary care provider or behavioral health provider located in the person's state of residence.

2. The health care provider provides fewer than ten telehealth encounters in a calendar year.

**41-1073. Time frames; exception**

A. No later than December 31, 1998, an agency that issues licenses shall have in place final rules establishing an overall time frame during which the agency will either grant or deny each type of license that it issues. Agencies shall submit their overall time frame rules to the governor's regulatory review council pursuant to the schedule developed by the council. The council shall schedule each agency's rules so that final overall time frame rules are in place no later than December 31, 1998. The rule regarding the overall time frame for each type of license shall state separately the administrative completeness review time frame and the substantive review time frame.

B. If a statutory licensing time frame already exists for an agency but the statutory time frame does not specify separate time frames for the administrative completeness review and the substantive review, by rule the agency shall establish separate time frames for the administrative completeness review and the substantive review, which together shall not exceed the statutory overall time frame. An agency may establish different time frames for initial licenses, renewal licenses and revisions to existing licenses.

C. The submission by the department of environmental quality of a revised permit to the United States environmental protection agency in response to an objection by that agency shall be given the same effect as a notice granting or denying a permit application for licensing time frame purposes. For the purposes of this subsection, "permit" means a permit required by title 49, chapter 2, article 3.1 or section 49-426.

D. In establishing time frames, agencies shall consider all of the following:

1. The complexity of the licensing subject matter.

2. The resources of the agency granting or denying the license.

3. The economic impact of delay on the regulated community.

4. The impact of the licensing decision on public health and safety.

5. The possible use of volunteers with expertise in the subject matter area.

6. The possible increased use of general licenses for similar types of licensed businesses or facilities.

7. The possible increased cooperation between the agency and the regulated community.

8. Increased agency flexibility in structuring the licensing process and personnel.

E. This article does not apply to licenses issued either:

1. Pursuant to tribal state gaming compacts.

2. Within seven days after receipt of initial application.

3. By a lottery method.