

**BOARD OF BEHAVIORAL HEALTH EXAMINERS (O-17-1101)**

Title 4, Chapter 6, Article 1, Definitions; Article 2, General Provisions; Article 3, Licensure; Article 4, Social Work; Article 5, Counseling; Article 6, Marriage and Family Therapy; Article 7, Substance Abuse Counseling; Article 8, License Renewal and Continuing Education



**GOVERNOR'S REGULATORY REVIEW COUNCIL  
ANALYSIS OF ONE-YEAR REVIEW REPORT**

**MEETING DATE:** November 7, 2017

**AGENDA ITEM:** F-1

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

**FROM:** Council Staff

**DATE :** October 24, 2017

**SUBJECT: BOARD OF BEHAVIORAL HEALTH EXAMINERS (O-17-1101)**  
Title 4, Chapter 6, Article 1, Definitions; Article 2, General Provisions; Article 3, Licensure; Article 4, Social Work; Article 5, Counseling; Article 6, Marriage and Family Therapy; Article 7, Substance Abuse Counseling; Article 8, License Renewal and Continuing Education

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**COMMENTS ON THE ONE-YEAR REVIEW REPORT**

**Purpose of the Agency and Number of Rules in the Report**

The Board of Behavioral Health Examiners (Board) was established in 1989 to certify professionals in the fields of social work, professional counseling, marriage and family therapy, and substance abuse counseling. The Board's voluntary certification process transitioned to a mandatory licensure process in 2004. As of August 2017, the Board issues ten different types of licenses and regulates a total of 10,836 licensees.

The Board used the exempt rulemaking process to make significant revisions to its rules effective November 1, 2015. After that exempt rulemaking was completed, the Board made technical corrections and other clarifications in a separate exempt rulemaking that took effect on November 1, 2016. This one-year review report relates to the 22 rules amended in that 2016 exempt rulemaking.

The Board's report is the first to come before the Council as a direct consequence of the 2016 enactment of A.R.S. § 41-1095, which requires an agency that has been granted a one-time exemption from the rulemaking provisions of the state's Administrative Procedures Act (APA) to review the rules adopted under that exemption within one year, and "prepare and obtain council approval of a written report summarizing its findings, its supporting reasons and any proposed course of action." The Board's report is structured in the same manner as a five-year review report, as the analysis required by A.R.S. § 41-1095(A) for a one-year review report mirrors the analysis required by A.R.S. § 41-1056(A) for a five-year review report.

## **Proposed Action**

- Sections 210 and 211: In a letter dated April 26, 2017, Ms. Annette Stanley petitioned the Board to repeal or modify Section 210(3), under which licensed associate counselors cannot engage in the independent practice of behavioral health and may only practice under direct supervision, and Section 211(A), which sets forth restrictions for licensees working under direct supervision.<sup>1</sup> In addition, in a letter dated September 25, 2017, Mr. Jon Riches of the Goldwater Institute (Institute) notified the Board that the Institute represents Ms. Stanley in this matter and discussed the Institute's concerns with the legality of Section 211(A).<sup>2</sup> In response, the Board indicates that Ms. Stanley's petition has been discussed at its September 15, 2017 and October 6, 2017 regular meetings as well as a October 10, 2017 special meeting.<sup>3</sup> The Board has directed its staff to draft proposed language modifying Section 211(A) for consideration at its November 3, 2017 meeting. Board staff indicates that, if the Board elects to amend the rule, Board staff will begin the rulemaking process and draft a formal response to the petition accordingly.
- Section 306 – *Application for a Temporary License*: The Board has received approval from the Governor's Office to proceed with a rulemaking to modify or remove subsection (D)(1), which provides that a temporary license issued to an applicant who has not previously passed the required examination is immediately revoked if the temporary licensee fails to take the required examination by the expiration date of the temporary license. The Board has not provided a timeframe by which it expects this rulemaking to be submitted to the Council.

### **1. Has the agency analyzed whether the rules are authorized by statute?**

Yes. The Board cites to both general and specific statutory authority for the rules. A.R.S. § 32-3253(A)(1) requires the Board to “[a]dopt rules consistent with and necessary to carry out the purposes of this chapter [A.R.S. Title 32, Chapter 33, Behavioral Health Professionals.]”

### **2. Summary of the agency's economic impact comparison and identification of stakeholders:**

The current rules were made by exempt rulemaking and an EIS was not prepared. Stakeholders are applicants, licensees and consumers of behavioral health services. Because the exempt rulemaking made only technical corrections and no substantive changes, the rulemaking imposed little or no 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?**

Yes. The Board believes the benefits of the rules outweigh the costs to persons regulated by the rules, and that the rules impose the least burden and costs to those who are regulated.

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<sup>1</sup> A copy of the petition has been included as an attachment to the report.

<sup>2</sup> A copy of the Institute's letter has been included as an attachment to the report.

<sup>3</sup> Relevant pages of the Board's meeting minutes have been included as an attachment to the report.

4. **Has the agency received any written criticisms of the rules over the last five years?**

Yes. As described above, the Board has received a petition related to Sections 210 and 211 that the Board is scheduled to consider further at its November 3, 2017 meeting.

5. **Has the agency analyzed the rules' clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?**

Yes. Despite potential amendments to Sections 211 and 306, the Board indicates that the rules are clear, concise, and understandable, are consistent with statutes, and are effective in achieving their objectives.

6. **Has the agency analyzed the current enforcement status of the rules?**

Yes. The Board indicates that the rules are enforced as written.

7. **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 no federal laws correspond to the rules.

8. **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?**

Yes. The Board indicates that the licenses it issues are general permits consistent with A.R.S. § 41-1037 because they are issued to qualified individuals or entities to conduct activities that are substantially similar in nature.

9. **Conclusion**

The report generally meets the requirements of A.R.S. § 41-1095. Because of the Board's apparent efforts to address the concerns raised by the public, Council staff recommends approval of the report.



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# ARIZONA BOARD OF BEHAVIORAL HEALTH EXAMINERS

Arizona Administrative Code

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 6. BOARD OF BEHAVIORAL HEALTH EXAMINERS

Written report pursuant to A.R.S. § 41-1095

Exempt rulemaking effective November 1, 2016



## INTRODUCTION

The Arizona Board of Behavioral Health Examiners was established by law in 1989 to certify professionals in the fields of Social Work, Professional Counseling, Marriage and Family Therapy, and Substance Abuse Counseling. Voluntary certification changed to mandatory licensure on July 1, 2004.

As of August 2017, the Board's licensee counts are as follows:

Licensed Baccalaureate Social Worker	107
Licensed Master Social Worker	2229
Licensed Clinical Social Worker	2173
Licensed Associate Counselor	1463
Licensed Professional Counselor	2820
Licensed Associate Marriage and Family Therapist	216
Licensed Marriage and Family Therapist	377
Licensed Substance Abuse Technician	46
Licensed Associate Substance Abuse Counselor	294
Licensed Independent Substance Abuse Counselor	<u>1111</u>
Total Licensees as of August 8, 2017	10,836

In September of 2013, Laws 2013, Ch. 242 was enacted and significantly changed the statutes that govern the Board. In that legislation, the Board was granted an exemption from the rulemaking requirements of title 41, chapter 6, Arizona Revised Statutes, through November 1, 2015. Laws 2015, Chapter 154 further revised the Board's statutes, and extended the Board's rulemaking exemption through November 1, 2016.

Following the promulgation of the rules effective on November 1, 2015, the Board documented several technical corrections needed, in addition to other clarifications that became necessary as the rules were implemented. The Board filed an additional Notice of Final Exempt Rulemaking in October of 2016 which became effective on November 1, 2016. This rulemaking sought to make technical corrections and clarify confusing language to assist in eliminating unintended burdens and consequences of the rules promulgated as of November 1, 2015.

Because the legislature granted the rulemaking exemption, pursuant to A.R.S. § 41-1095, the Board respectfully submits this report for consideration to the Governor's Regulatory Review Council for the exempt rulemaking adopted on November 1, 2016.

A copy of the full text of the rules included in the Notice of Final Exempt Rulemaking is attached, however changes of note include:

- Requiring applicants and licensees to maintain contact information for all places of employment
- Clarified individuals eligible to provide direct supervision
- Clarified the amount of individual and group clinical supervision hours needed for licensure
- Expanded the ability for supervisees to hire outside clinical supervisors
- Established a continuing education hour value for the Board approved tutorials
- Clarified the requirements for licensure by endorsement
- Extended the term of temporary licenses to allow for additional time to test
- Allowed for granting extensions to the testing period for licensure
- Clarified the curriculum requirements for marriage and family therapy and substance abuse counselor licensure

## **I. INFORMATION THAT IS THE SAME FOR A GROUP OF RULES**

Statute that generally authorizes the agency to make rules:

A.R.S. § 32-3253(A)(1), which permits the Board to adopt rules consistent with and necessary to carry out the purposes of this Chapter, is the general authorizing statute for each rule.

1. Effectiveness of the rule in achieving the objective including a summary of any available data supporting the conclusions reached:

Each rule is effective in achieving its objective.

2. Summary of written criticisms of the rule received by the agency since the rule was adopted, including any written analyses submitted questioning whether the rule is based on valid scientific or reliable principles or methods:

The Board has received one written criticism of A.A.C. R4-6-211(A) which prohibits a non-independent level licensee from having ownership interest in the entity having immediate responsibility for the behavioral health services provided by the licensee. The criticism indicates that some states allow non-independent level practitioners to obtain their supervised work experience while working in their own practice.

The Board is considering modifications to A.A.C. R4-6-211(A) at its November 3, 2017 meeting.

3. Statute that generally authorizes the agency to make rules:

A.R.S. § 32-3253(A)(1), which permits the Board to adopt rules consistent with and necessary to carry out the purposes of this Chapter, is the general authorizing statute for each rule.

4. Consistency of the rule with statutes and other rules made by the agency, and current agency enforcement policy:

The current rules are consistent with the current statutes.

5. Clarity, conciseness, and understandability of the rule:

The rules are generally clear, concise, and understandable. The exempt rulemaking effective on November 1, 2016 further clarified previously confusing language.

6. The estimated economic, small business, and consumer impact of the rule:

The current rules were made by exempt rulemaking, so an EIS was not prepared. Because the rulemaking made only technical corrections and no substantive changes, the Board did not anticipate any economic impact on applicants and licensees and consumers of behavioral health services.

7. Any analysis submitted to the agency by another person regarding the rule's impact on this state's business competitiveness as compared to the competitiveness of businesses in other states:

No analysis has been submitted.

8. Additional processes completed by the agency required by law, including the requirement for the agency to publish otherwise exempt rules or provide the public with an opportunity to comment on the rules:

The Board published a Notice of Docket Opening in 22 A.A.R. 2405, September 2, 2016. In addition, Laws 2015, Chapter 154, Sec 10 required the Board to:

- Allow interested parties to provide written comments or testimony on the proposed exempt rules.
- Adequately address all comments including those regarding information contained in the economic, small business, and consumer impact statement.
- Prepare a mailing list of persons who wish to be notified on hearings relating to the proposed exempt rules.
- Hold at least two public hearings on the proposed exempt rules.
- Testify before the JLBC regarding the proposed exempt rules.

The Board completed the required actions required above.

9. A determination after analysis that the probable benefits of the rule within this state outweigh 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:

The benefits of the rules outweigh the costs to persons regulated by the rules. There is very little impact to hard costs to our applicants or licensees.

10. A determination after analysis that the rule is not more stringent than a corresponding federal law unless there is statutory authority to exceed the requirements of that federal law:

There is not a corresponding Federal law.

11. For a rules that require the issuance of a regulatory permit, license, or agency authorization, whether the rule complies with A.R.S. § 41-1037:

The licenses issued by the Board are general permits consistent with A.R.S. § 41-1037 because they are issued to qualified individuals or entities to conduct activities that are substantially similar in nature.

12. Proposed course of action:

The Board has received approval for an exemption from the rulemaking moratorium from the Governor's office to proceed with a rulemaking to modify R4-6-306. Specifically, the Board will be proposing changing the language in (D) which indicates a temporary license is revoked if an applicant fails to take or fails the exam required for licensure.

Pursuant to A.R.S. § 41-1093.02, the Board has ninety days to respond to the petition filed (as described in #2 above). The matter was discussed at the Board's September 15, 2017 meeting, the October 6, 2017 meeting, and again at a special telephonic meeting on October 10, 2017 (Attachment A contains the applicable meeting minutes for this agenda item, complete Board meeting minutes may be viewed on the Board's website).

The Board has directed staff to draft proposed language modifying R4-6-211(A), to be considered at its November 3, 2017 meeting. If the Board elects to modify the rule, the Board will draft a formal response to the petition, and open a docket for rulemaking to seek stakeholder and public feedback on the proposed rules.

## **II. INFORMATION THAT IS NOT THE SAME FOR ALL RULES**

### **ARTICLE 1. DEFINITIONS**

#### **R4-6-101. Definitions**

*1. Objective:*

The objective of this rule is to provide uniform definitions of the words used in the Board's rules to ensure the rules are clear and understandable.

*3. Specific statute authorizing the rule:*

A.R.S. § 32-3253

### **ARTICLE 2. GENERAL PROVISIONS**

#### **R4-6-205. Change of Contact Information**

*1. Objective:*

The objective of this rule is to require licensees and applicants for licensure to maintain current contact information with the Board.

*3. Specific statute authorizing the rule:*

A.R.S. § 32-3276

#### **R4-6-211. Direct Supervision: Supervised Work Experience: General**

*1. Objective:*

The objective of this rule is to establish restrictions on a direct supervisor and provide an exemption process for an applicant seeking direct supervision from a supervisor precluded by the rule from providing the direct supervision.

*2. Written criticisms received since adoption:*

The criticism indicates that some states allow non-independent level practitioners to obtain their supervised work experience while working in their own practice.

*3. Specific statutes authorizing the rule:*

A.R.S. §§ 32-3253, 32-3292, 32-3303, 32-3311, 32-3313, and 32-3321

#### **R4-6-212. Clinical Supervision Requirements**

*1. Objective:*

The objective of this rule is to establish the qualifications for individuals seeking to provide clinical supervision. The rule also establishes minimum requirements for content to be covered in clinical supervision, the setting in which clinical supervision is received (individual or group), and maintaining documentation of clinical supervision sessions.

3. *Specific statutes authorizing the rule:*

A.R.S. §§ 32-3253, 32-3293, 32-3301, 32-3311, and 32-3321

#### **R4-6-212.01 Exemptions to the Clinical Supervision Requirements**

1. *Objective:*

The objective of this rule is to provide an exemption process for an applicant seeking clinical supervision from a supervisor precluded by the rule from providing the clinical supervision.

3. *Specific statutes authorizing the rule:*

A.R.S. §§ 32-3253, 32-3293, 32-3301, 32-3311, and 32-3321

#### **R4-6-214. Clinical Supervisor Educational Requirements**

1. *Objective:*

The objective of this rule is to establish the educational requirements for individuals who will provide clinical supervision to applicants for independent licensure.

3. *Specific statutes authorizing the rule:*

A.R.S. §§ 32-3253, 32-3293, 32-3301, 32-3311, and 32-3321

### **ARTICLE 3. LICENSURE**

#### **R4-6-301. Application for a License by Examination**

1. *Objective:*

The objective of this rule is to establish the processes required for licensure applications by examination.

3. *Specific statutes authorizing the rule:*

A.R.S. §§ 32-3253, 32-3275, 32-3280, 25-320(P), and 25-502(K)

#### **R4-6-304. Application for a License by Endorsement**

1. *Objective:*

The objective of this rule is to establish the standards under which an applicant with a license to practice behavioral health in another jurisdiction may qualify for licensure by endorsement.

3. *Specific statute authorizing the rule:*

A.R.S. § 32-3274

#### **R4-6-306. Application for a Temporary License**

1. *Objective:*

The objective of this rule is to establish the standards under which an applicant for licensure may be granted a temporary license to practice pending completion of the application and examination process.

3. *Specific statute authorizing the rule:*

## ARTICLE 4. SOCIAL WORK

### **R4-6-402. Examination**

*1. Objective:*

The objective of this rule is to establish the examination requirements for social worker licensure.

*3. Specific statutes authorizing the rule:*

A.R.S. §§ 32-3291, 32-3292, and 32-3293

### **R4-6-403. Supervised Work Experience for Clinical Social Worker Licensure**

*1. Objective:*

The objective of this rule is to clarify the supervised work experience requirement for clinical social worker licensure.

*3. Specific statute authorizing the rule:*

A.R.S. § 32-3293

## ARTICLE 5. COUNSELING

### **R4-6-502. Examination**

*1. Objective:*

The objective of this rule is to establish the examination requirements for counseling licensure.

*3. Specific statutes authorizing the rule:*

A.R.S. §§ 32-3301 and 32-3303

### **R4-6-503. Supervised Work Experience for Professional Counselor Licensure**

*1. Objective:*

The objective of this rule is to clarify the supervised work experience requirement for professional counselor licensure.

*3. Specific statute authorizing the rule:*

A.R.S. § 32-3301

## ARTICLE 6. MARRIAGE AND FAMILY THERAPY

### **R4-6-601. Curriculum**

*1. Objective:*

The objective of this rule is to establish the curriculum requirements for marriage and family therapist licensure.

*3. Specific statutes authorizing the rule:*

A.R.S. §§ 32-3311 and 32-3313

**R4-6-602. Examination**

*1. Objective:*

The objective of this rule is to establish the examination requirements for marriage and family therapist licensure.

*3. Specific statutes authorizing the rule:*

A.R.S. §§ 32-3311 and 32-3313

**R4-6-603. Supervised Work Experience for Marriage and Family Therapy Licensure**

*1. Objective:*

The objective of this rule is to clarify the supervised work experience requirement for marriage and family therapist licensure.

*3. Specific statute authorizing the rule:*

A.R.S. § 32-3311

**ARTICLE 7. SUBSTANCE ABUSE COUNSELING**

**R4-6-701. Licensed Substance Abuse Technician Curriculum**

*1. Objective:*

The objective of this rule is to establish the curriculum requirements for substance abuse technician licensure.

*3. Specific statute authorizing the rule:*

A.R.S. § 32-3321

**R4-6-702. Licensed Associate Substance Abuse Counselor Curriculum**

*1. Objective:*

The objective of this rule is to establish the curriculum requirements for associate substance abuse counselor licensure.

*3. Specific statute authorizing the rule:*

A.R.S. § 32-3321

**R4-6-703. Licensed Independent Substance Abuse Counselor Curriculum**

*1. Objective:*

The objective of this rule is to establish the curriculum requirements for independent substance abuse licensure.

*3. Specific statute authorizing the rule:*

A.R.S. § 32-3321

**R4-6-704. Examination**

*1. Objective:*

The objective of this rule is to establish the examination requirements for substance abuse

licensure.

3. *Specific statute authorizing the rule:*  
A.R.S. § 32-3321

#### **R4-6-705. Supervised Work Experience for Substance Abuse Counselor Licensure**

1. *Objective:*

The objective of this rule is to clarify the supervised work experience requirement for associate substance abuse counselor licensure and independent substance abuse counselor licensure.

3. *Specific statute authorizing the rule:*  
A.R.S. § 32-3321

### **ARTICLE 8. LICENSE RENEWAL AND CONTINUING EDUCATION**

#### **R4-6-802. Continuing Education**

1. *Objective:*

The objective of this rule is to establish the general continuing education requirements for licensure renewal.

3. *Specific statute authorizing the rule:*  
A.R.S. § 32-3273

**The full text of the rules adopted under exempt rulemaking on 11/01/16 follows:**

**TITLE 4. PROFESSIONS AND OCCUPATIONS**

**CHAPTER 6. BOARD OF BEHAVIORAL HEALTH EXAMINERS**

**ARTICLE 1. DEFINITIONS**

Section

R4-6-101. Definitions

**ARTICLE 2. GENERAL PROVISIONS**

Section

R4-6-205. Change of Contact Information

R4-6-211. Direct Supervision; Supervised Work Experience: General

R4-6-212. Clinical Supervision Requirements

R4-6-212.01. Exemptions to Clinical Supervision Requirements

R4-6-214. Clinical Supervisor Educational Requirements

**ARTICLE 3. LICENSURE**

Section

R4-6-301. Application for a License by Examination

R4-6-304. Application for a License by Endorsement

R4-6-306. Application for a Temporary License

**ARTICLE 4. SOCIAL WORK**

Section

R4-6-402. Examination

R4-6-403. Supervised Work Experience for Clinical Social Worker Licensure

**ARTICLE 5. COUNSELING**

Section

R4-6-502. Examination

R4-6-503. Supervised Work Experience for Professional Counselor Licensure

## **ARTICLE 6. MARRIAGE AND FAMILY THERAPY**

### Section

R4-6-601. Curriculum

R4-6-602. Examination

R4-6-603. Supervised Work Experience for Marriage and Family Therapy Licensure

## **ARTICLE 7. SUBSTANCE ABUSE COUNSELING**

### Section

R4-6-701. Licensed Substance Abuse Technician Curriculum

R4-6-702. Licensed Associate Substance Abuse Counselor Curriculum

R4-6-703. Licensed Independent Substance Abuse Counselor Curriculum

R4-6-704. Examination

R4-6-705. Supervised Work Experience for Substance Abuse Counselor Licensure

## **ARTICLE 8. LICENSE RENEWAL AND CONTINUING EDUCATION**

### Section

R4-6-802. Continuing Education

## ARTICLE 1. DEFINITIONS

### R4-6-101. Definitions

The definitions at A.R.S. § 32-3251 apply to this Chapter. Additionally, the following definitions apply to this Chapter, unless otherwise specified:

1. No change
2. No change
3. No change
4. No change
5. No change
6. No change
7. No change
8. “CACREP” means the Council ~~on~~ for Accreditation ~~for~~ of Counseling and Related Educational Programs.
9. No change
10. No change
11. 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
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
34. No change
35. No change
36. No change
37. No change
38. No change
39. No change
40. No change
41. No change
42. No change
43. No change
44. No change
45. No change
46. No change
47. No change
48. No change
49. No change
50. No change
51. No change
52. No change
53. No change
54. No change
55. No change
56. No change

## **ARTICLE 2. GENERAL PROVISIONS**

### **R4-6-205. Change of Contact Information**

- A. No change
  1. No change
  2. ~~Office address~~ Address and telephone number for all places of employment,
  3. No change

4. No change

**B.** No change

**R4-6-211. Direct Supervision: Supervised Work Experience: General**

**A.** No change

1. No change

2. Receive supervision from ~~a family member or an individual whose objective assessment may be limited by a relationship with the licensee:~~

a. A family member;

b. An individual whose objective assessment may be limited by a relationship with the licensee;

or

c. An individual not employed or contracted by the same behavioral health entity as the licensee;

3. No change

4. No change

**B.** No change

1. No change

2. No change

3. No change

4. No change

5. No change

6. No change

**C.** No change

**R4-6-212. Clinical Supervision Requirements**

**A.** No change

1. No change

a. No change

b. No change

2. No change

3. No change

a. No change

b. No change

- i. No change
  - ii. No change
- c. No change
- B.** No change
  - 1. No change
  - 2. No change
- C.** No change
  - 1. No change
  - 2. No change
  - 3. No change
  - 4. No change
    - a. No change
    - b. No change
    - c. No change
    - d. No change
    - e. No change
  - 5. No change
  - 6. No change
  - 7. No change
    - a. No change
    - b. No change
  - 8. No change
  - 9. No change
    - a. No change
    - b. No change
    - c. No change
    - d. No change
  - 10. No change
  - 11. No change
- D.** No change
  - 1. No change
  - 2. No change
  - 3. No change
  - 4. No change
- E.** No change

1. No change
2. No change
3. No change
4. No change

**F.** No change

**G.** No change

1. At least 25 percent of the clinical supervision hours involve individual supervision, and
2. ~~No more than 75 percent of the~~ Of the minimum 100 hours of clinical supervision required for licensure, the Board may accept: hours may involve a group of two supervisees;
  - a. Up to 75 of the clinical supervision hours involving a group of two supervisees, and
  - b. Up to 50 of the clinical supervision hours involving a group of three to six supervisees.
3. ~~No more than 50 percent of the clinical supervision hours involve a group of three to six supervisees.~~

**H.** If an applicant provides evidence that a catastrophic event prohibits the applicant from obtaining documentation of clinical supervision that meets the standard specified in subsection (C)(4), the Board ~~shall~~ may consider alternate documentation.

#### **R4-6-212.01. Exemptions to the Clinical Supervision Requirements**

The Board shall accept hours of clinical supervision submitted by an applicant if the clinical supervision meets the requirements specified in R4-6-212 and R4-6-404, R4-6-504, R4-6-604, or R4-6-706, as applicable to the license for which application is made, unless an exemption is granted as follows:

1. No change
  - a. Qualifications of the clinical supervisor. The Board may grant an exemption to the supervisor qualification requirements in R4-6-212(A) and R4-6-404, R4-6-504, R4-6-604, or R4-6-706, as applicable to the license for which application is made, if the Board determines that the behavioral health professional who provided or will provide the clinical supervision has education, training, and experience necessary to provide clinical supervision and has complied with the educational requirements specified in R4-6-214 and:
    - i. No change
    - ii. The behavioral health professional who provided or will provide the clinical supervision holds an active and unrestricted license issued under A.R.S. Title 32 as a physician under Chapter 13 or 17 with certification in psychiatry or addiction medicine or as a nurse practitioner under Chapter 15 with certification in mental health; ~~and~~



- d. No change
  - 2. Beginning January 1, 2018, completes a three clock hour Board-approved tutorial on Board statutes and rules.
- B.** No change
- 1. No change
    - a. No change
    - b. No change
  - 2. No change
  - 3. No change
- C.** To continue providing clinical supervision, an individual qualified under subsection (A)(1)(a) shall, at least every three years, complete a minimum of nine hours of continuing training that:
- 1. ~~Complete a minimum of nine hours of continuing training that meets~~ Meets the standard specified in R4-6-802(D);~~;~~
  - 2. ~~concerns~~ Concerns clinical supervision;~~;~~ and
  - 3. ~~addresses~~ Addresses the topics listed in subsection (A)(1)(a); and
- ~~2.4.~~ Beginning January 1, 2018, includes three clock hours of ~~complete~~ a Board-approved tutorial on Board statutes and rules.
- D.** To continue providing clinical supervision, an individual qualified under subsections (A)(1)(b) through (d) shall:
- 1. No change
  - 2. Beginning January 1, 2018, complete a three clock hour Board-approved tutorial on Board statutes and rules.

### **ARTICLE 3. LICENSURE**

**R4-6-301. Application for a License by Examination**

An applicant for a license by examination shall submit a completed application packet that contains the following:

- 1. No change
- 2. No change
- 3. No change
- 4. No change
- 5. No change
- 6. No change
- 7. No change

- a. No change
- b. No change
- 8. No change
- 9. No change
- 10. No change
- 11. No change
- 12. No change
- 13. A completed and legible fingerprint card for a state and federal criminal history background check and payment as prescribed under R4-6-215 if the applicant has not previously submitted a full set of fingerprints to the Board, or verification that the applicant holds a current fingerprint card issued by the Arizona Department of Public Safety; and
- ~~14. A completed application supplement for the license for which application is made; and~~
- ~~15.~~ 14. Other documents or information requested by the ARC Board to determine the applicant's eligibility.

**R4-6-304. Application for a License by Endorsement**

An applicant who meets the requirements specified under A.R.S. § 32-3274 for a license by endorsement shall submit a completed application packet, as prescribed in R4-6-301, and the following:

- 1. The name of one or more other states where the applicant was certified or licensed as a behavioral health professional by a state regulatory entity for at least three years;
- 2. No change
  - a. No change
  - b. No change
  - c. No change
  - d. No change
- 3. An affidavit verifying the work experience required under A.R.S. § 32-3274(A)(3) from an individual who can verify the work experience required under A.R.S. § 32-3274(A)(3) whose objective assessment is not limited by a relationship with the applicant; and
- 4. No change
  - a. No change
  - b. No change

**R4-6-306. Application for a Temporary License**

- A. No change
  - 1. No change

2. No change
  3. No change
    - a. No change
    - b. No change
      - i. No change
      - ii. No change
      - iii. No change
    - c. Applying for a license by examination and currently licensed or certified by a another state behavioral health regulatory entity.
- B.** No change
1. No change
  2. No change
  3. No change
  4. No change
- C.** ~~The Board shall ensure that a~~ A temporary license issued to an applicant for licensure ~~by examination; expires one year after issuance by the Board.~~
- ~~1. Under subsection (A)(3)(b):~~
    - ~~a. Expires 180 days after issuance by the Board., and~~
    - ~~b. Is revoked immediately if the applicant fails to take the required examination within 180 days after the temporary license is issued or fails the required examination; or~~
  - ~~2. Under subsection (A)(3)(c), expires in one year after issuance by the Board.~~
- D.** ~~A temporary licensee shall provide written notice and return the temporary license to the Board~~ license issued to an applicant who has not previously passed the required examination for licensure is revoked immediately if the temporary licensee:
1. Fails to take the required examination by the expiration date of the temporary license; or
  2. No change
- E.** ~~The Board shall ensure that a temporary license issued to an applicant for licensure by endorsement:~~ A temporary licensee shall provide written notice and return the temporary license to the Board if the temporary licensee fails the required examination.
- ~~1. Expires 180 days after issuance by the Board if the applicant has not previously taken the required examination and is revoked immediately if the applicant fails to take the required examination within 180 days after the temporary license is issued or fails the required examination; or~~

2. ~~Expires one year after the date of issuance if the applicant has previously passed the required examination and is revoked immediately when the applicant is issued or denied a license by endorsement.~~

- F. No change
- G. No change
- H. No change
- I. No change
- J. No change
- K. No change

## ARTICLE 4. SOCIAL WORK

### **R4-6-402. Examination**

- A. No change
- B. No change
- C. No change
- D. No change
- E. No change
- F. The Board may grant a one-time 90-day examination extension request to an applicant who demonstrates good cause as specified under R4-6-305(G).
- ~~F.~~ G. No change
  1. No change
  2. No change
    - a. No change
    - b. No change
    - c. No change

### **R4-6-403. Supervised Work Experience for Clinical Social Worker Licensure**

- A. No change
  1. At least 1600 hours of direct client contact involving the use of psychotherapy, ~~no more than 400 hours of which are in psychoeducation;~~
  2. No more than 400 of the 1600 hours of direct client contact are in psychoeducation;
  - ~~2.3.~~ At least 100 hours of clinical supervision as prescribed under R4-6-212 and R4-6-404; and

~~34.~~ For the purpose of licensure, no more than 1600 hours of indirect client contact related to psychotherapy services.

- B. No change
- C. No change
- D. No change
- E. No change

## ARTICLE 5. COUNSELING

### R4-6-502. Examination

- A. No change
  - 1. No change
  - 2. No change
  - 3. No change
- B. No change
- C. No change
- D. No change
- E. The Board may grant a one-time 90-day examination extension request to an applicant who demonstrates good cause as specified under R4-6-305(G).

### R4-6-503. Supervised Work Experience for Professional Counselor Licensure

- A. No change
  - 1. At least 1600 hours of direct client contact involving the use of psychotherapy, ~~no more than 400 hours of which are in psychoeducation~~ ;
  - 2. No more than 400 of the 1600 hours of direct client contact are in psychoeducation;
  - ~~3.~~ No change
  - ~~4.~~ No change
- B. No change
- C. No change
- D. No change
- E. No change

## ARTICLE 6. MARRIAGE AND FAMILY THERAPY

### R4-6-601. Curriculum

- A. No change

1. No change
2. No change
3. No change

**B.** A program under subsection (A)(3) shall include:

1. Marriage and family studies: Three courses from a family systems theory orientation including but not limited to that collectively contain at minimum the following elements:
  - a. Introductory family systems theory;
  - b. No change
  - c. Family systems, including marital, sibling, and individual subsystems; and
  - d. ~~Special family issues; and~~
  - e. No change
2. Marriage and family therapy: Three courses ~~including but not limited to~~ that collectively contain at minimum the following elements:
  - a. Advanced family systems theory and interventions;
  - b. Major systemic marriage and family therapy treatment approaches;
  - c. ~~Group and family therapy~~;
  - d. ~~Communications; and~~
  - e. Sex therapy;
  - f. ~~Psychopharmacology~~;
3. Human development: Three courses that may integrate family systems theory including but not limited to that collectively contain at minimum the following elements:
  - a. No change
  - b. ~~Personality theory~~;
  - e. No change
  - d. No change
4. Professional studies: One course including at minimum but not limited to:
  - a. No change
  - b. No change
5. No change
6. No change

**C.** No change

**D.** No change

1. No change
2. No change
3. No change

- E. No change
- F. No change

**R4-6-602. Examination**

- A. No change
- B. No change
- C. No change
- D. No change
- E. The Board may grant a one-time 90-day examination extension request to an applicant who demonstrates good cause as specified under R4-6-305(G).

**R4-6-603. Supervised Work Experience for Marriage and Family Therapy Licensure**

- A. No change
  - 1. No change
    - a. At least 1000 of the 1600 hours of direct client contact are with couples or families; and
    - b. No more than 400 of the 1600 hours of direct client contact are in psychoeducation and at least 60 percent of psychoeducation hours are with couples or families;
  - 2. No change
  - 3. No change
- B. No change
- C. No change
- D. No change
- E. No change

**ARTICLE 7. SUBSTANCE ABUSE COUNSELING**

**R4-6-701. Licensed Substance Abuse Technician Curriculum**

- A. No change
  - 1. No change
  - 2. No change
  - 3. No change
- B. An associate's or bachelor's degree under subsection (A)(3), shall include at least three semester or four quarter credit hours in each of the following core content areas:
  - 1. No change

- a. No change
  - b. No change
  - c. No change
  - d. No change
  - e. No change
2. No change
- a. No change
  - b. No change
  - c. No change
  - d. No change
3. No change
4. No change
5. No change
- a. No change
  - b. No change
  - c. No change
6. No change
- a. No change
  - b. No change
  - c. No change
  - d. Confidentiality and other legal considerations in ~~substance abuse counseling~~ the practice of behavioral health; and
7. No change
- C.** No change
- 1. No change
  - 2. No change
  - 3. No change
  - 4. No change
- D.** No change
- E.** No change

**R4-6-702. Licensed Associate Substance Abuse Counselor Curriculum**

- A.** An applicant for licensure as an associate substance abuse counselor shall have one of the following:
- 1. No change

2. A master's or higher degree from a regionally accredited college or university in a program accredited by NASAC ~~and includes at least 300 hours of supervised practicum as prescribed under subsection (C);~~

3. No change

4. No change

5. No change

6. No change

**B.** No change

**C.** No change

**D.** No change

**E.** No change

#### **R4-6-703. Licensed Independent Substance Abuse Counselor Curriculum**

**A.** No change

1. A program accredited by NASAC ~~that includes at least 300 hours of supervised practicum as prescribed under subsection (D);~~

2. No change

3. No change

**B.** No change

**C.** No change

**D.** No change

**E.** No change

**F.** No change

#### **R4-6-704. Examination**

**A.** No change

1. No change

2. No change

**B.** No change

1. No change

2. No change

3. No change

**C.** No change

**D.** The Board shall deem an applicant for independent substance abuse counselor licensure as meeting the examination requirements if all of the following apply:

1. The applicant has an active associate substance abuse counselor license;
2. The applicant passed a written examination listed in subsection (A) before November 1, 2015;  
and
3. The applicant submitted an application to the Board on or after November 1, 2015.

~~D. E.~~ No change

~~E. F.~~ No change

G. The Board may grant a one-time 90-day examination extension request to an applicant who demonstrates good cause as specified under R4-6-305(G).

#### **R4-6-705. Supervised Work Experience for Substance Abuse Counselor Licensure**

A. No change

1. No change
2. No more than 400 of the 1600 hours of direct client contact are in psychoeducation,
3. No change
4. No change
5. No change

B. No change

C. No change

1. No change
2. No change
3. No change

D. No change

E. No change

F. No change

1. No change
2. No change

### **ARTICLE 8. LICENSE RENEWAL AND CONTINUING EDUCATION**

#### **R4-6-802. Continuing Education**

A. No change

B. No change

1. No change

2. No change
  - a. No change
  - b. No change
  - c. No change

3. No change

**C.** No change

1. No change
  - a. No change
  - b. No change

2. Beginning January 1, 2018, in addition to the requirement under subsection (C)(1), complete a three clock hour Board-approved tutorial on Board statutes and rules.

**D.** No change

1. No change
2. No change
3. No change
4. No change
5. No change
6. 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

# ATTACHMENT A

the tutorial as presented. The motion passed unanimously.

**D. Review, consideration, and possible action regarding request to repeal or modify rules R4-6-210(3) and R4-6-211(A)**

Annette Stanley was present and accompanied by Matt Miller of the Goldwater Institute.

Ms. Dalton informed the Board that it received a petition from Ms. Stanley, an applicant for licensure at the independent level, requesting that the Board repeal or modify A.A.C. R4-6-210(3) and R4-6-211(A). Ms. Dalton suggested that since it was the first petition the Board received under the recently enacted statute, A.R.S. § 41-1093.02, the Board may want to consider going into executive session for legal advice before proceeding further.

Mr. Barnett moved, seconded by Dr. Davis to go into executive session pursuant to A.R.S. § 38-431.03(A)(3) to obtain legal advice. The motion passed unanimously and the Board went into executive session at 3:36 pm, reconvening its public meeting at 3:50 pm following a 4 minute break.

Ms. Dalton informed the Board that Ms. Stanley is a licensed associate counselor and has applied for licensure as a professional counselor. Ms. Dalton stated that the Counseling Academic Review Committee reviewed Ms. Stanley's application and recommended to the Board that it deny it because she failed to meet the requirements of A.A.C. R4-6-211(A)(1).

Ms. Dalton then went on to summarize Ms. Stanley's petition and the reasons why she was requesting that the Board repeal or modify the regulation related to practicing under supervision and the regulation that prohibits a licensee from acquiring work experience at an agency that they have an ownership interest in.

Both Ms. Stanley and Mr. Miller introduced themselves to the Board. Ms. Stanley briefly addressed the Board indicating that she was asking it to modify its regulations so that she could use the work experience hours she acquired in Kansas as a licensed professional counselor to meet the requirements for independent licensure in Arizona. Ms. Stanley stated that that she acquired her supervised work experience hours in accordance with the Kansas regulations. Ms. Stanley concluded by stating that she did not have anything in addition to add to her petition and thanked the Board for its time and consideration. Mr. Miller also briefly addressed the Board. Mr. Miller indicated that he was present to monitor the matter and to ensure that the Board was following the process set forth in the new statute.

Board members discussed their concerns regarding repealing or modifying the regulation that requires associate level counselors to practice under direct supervision. Board members also expressed concern about modifying or repealing the regulation that prohibits a licensee from acquiring work experience for independent licensure at an agency in which they have an ownership interest in.

Ms. Zavala suggested that the Board may want to consider creating an exception, like it had done for clinical supervision hours acquired outside of Arizona. Board members were receptive to this idea and discussed continuing this matter to its October meeting in order to give Board staff time to draft proposed language to that effect for its consideration.

Following review and discussion by members, Ms. Shields moved, seconded by Mr. Barnett, to direct staff to draft language that would create an exemption to the supervised work experience requirements acquired outside of Arizona for its consideration. The motion passed unanimously.

**15. Request for extension of inactive status: review, consideration and action**

N/A

**16. National and regional news regarding the profession(s)**

N/A

**17. Future agenda items**

unanimously.

*B. Review, consideration, and possible action regarding applications for educational programs*  
N/A

**12. Report from Chair**

*A. Summary of current events*  
No report.

*B. Update regarding the National Board for Certified Counselors Conference*  
Tabled.

**13. Report from the Treasurer**

*A. September financial report*

Following review and discussion by members, Mr. Szymanski moved, seconded by Mr. Coffey, to accept the September monthly financial report as presented. The motion passed unanimously.

**14. Report from the Executive Director and/or staff**

*A. General Agency Operations*  
No report.

*B. Discussion regarding relocation of the Board's office*

Ms. Zavala informed members that there was not a current update, and that the Board is scheduled to move the week of December 18, 2017.

*C. Review, consideration, and possible action regarding tutorials*

Ms. Dalton presented information on the structure and content of the clinical supervision tutorial.

Following review and discussion by members, Mr. Coffey moved, seconded by Ms. Quinlan, to approve the tutorial as presented. The motion passed unanimously.

**D. *Review, consideration, and possible action regarding request to repeal or modify rules R4-6-210(3) and R4-6-211(A)***

Ms. Zavala presented a letter the Board received from the Goldwater Institute dated September 25<sup>th</sup>.

Following discussion, members agreed to add a teleconference meeting on October 10, 2017 at 8:00 a.m. for purposes of review, consideration, and possible action regarding the request to repeal or modify rules R4-6-210(3) and R4-6-211(A).

**15. Request for extension of inactive status: review, consideration and action**

N/A

**16. National and regional news regarding the profession(s)**

N/A

**17. Future agenda items**

- A. Applications: denials vs consent agreements for issuance*
- B. Application background question #9*
- C. Board designee training*
- D. Safety of the public vs Agency policies*
- E. Templates for treatment plans and progress notes*
- F. Court appointed and Therapeutic Interventionist cases*
- G. Board Correspondence*

**18. Call for public comment**

No one was present to respond to the call for public comment.



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BOARD OF BEHAVIORAL HEALTH EXAMINERS  
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DOUGLAS A. DUCEY  
Governor

TOBI ZAVALA  
Executive Director

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BOARD OF BEHAVIORAL HEALTH EXAMINERS  
TELECONFERENCE MEETING MINUTES  
October 10, 2017

Members Present  
telephonically:

Kimberly Bailey (in at 8:10 a.m.), Bradley Barnett, Mary Coonrod, Cedric Davis, Gary Goodwin, Nikole Hintz-Lyon, Meaghan Kramer, Heidi Quinlan, Jerri Shields

Members Absent: Chip Coffey, Gerald Szymanski

Staff Present: Tobi Zavala, Executive Director; Marc Harris, A.A.G.; Donna Dalton, Deputy Director; Joey Ordonez, Assistant Director

**1. Call to Order**

A meeting of the Arizona Board of Behavioral Health Examiners was called to order on October 10, 2017, at 8:05 a.m. with Ms. Shields presiding.

**2. Roll Call**

See above.

**3. Report from the Executive Director and/or staff**

The Board may go into executive session to discuss personnel matters pursuant to A.R.S. § 38-431.03(A)(1), to discuss confidential records pursuant to A.R.S. § 38-431.03(A)(2) or to obtain legal advice pursuant to A.R.S. § 38-431.03(A)(3).

**A. *Review, consideration, and possible action regarding request to repeal or modify rules R4-6-210(3) and R4-6-211(A)***

Ms. Stanley appeared telephonically and was accompanied by her husband. Matt Miller of the Goldwater Institute was also present telephonically.

Ms. Zavala provided the Board with a brief summary of its discussion from its September 15<sup>th</sup> meeting regarding Ms. Stanley's petition. Ms. Zavala also directed the Board to the letter it received from the Goldwater Institute dated September 25<sup>th</sup>. Ms. Zavala reminded the Board that at its meeting on the 15<sup>th</sup>, the Board directed staff to draft language that would create an exemption to the work experience requirements for supervised work experience acquired outside of Arizona for its consideration.

Ms. Zavala informed the Board that since that meeting and the receipt of the letter from the Goldwater Institute, she along with Ms. Dalton and Marc Harris, A.A.G., met with Ms. Stanley and representatives of the Goldwater Institute. Ms. Zavala indicated that at that meeting she received clarifying information regarding Ms. Stanley's petition. In particular, Ms. Zavala stated that the discussion focused primarily on R4-6-211(A) and its effect on non-independent level licensees' abilities to earn a living since the rule currently prohibits them from, among other things, having an ownership interest in an entity.

Board members discussed whether it would be possible to modify the regulation that requires non-independent level licensees to practice under the requirements currently set forth in A.A.C. R4-6-211(A) while preserving the integrity of the supervisor/supervisee relationship. Board members also expressed concerns about the impact any modification may have on its ability to protect the public. While sharing those concerns, Ms. Zavala suggested that there may be ways to modify the rule for purposes of allowing master level non-independent licensees to have an ownership interest in an entity while preserving the public protection safeguards that are currently in place. Board members were receptive to this idea and discussed continuing this matter to its November meeting in order to give Board staff time to draft proposed language to that effect for its consideration.

Ms. Shields moved, seconded by Ms. Coonrod, to direct staff to draft language modifying R4-6-211(A) to allow master level non-independent licensees to work in a private practice setting while practicing under supervision for the Board’s consideration at its November meeting. The motion passed unanimously.

	Kimberly Bailey	Brad Barnett	Chip Coffey	Mary Coonrod	Cedric Davis	Gary Goodwin	Nikole Hintz-Lyon	Meaghan Kramer	Heidi Quinlan	Jerri Shields	Gerald Szymanski
AYE	X	X		X	X	X	X	X	X	X	
NAY											
Absent			X								X

Following further discussion, Dr. Davis moved, seconded by Ms. Quinlan, to direct staff to also draft language that would create an exemption to the work experience requirements for supervised work experience acquired outside of Arizona for its consideration. The motion carried with Mr. Goodwin and Ms. Shields opposed.

	Kimberly Bailey	Brad Barnett	Chip Coffey	Mary Coonrod	Cedric Davis	Gary Goodwin	Nikole Hintz-Lyon	Meaghan Kramer	Heidi Quinlan	Jerri Shields	Gerald Szymanski
AYE	X	X		X	X		X	X	X		
NAY						X				X	
Absent			X								X

**4. Future agenda items**

N/A

**5. Call for public comment**

None.

**6. Establishment of future meeting dates**

The next meeting is scheduled for Friday, November 3, 2017, at 9:00 a.m., at 3443 North Central Avenue, Room 1705.

**7. Adjournment**

Dr. Davis moved, seconded by Mr. Barnett, to adjourn. The motion passed unanimously and the meeting was adjourned at 8:39 a.m.

\_\_\_\_\_  
 Gerald Szymanski  
 Secretary/Treasurer

\_\_\_\_\_  
 Date

**Annette Stanley**  
5717 W. Monona Dr.  
Glendale, AZ 85308



(913) 626-9915

erikannette@outlook.com

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April 26, 2017

Tobi Zavala  
Executive Director  
State of Arizona  
Board of Behavioral Health Examiners  
3443 N. Central Avenue, Suite 1700  
Phoenix, AZ 85012

RE: Petition to Repeal or Modify Rules R4-6-210(3) and R4-6-211(A)

Dear Ms. Zavala:

This letter serves as my Petition, pursuant to A.R.S. §41-1093.02<sup>1</sup>, requesting that the Arizona Board of Behavioral Health repeal or modify Rules R4-6-210(3) and R4-6-211(A). These rules, together, prohibit a Licensed Associate Counselor (LAC) from practicing in an independent setting. The rules burden the entry into and participation in the practice of counseling, and they are not necessary to fulfill a public health, safety, or welfare concern.

Arizona is one of only seventeen states in the nation to have a requirement that counselors working under supervision are not allowed in any circumstance to practice in an independent setting.<sup>2</sup> Thirty-three states do not have such a requirement, and they allow counselors under supervision to work in an independent setting. This requirement is a direct and substantial burden on the entry into and participation in the practice of counseling. When the Board amended Rule R4-6-211 in 2015, it noted that: "The majority of the associate level professionals work under supervision in behavioral health agencies licensed by the Department of Health Services." See 21 A.A.R. 2633 (Nov. 6, 2015). This is unsurprising given the fact that, other than behavioral health agencies licensed by DHS, it is very difficult to find employment in a private practice setting where a supervisor is available to meet the Board's requirements for

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<sup>1</sup> This statute was recently enacted by the Legislature and a copy is included with this Petition.

<sup>2</sup> The other states are California, Illinois, Indiana, Louisiana, Missouri, Nevada, New Hampshire, New Jersey, New York, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, Utah, and West Virginia.

direct supervision. There are very few part-time positions available at state health agencies for associate level counselors. For associate level counselors like myself who have children at home or whose life circumstances prohibit full time employment, finding a place to practice is very difficult. Thus, the Rules that are the subject of this Petition plainly burden entry into and participation in the practice of counseling.

In addition, these rules burden the entry into and participation in the counseling profession by counselors moving into Arizona from one of the thirty-three other states where practice in an independent setting while under supervision is allowed.<sup>3</sup> For example, Rule R4-6-212.01(2) allows for an exception to the clinical supervision requirements for supervised work experience acquired outside of Arizona. However, the exception only pertains to "supervised work experience" and has no application to the general "direct supervision" requirements contained in R4-6-211 and more specifically R4-6-211(A). Therefore, the Board holds out of state applicants to the direct supervision requirements in R4-6-211(A) and assumes that an out of state applicant to this Board should anticipate a change in work locations as well as knowledge and compliance of the Arizona statutes and rules applicable to his/her license while working in another state. This does not demonstrate respect for other states and their rules which the licensee has followed in anticipation of satisfactorily meeting that state's requirements for independent licensure upon completion of the supervised work experience. Of the sixteen other states that have a requirement similar to Arizona, seven<sup>4</sup> have provisions that allow the portability of supervised work experience and licenses from other states wherein that licensee has complied with the requirements for supervision of the state in which the license was held. Only nine<sup>5</sup> other states prohibit outright any counselors moving from other states who obtained supervision hours that do not meet R4-6-211(A). This is powerful evidence that these rules are a direct and substantial burden on the entry into the counseling profession, especially by those counselors moving to Arizona from another state.

On March 24, 2017, the Counseling Academic Review Committee recommended my application for independent licensure (LPC) be denied based solely on the issue of ownership interest. The Board of Kansas has provided me with a letter certifying and accepting the hours I accrued under my board-approved supervision plan.<sup>67</sup> The Committee's denial substantially burdens my ability to work in the state of Arizona. The rules, especially as applied to licensure portability,

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<sup>3</sup> While all 50 state licensing boards agree that counselors should complete post-graduate supervised work experience, the majority of states offer protection to the public community through other less burdensome rules, such as requiring board-approved supervision plans, and subsequent testing prior to independent licensure.

<sup>4</sup> New York, North Dakota, South Dakota, Tennessee, Texas, Utah, West Virginia

<sup>5</sup> California, Illinois, Indiana, Louisiana, Missouri, Nevada, New Hampshire, New Jersey, Oklahoma

<sup>6</sup> See copy of attached letter from the Kansas Board of Behavioral Health Sciences dated April 13, 2017. The original of that letter is contained in a signed and sealed envelope from the Board in my possession and will be made available at the Board's request.

<sup>7</sup> Copy of my Kansas Board-approved supervision has been submitted with my application for LPC.

are discriminatory in nature and work a substantial hardship against counselors moving to Arizona from other states. Further, the Arizona Board does not allow any subjectivity for situations such as mine, and as a result is seeking to disqualify (through their recommended denial of my application for LPC) 1,155 direct client hours (all face-to-face therapy hours), 78 doctoral –level supervision hours, and 2,500+ professional/indirect hours which represents 3.5+ years of post-graduate work and over \$6,500 spent on supervision. These rules are plainly a burden on participation in and entry into the counseling profession in Arizona.

Further, due to the Arizona Board's strong position regarding objectivity versus subjectivity,<sup>8</sup> the committee is required to also dismiss the professional recommendations of two qualified supervisors that I have the knowledge, skill set and training to work as an independent counselor. Rather than trusting the professionals it designates as qualified and competent to make such recommendations, the Board of Arizona, as reflected in its overly burdensome Rules, seems more concerned about checking a series of "boxes" than counselor competency. Due to the lack of subjectivity within the Rules, the Committee is not allowed to even take the recommendations of my supervisors into consideration when making a recommendation for approval or denial to the Board. Not only did I work under a doctoral-level supervisor in the state of Kansas, but she completed her doctoral training in "counselor supervision" and held my training to a high level of scrutiny. Then, when I relocated to the state of Arizona, I completed my remaining hours under the supervision of Chris Andersen, MA LPC, a Board-approved clinical supervisor. Both of my supervisors have made recommendations for the approval of my independent license to the Committee and are prepared to testify of my clinical and ethical competence.

Rules R4-6-210(3) and R4-6-211(A) are also not necessary to fulfill a public health, safety, or welfare concern. A "health, safety, or welfare concern" is defined by statute to mean: "The protection of members of the public against harm, fraud or loss, including the preservation of public security, order or health." A.R.S. §41-1093(1)(A). It is difficult to believe that these rules are necessary to prevent harm, fraud, or loss when thirty-four other states allow counselors under supervision to practice in a setting where they have an ownership or management interest and accept payments directly from clients. For example, I moved here in 2014 from Kansas where I had spent almost three years under supervision in a practice that I started and where I had an ownership and management interest and took payments directly from clients. Kansas allows counselors under supervision to practice in such a setting and to obtain clinical supervision from a supervisor contracted by the practice. During that time, I was subject to all the rules and regulations of the Kansas Behavioral Science Regulatory Board, including its extensive rules of unprofessional conduct that are intended to protect the health, safety, and

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<sup>8</sup> This position confirmed in a telephone call with Tobi Zavala on March 30, 2017.

welfare of the public. *See e.g.* Kansas BSRB Rule 102-3-12(a).<sup>9</sup> Arizona has similar extensive statutes regarding unprofessional conduct. *See e.g.*, A.R.S. §32-3251(16). In fact, these Arizona statutes already contain numerous prohibitions against activities that would result in harm, fraud, or loss to the public. *See e.g.*, A.R.S. §32-3251(16)(b), (h) (prohibiting fraud in rendering services, obtaining a license, or obtaining a fee). The statutes also prohibit any conduct that “constitutes a danger to the health, welfare or safety of a client.” A.R.S. §32-3251(16)(k). Because these prohibitions are already in the statutes and rules of the Board, it is difficult to see how the prohibition against supervised practice in an independent setting contained in Rules R4-6-210(3) and R4-6-211(A) are necessary to protect the public against harm, fraud, or loss.

Pursuant to A.R.S. §41-1093.02, I request that the Board repeal or modify Rules R-4-6-210(3) and R-4-6-211(A). Pursuant to section 41-1093.02(B), I look forward to your response within ninety (90) days either repealing or modifying these Rules or stating the basis on which the Board concludes that these Rules comply with 41-1093.01.<sup>10</sup>

Sincerely,

*Annette Stanley, MA LAC*

Annette Stanley, MA, LAC-15568

---

<sup>9</sup> Available at the BSRB website: <https://ksbsrb.ks.gov/docs/default-source/regulations/professional-counselors/102-3-12a.pdf?sfvrsn=4>.

<sup>10</sup> Please note that I am also appealing the Academic Review Committee’s recommendation to the Board for denial of my application (dated March 24, 2017) for Licensed Professional Counselor concurrently with this petition.

Sam Brownback  
Governor

Max L. Foster, Jr.  
Executive Director



700 SW Harrison St. Suite 420  
Topeka, KS 66603-3929  
(785) 296-3240  
Fax (785)296-3112  
www.ksbsrb.org

April 13, 2017

Annette Stanley  
5717 Monona Dr.  
Glendale, Az. 85308

Dear Annette:

On December 11, 2012 you were mailed an approval letter from the Behavioral Sciences Regulatory Board (BSRB) in the state of Kansas. This letter approved the application for your clinical training plan submitted by you and a selected clinical training plan supervisor. You were given a starting date to begin accruing hours for the training plan beginning October 30, 2011 the date your plan officially arrived at BSRB and by approval became active.

Your approved clinical supervisor was Dr. Tricia Brown, Ph.D., LCPC #756, NCC, RPT-S and clinically licensed as a professional counselor in the states of Kansas and Missouri. Dr. Brown was qualified and approved to conduct clinical supervision in both states.

Your clinical training plan was conducted with work at Thrive, an independent practice in Leawood, Kansas. Your training plan in Kansas was active from 10/11/2011 to 07/01/2014 during which time you accrued 1155 post graduate experience hours that involved direct face to face contact with clients for whom you provided psychotherapy and evaluation. You accrued 3665 post graduate clinical experience hours that included the previously listed 1155 direct client contact hours.

On July 1, 2014 Dr. Brown, informed BSRB, that as of June 30, 2014, she would no longer be providing your supervision as you would be relocating and no longer seeing clients in Kansas.

On July 1, 2014 Dr. Brown provided BSRB with the Post-Graduate Supervised Clinical Work Experience Supervisor's Attestation (consent and authorization to release information), to attest to the training plan hours that you had completed until that time.

Included with this letter are pages 2 and 3 of the LCPC Post-Graduate Supervisor's Attestation Form that were not included with the form you had from Dr. Brown.

Should additional help be required to assist in gathering information regarding your efforts to apply for LPC licensure in the state of Arizona, feel free to contact BSRB and every effort will be made to find and provide you with the information needed.

Bruno Langer  
Investigator/Licensing Specialist  
(785) 296-5097  
Email: [bruno.langer@ks.gov](mailto:bruno.langer@ks.gov)

III. Supervisor's Qualifications at the time supervision was provided:

- Doctoral degree Ph.D Counselor Education, Supervision & Counseling 2000  
A. Masters degree in: Masters of Education Year conferred: 1997  
B. License type and number: 756 LCPC  
C. Original date of issue: June 2009 State: Ks  
D. If licensed in a state other than Kansas at the time supervision was provided, was this license the independent, clinical of licensure? Yes  No   
E. Were you under any disciplinary sanction, restriction or have any disciplinary action pending by a professional licensing or credentialing board at the time you provided supervision? Yes  No   
F. Did you have, at least in part, clinical responsibility for the supervisee's practice of professional counseling? Yes  No   
G. Did you have knowledge and experience with the supervisee's client population? Yes  No   
H. Did you have knowledge and experience with the methods of practice that the supervisee employs? Yes  No   
I. Were you a member of the staff in the supervisee's practice setting? Yes  No   
If "no", please answer the following questions:  
1. Did you have an understanding of the organization and administrative policies and procedures of the practice setting? Yes  No   
2. Did you have an understanding of the mission of the practice setting? Yes  No   
3. Was the extent of your of your responsibilities clearly defined with respect to the client cases to be supervised and your role, if any, in the personnel evaluation within the practice setting? Yes  No   
4. Was the responsibility for payment for supervision clearly defined? Yes  No   
5. If the supervisee paid you directly for supervision, did you maintain your responsibility to the client and the practice setting? Yes  No   
6. Were the parameters of client confidentiality defined and agreed to by the client? Yes  No

IV. Supervisor's requirements within the supervision process:

- A. Did you meet in person with the supervisee to provide at least 1 hour of supervision session for every 15 hours of direct clinical client contact? Yes  No   
B. Did you provide at least 2 separate supervisory sessions per month? Yes  No   
C. If you provided supervision in a group format, how many supervisees were in those groups? 3  
D. Did you provide oversight, guidance and direction of the supervisee's practice by assessing and evaluating the supervisee's performance? Yes  No   
E. Did you provide supervision in a process distinct from personal therapy, didactic instruction, or professional counseling consultation? Yes  No   
F. Did you ensure that your scope of responsibility and authority in the supervisee's practice setting was clearly defined? Yes  No   
G. Did you periodically evaluate the supervisee's role and their use of a theoretical base, and their use of professional counseling principles? Yes  No   
H. Did you provide supervision consistent with the education, training, experience, and ability of the supervisee? Yes  No

V. Evaluation of the Applicant's supervised experience:

- A. Please summarize the types of clients and client situations dealt with during the supervised experience:

Supervisor worked with individuals, couples and families regarding relational, life space transition and mental health concerns.

- B. Did the applicant complete all supervision goals and objectives? Yes  No   
If "no", please explain the reasons why all supervision goals and objectives were not met.

C. Please assess the applicant's performance in regard to the following components of the clinical professional counseling practice. **NOTE: If any of the following areas are rated as "unacceptable", please attach a statement outlining the basis for those ratings or for your reservations concerning licensing this applicant for independent clinical professional counseling.**

	Acceptable	Unacceptable
1. Assessment	<u>X</u>	_____
2. Diagnosis	<u>X</u>	_____
3. Treatment (psychotherapy)	<u>X</u>	_____
4. Client centered advocacy	<u>X</u>	_____
5. Consultation	<u>X</u>	_____
6. Evaluation	<u>X</u>	_____

D. Was the applicant's performance throughout the period of supervision consistently acceptable? Yes X No \_\_\_\_\_  
 E. Please evaluate the applicant's merit of public trust in regard to the following qualities:

	Acceptable	Unacceptable
1. Good judgment:	<u>X</u>	_____
2. Integrity:	<u>X</u>	_____
3. Honesty:	<u>X</u>	_____
4. Fairness:	<u>X</u>	_____
5. Credibility:	<u>X</u>	_____
6. Reliability:	<u>X</u>	_____
7. Respect for others:	<u>X</u>	_____
8. Respect for state and federal laws:	<u>X</u>	_____
9. Self discipline:	<u>X</u>	_____
10. Self-evaluation:	<u>X</u>	_____
11. Initiative:	<u>X</u>	_____
12. Commitment to professional counseling values/ethics:	<u>X</u>	_____

F. Do you recommend this applicant for licensure at the independent, clinical level in professional counseling? Yes X No \_\_\_\_\_ If your response is "no", attach a statement that describes the basis for your denial.

**VI. Attestation of the Supervisor:**

I have personally known the above applicant who has made application to the Behavioral Science Regulatory Board (BSRB) for licensure as a clinical professional counselor, and attest that said applicant has been practicing in the clinical setting as indicated, and has been supervised by me in that specialty.

In signing this form, I understand that I am attesting that all the information provided in this attestation form is true, accurate, and submitted in good faith. I understand that in accordance with Kansas statutes, anyone knowingly making a false statement on any form of the BSRB shall be guilty of a Class B misdemeanor.

Tricia K Brown  
Printed Name

Tricia K Brown  
Signature

7-1-14  
Date



September 25, 2017

Jerri Shields, Chairperson  
Arizona State Board of Behavioral Health Examiners  
3443 N. Central Ave., Suite 1700  
Phoenix, AZ 85012

**SENT VIA U.S. MAIL AND E-MAIL**

Re: Ms. Annette Stanley and Rule R4-6-211(A)

Dear Ms. Shields:

The Goldwater Institute represents Ms. Annette Stanley for her application to become a Licensed Professional Counselor before the Arizona State Board of Behavioral Health Examiners ("Board").

We understand that the Counseling Academic Review Committee, a subcomponent of the Board, has determined that Ms. Stanley does not meet the requirements for licensure because she had an ownership interest in an entity where she acquired supervised work experience outside the state of Arizona. The Review Committee evidentially based this determination on R4-6-211(A), an Exempt Rule under the Arizona Administrative Code.

We believe the Board's actions violate A.R.S. § 41-1093 *et seq.* because the requirements under R4-6-211(A) are not "demonstrated to be necessary to specifically fulfill a public health, safety or welfare concern." The Board's actions may also violate Ms. Stanley's constitutional right to earn a living.

R4-6-211(A) plainly burdens entry into the field of professional counselling. That is, it prevents an otherwise qualified professional from receiving occupational licensure from the State.

At the same time, the prohibition that a supervisee not "[h]ave an ownership interest in, operate, or manage the entity with immediate responsibility for the behavioral health services provided by the licensee" does not advance an appropriate public health or safety concern.

Of course, the purpose of supervised work is to ensure that a licensee has received professional experience overseen by a qualified counselor prior to offering unsupervised counselling to the public. Prohibiting a supervisee from having an ownership or management interest simply does not advance this government interest. In fact, supervised work in an

independent practice may better qualify supervisees to engage in the full spectrum of counseling services and the business of professional counseling than supervised work in other settings. This is likely why Arizona is in a small minority of states to prohibit supervised work in an independent setting. There is simply no evidence that R4-6-211(A) advances an appropriate government interest as required under the law.

As you know, Ms. Stanley holds a Masters of Arts Degree in Professional Counseling and has over 4,200 work experience hours, including over 1,600 hours of direct client contact hours, and over 118 hours of direct supervision. She comes highly qualified from her previous supervisor and her current Arizona supervisor has given Ms. Stanley high marks in all areas under scrutiny and has recommended her for independent licensure to this Board. As your Review Board has previously acknowledged, on the record, there is no question as to Ms. Stanley's professional qualifications.

The arbitrary requirements of R4-6-211(A) advance neither the interests of the public nor of the clients who would otherwise depend on Ms. Stanley's professional services.

For these reasons, and others, the Board's actions are unlawful.

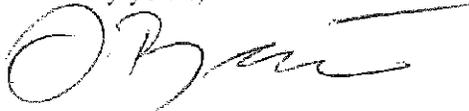
A.R.S. §41-1093.02(C) permits a cause of action and the recovery of attorney fees and costs in a successful action against an unlawful occupational regulation. In order to prevent the possibility of legal action against the Board, we respectfully request that the Board repeal or revise R4-6-211(A) to comply with Arizona law, and immediately grant Ms. Stanley's application for licensure.

I am available at any time to discuss the statutory and constitutional issues raised by R4-6-211(A) and the Board's related actions.

We also appreciate your thoughtful review of Ms. Stanley's licensure application and her Petition for repeal or modification of R4-6-211(A), and in light of the foregoing, we look forward to working with you to arrive at an acceptable solution regarding her application.

Should you have any questions, please do not hesitate to contact me directly at [jriches@goldwaterinstitute.org](mailto:jriches@goldwaterinstitute.org) or (602) 462-5000.

Sincerely yours,



Jon Riches  
Director of National Litigation

cc. Ms. Tobi Zavala, [tobi.zavala@azbbhc.us](mailto:tobi.zavala@azbbhc.us)



Within the stated calendar quarter, this Title 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.

**TITLE 4. Professions and Occupations**  
**Chapter 6. Board of Behavioral Health Examiners**  
Corrections

REMOVE Supp. 16-4  
Pages: 1 - 26

REPLACE with Supp. 17-2  
Pages: 1 - 26

*The agency's contact person who can answer questions about rules corrected in this Chapter:*

Name: Donna Dalton, Deputy Director  
Address: Arizona Board of Behavioral Health Examiners  
3443 N. Central Ave, Ste. 1700  
Phoenix, AZ 85012  
Telephone: (602) 542-1811  
Website: www.azbbhe.us

*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.*

**PUBLISHER**  
**Arizona Department of State**  
**Office of the Secretary of State, Administrative Rules 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  
ADMINISTRATIVE RULES DIVISION  
June 30, 2017

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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 2017 is cited as Supp. 17-1.

### **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 4. PROFESSIONS AND OCCUPATIONS**  
**CHAPTER 6. BOARD OF BEHAVIORAL HEALTH EXAMINERS**

*Editor’s Note: Former 4 A.A.C. 6 repealed; new 4 A.A.C. 6 made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004. Under Laws 2003, Ch. 65, the rules for the Board of Behavioral Health Examiners are repealed and replaced with new rules, and the Board is exempt from the Administrative Procedure Act for one year. The former rules and all Historical Notes are on file in the Office of the Secretary of State (Supp. 04-2).*

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## ARTICLE 1. DEFINITIONS

**R4-6-101. Definitions**

The definitions at A.R.S. § 32-3251 apply to this Chapter. Additionally, the following definitions apply to this Chapter, unless otherwise specified:

1. "Applicant" means:
  - a. An individual requesting a license by examination, temporary license, or a license by endorsement by submitting a completed application packet to the Board; or
  - b. A regionally accredited college or university seeking Board approval of an educational program under R4-6-307.
2. "Application packet" means the required documents, forms, fees, and additional information required by the Board of an applicant.
3. "ARC" means an academic review committee established by the Board under A.R.S. § 32-3261(A).
4. "Assessment" means the collection and analysis of information to determine an individual's behavioral health treatment needs.
5. "ASWB" means the Association of Social Work Boards.
6. "Behavioral health entity" means any organization, agency, business, or professional practice, including a for-profit private practice, which provides assessment, diagnosis, and treatment to individuals, groups, or families for behavioral health related issues.
7. "Behavioral health service" means the assessment, diagnosis, or treatment of an individual's behavioral health issue.
8. "CACREP" means the Council for Accreditation of Counseling and Related Educational Programs.
9. "Client record" means collected documentation of the behavioral health services provided to and information gathered regarding a client.
10. "Clinical social work" means social work involving clinical assessment, diagnosis, and treatment of individuals, couples, families, and groups.
11. "Clinical supervision" means direction or oversight provided either face to face or by videoconference or telephone by an individual qualified to evaluate, guide, and direct all behavioral health services provided by a licensee to assist the licensee to develop and improve the necessary knowledge, skills, techniques, and abilities to allow the licensee to engage in the practice of behavioral health ethically, safely, and competently.
12. "Clinical supervisor" means an individual who provides clinical supervision.
13. "COAMFTE" means the Commission on Accreditation for Marriage and Family Therapy Education.
14. "Clock hour" means 60 minutes of instruction, not including breaks or meals.
15. "Contemporaneous" means documentation is made within 10 business days.
16. "Continuing education" means training that provides an understanding of current developments, skills, procedures, or treatments related to the practice of behavioral health, as determined by the Board.
17. "Co-occurring disorder" means a combination of substance use disorder or addiction and a mental or personality disorder.
18. "CORE" means the Council on Rehabilitation Education.
19. "Counseling related coursework" means education that prepares an individual to provide behavioral health services, as determined by the ARC.
20. "CSWE" means Council on Social Work Education.
21. "Date of service" means the postmark date applied by the U.S. Postal Service to materials addressed to an applicant or licensee at the address the applicant or licensee last placed on file in writing with the Board.
22. "Day" means calendar day.
23. "*Direct client contact*" means, beginning November 1, 2015, the performance of therapeutic or clinical functions related to the applicant's professional practice level of psychotherapy that includes diagnosis, assessment and treatment and that may include psychoeducation for mental, emotional and behavioral disorders based primarily on verbal or nonverbal communications and intervention with, and in the presence of, one or more clients. A.R.S. § 32-3251.
24. "Direct supervision" means responsibility and oversight for all services provided by a supervisee as prescribed in R4-6-211.
25. "Disciplinary action" means any action taken by the Board against a licensee, based on a finding that the licensee engaged in unprofessional conduct, including refusing to renew a license and suspending or revoking a license.
26. "Documentation" means written or electronic supportive evidence.
27. "Educational program" means a degree program in counseling, marriage and family therapy, social work, or substance use or addiction counseling that is:
  - a. Offered by a regionally accredited college or university, and
  - b. Not accredited by an organization or entity recognized by the Board.
28. "Electronic signature" means an electronic sound, symbol, or process that is attached to or logically associated with a record and that is executed or adopted by an individual with the intent to sign the record.
29. "Family member" means a parent, sibling, half-sibling, child, cousin, aunt, uncle, niece, nephew, grandparent, grandchild, and present and former spouse, in-law, step-child, stepparent, foster parent, or significant other.
30. "Gross negligence" means careless or reckless disregard of established standards of practice or repeated failure to exercise the care that a reasonable practitioner would exercise within the scope of professional practice.
31. "Inactive status" means the Board has granted a licensee the right to suspend behavioral health practice temporarily by postponing license renewal for a maximum of 48 months.
32. "Independent contractor" means a licensed behavioral health professional whose contract to provide services on behalf of a behavioral health entity qualifies for independent contractor status under the codes, rules, and regulations of the Internal Revenue Service of the United States.
33. "Independent practice" means engaging in the practice of marriage and family therapy, professional counseling, social work, or substance abuse counseling without direct supervision.
34. "*Indirect client service*" means, beginning November 1, 2015, training for, and the performance of, functions of an applicant's professional practice level in preparation for or on behalf of a client for whom direct client contact functions are also performed, including case consultation and receipt of clinical supervision. Indirect client service does not include the provision of psychoeducation. A.R.S. § 32-3251.
35. "Individual clinical supervision" means clinical supervision provided by a clinical supervisor to one supervisee.

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36. "Informed consent for treatment" means a written document authorizing treatment of a client that:
- Contains the requirements of R4-6-1101;
  - Is dated and signed by the client or the client's legal representative, and
  - Beginning on July 1, 2006, is dated and signed by an authorized representative of the behavioral health entity.
37. "Legal representative" means an individual authorized by law to act on a client's behalf.
38. "License" means written authorization issued by the Board that allows an individual to engage in the practice of behavioral health in Arizona.
39. "License period" means the two years between the dates on which the Board issues a license and the license expires.
40. "NASAC" means the National Addiction Studies Accreditation Commission.
41. "*Practice of behavioral health*" means the practice of marriage and family therapy, professional counseling, social work and substance abuse counseling pursuant to this Chapter. A.R.S. § 32-3251.
42. "*Practice of marriage and family therapy*" means the professional application of family systems theories, principles and techniques to treat interpersonal relationship issues and nervous, mental and emotional disorders that are cognitive, affective or behavioral. The practice of marriage and family therapy includes:
- Assessment, appraisal and diagnosis.
  - The use of psychotherapy for the purpose of evaluation, diagnosis and treatment of individuals, couples, families and groups. A.R.S. § 32-3251.
43. "*Practice of professional counseling*" means the professional application of mental health, psychological and human development theories, principles and techniques to:
- Facilitate human development and adjustment throughout the human life span.
  - Assess and facilitate career development.
  - Treat interpersonal relationship issues and nervous, mental and emotional disorders that are cognitive, affective or behavioral.
  - Manage symptoms of mental illness.
  - Assess, appraise, evaluate, diagnose and treat individuals, couples, families and groups through the use of psychotherapy. A.R.S. § 32-3251.
44. "*Practice of social work*" means the professional application of social work theories, principles, methods and techniques to:
- Treat mental, behavioral and emotional disorders.
  - Assist individuals, families groups and communities to enhance or restore the ability to function physically, socially, emotionally, mentally and economically.
  - Assess, appraise, diagnose, evaluate and treat individuals, couples, families and groups through the use of psychotherapy. A.R.S. § 32-3251.
45. "*Practice of substance abuse counseling*" means the professional application of general counseling theories, principles and techniques as specifically adapted, based on research and clinical experience, to the specialized needs and characteristics of persons who are experiencing substance abuse, chemical dependency and related problems and to the families of those persons. The practice of substance abuse counseling includes the following as they relate to substance abuse and chemical dependency issues:
- Assessment, appraisal, and diagnosis.
  - The use of psychotherapy for the purpose of evaluation, diagnosis and treatment of individuals, couples, families and groups. A.R.S. § 32-3251.
46. "Progress note" means contemporaneous documentation of a behavioral health service provided to an individual that is dated and signed or electronically acknowledged by the licensee.
47. "*Psychoeducation*" means the education of a client as part of a treatment process that provides the client with information regarding mental health, emotional disorders or behavioral health." A.R.S. § 32-3251.
48. "Quorum" means a majority of the members of the Board or an ARC. Vacant positions do not reduce the quorum requirement.
49. "Regionally accredited college or university" means approved by the:
- New England Association of Schools and Colleges,
  - Middle States Commission on Higher Education,
  - North Central Association,
  - Northwest Commission on Colleges and Universities,
  - Southern Association of Colleges and Schools, or
  - Western Association of Schools and Colleges.
50. "Significant other" means an individual whose participation a client considers to be essential to the effective provision of behavioral health services to the client.
51. "Supervised work experience" means practicing clinical social work, marriage and family therapy, professional counseling, or substance abuse counseling for remuneration or on a voluntary basis under direct supervision and while receiving clinical supervision as prescribed in R4-6-212 and Articles 4 through 7.
52. "*Telepractice*" means providing behavioral health services through interactive audio, video or electronic communication that occurs between a behavioral health professional and the client, including any electronic communication for evaluation, diagnosis and treatment, including distance counseling, in a secure platform, and that meets the requirements of telemedicine pursuant to A.R.S. § 36-3602. A.R.S. § 32-3251.
53. "Treatment" means the application by a licensee of one or more therapeutic practice methods to improve, eliminate, or manage a client's behavioral health issue.
54. "Treatment goal" means the desired result or outcome of treatment.
55. "Treatment method" means the specific approach a licensee used to achieve a treatment goal.
56. "Treatment plan" means a description of the specific behavioral health services that a licensee will provide to a client that is documented in the client record, and meets the requirements found in R4-6-1102.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 14 A.A.R. 3895, effective September 16, 2008 (Supp. 08-3). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4). Formatting error with "theories" not in italics in subsection 44 corrected at the request of the Board (Supp. 17-2).

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**ARTICLE 2. GENERAL PROVISIONS****R4-6-201. Board Meetings; Elections**

- A.** The Board:
1. Shall meet at least annually in June and elect the officers specified in A.R.S. § 32-3252(E);
  2. Shall fill a vacancy that occurs in an officer position at the next Board meeting; and
  3. May hold additional meetings:
    - a. As necessary to conduct the Board's business; and
    - b. If requested by the Chair, a majority of the Board members, or upon written request from two Board members.
- B.** The Board shall conduct official business only when a quorum is present.
- C.** The vote of a majority of the Board members present is required for Board action.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-202. Repealed****Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Section repealed by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-203. Academic Review Committee Meetings; Elections**

- A.** Each ARC:
1. Shall meet at least annually in June and elect a Chair and Secretary;
  2. Shall fill a vacancy that occurs in an officer position at the next ARC meeting; and
  3. May hold additional meetings:
    - a. As necessary to conduct the ARC's business; and
    - b. If requested by the Chair of the ARC, a majority of the ARC, or upon written request from two members of the ARC.
- B.** An ARC shall conduct official business only when a quorum is present.
- C.** The vote of a majority of the ARC members present is required for ARC action.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-204. Repealed****Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Section repealed by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-205. Change of Contact Information**

- A.** The Board shall communicate with a licensee or applicant using the contact information provided to the Board including:

1. Home address and telephone number,
2. Address and telephone number for all places of employment,
3. Mobile telephone number, and
4. E-mail address.

- B.** To ensure timely communication with the Board, a licensee or applicant shall notify the Board in writing within 30 days after any change of the licensee's or applicant's contact information listed in subsection (A). The licensee or applicant shall ensure that the written notice provided to the Board includes the new contact information.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4).

**R4-6-206. Change of Name**

A licensee or an applicant shall notify the Board in writing within 30 days after the applicant's or licensee's name is changed. The applicant or licensee shall attach to the written notice:

1. A copy of a legal document that establishes the name change; or
2. A copy of two forms of identification, one of which includes a picture of the applicant or licensee, reflecting the changed name.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-207. Confidential Records**

- A.** Except as provided in A.R.S. § 32-3282, the following records are confidential and not open to public inspection:
1. Minutes of executive session;
  2. Records classified as confidential by other laws, rules, or regulations;
  3. College or university transcripts, licensure examination scores, medical or mental health information, and professional references of applicants except that the individual who is the subject of the information may view or copy the records or authorize release of these records to a third party.
  4. Records for which the Board determines that public disclosure would have a significant adverse effect on the Board's ability to perform its duties or would otherwise be detrimental to the best interests of the state. When the Board determines that the reason justifying the confidentiality of the records no longer exists, the record shall be made available for public inspection and copying; and
  5. All investigative materials regarding any pending or resolved complaint.
- B.** As provided under A.R.S. § 39-121, a person wanting to inspect Board records that are available for public inspection may do so at the Board office by appointment.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1,

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2015 (Supp. 15-4).

**R4-6-208. Conviction of a Felony or Prior Disciplinary Action**

The Board shall consider the following factors to determine whether a felony conviction or prior disciplinary action will result in imposing disciplinary sanctions including refusing to renew the license of a licensee or to issue a license to an applicant:

1. The age of the licensee or applicant at the time of the felony conviction or when the prior disciplinary action occurred;
2. The seriousness of the felony conviction or prior disciplinary action;
3. The factors underlying the conduct that led to the felony conviction or imposition of disciplinary action;
4. The length of time since the felony conviction or prior disciplinary action;
5. The relationship between the practice of the profession and the conduct giving rise to the felony conviction or prior disciplinary action;
6. The licensee's or applicant's efforts toward rehabilitation;
7. The assessments and recommendations of qualified professionals regarding the licensee's or applicant's rehabilitative efforts;
8. The licensee's or applicant's cooperation or non-cooperation with the Board's background investigation regarding the felony conviction or prior disciplinary action; and
9. Other factors the Board deems relevant.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Formatting error to subsection 7; corrected indent at the request of the Board (Supp. 17-2).

**R4-6-209. Deadline Extensions**

- A. Deadlines established by date of service may be extended a maximum of two times by the chair of the Board or the chair of the ARC if a written request is postmarked or delivered to the Board no later than the required deadline.
- B. The Board shall not grant an extension for deadlines regarding renewal submission or late renewal submission.
- C. If a deadline falls on a Saturday, Sunday, or official state holiday, the Board considers the next business day the deadline.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-210. Practice Limitations**

The following licensees shall not engage in the independent practice of behavioral health but rather, shall practice behavioral health only under direct supervision as prescribed in R4-6-211:

1. Licensed baccalaureate social worker,
2. Licensed master social worker,
3. Licensed associate counselor,
4. Licensed associate marriage and family therapist,
5. Licensed substance abuse technician,
6. Licensed associate substance abuse counselor, or
7. Temporary licensee.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by

exempt rulemaking at 11 A.A.R. 2713, effective June 27, 2005 (Supp. 05-2). Section repealed; new Section made by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-211. Direct Supervision: Supervised Work Experience: General**

- A. A licensee working under direct supervision shall not:
  1. Have an ownership interest in, operate, or manage the entity with immediate responsibility for the behavioral health services provided by the licensee;
  2. Receive supervision from:
    - a. A family member;
    - b. An individual whose objective assessment may be limited by a relationship with the licensee; or
    - c. An individual not employed or contracted by the same behavioral health entity as the licensee;
  3. Engage in the independent practice of behavioral health; or
  4. Be directly compensated by behavioral health clients.
- B. To meet the supervised work experience requirements for licensure, supervision shall:
  1. Meet the specific supervised work experience requirements contained in Articles 4, 5, 6, and 7;
  2. Be acquired after completing the degree required for licensure and receiving certification or licensure from a state regulatory entity;
  3. Be acquired before January 1, 2006, if acquired as an unlicensed professional practicing under an exemption provided in A.R.S. § 32-3271;
  4. Meet the direct supervision requirements specified in subsection (A);
  5. Involve the practice of behavioral health; and
  6. Be for a term of no fewer than 24 months.
- C. If the Board determines that an applicant engaged in unprofessional conduct related to services rendered while acquiring hours under supervised work experience, including clinical supervision, the Board shall not accept the hours to satisfy the requirements of R4-6-403, R4-6-503, R4-6-603, or R4-6-706. Hours accrued before and after the time during which the conduct that was the subject of the finding of unprofessional conduct occurred, as determined by the Board, may be used to satisfy the requirements of R4-6-403, R4-6-503, R4-6-603, or R4-6-706 so long as the hours are not the subject of an additional finding of unprofessional conduct.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 11 A.A.R. 2713, effective June 27, 2005 (Supp. 05-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4).

**R4-6-212. Clinical Supervision Requirements**

- A. The Board shall accept hours of clinical supervision submitted by an applicant if the clinical supervision meets the requirements specified in R4-6-404, R4-6-504, R4-6-604, or R4-6-706, as applicable to the license for which application is made, and was provided by one of the following:
  1. A clinical social worker, professional counselor, independent marriage and family therapist, or independent substance abuse counselor who:

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- a. Holds an active and unrestricted license issued by the Board, and
  - b. Has complied with the educational requirements specified in R4-6-214;
2. A mental health professional who holds an active and unrestricted license issued under A.R.S. Title 32, Chapter 19.1 as a psychologist and has complied with the educational requirements specified in R4-6-214; or
  3. An individual who:
    - a. Holds an active and unrestricted license to practice behavioral health,
    - b. Is providing behavioral health services in Arizona:
      - i. Under a contract or grant with the federal government under the authority of 25 U.S.C. § 450-450(n) or § 1601-1683, or
      - ii. By appointment under 38 U.S.C. § 7402 (8-11), and
    - c. Has complied with the educational requirements specified in R4-6-214.
- B.** Unless an exemption was obtained under R4-6-212.01, the Board shall accept hours of clinical supervision submitted by an applicant if the clinical supervision was provided by an individual who:
1. Was qualified under subsection (A), and
  2. Was employed by the behavioral health entity at which the applicant obtained hours of clinical supervision.
- C.** The Board shall accept hours of clinical supervision submitted by an applicant if the clinical supervision includes all of the following:
1. Reviewing ethical and legal requirements applicable to the supervisee's practice, including unprofessional conduct as defined in A.R.S. § 32-3251;
  2. Monitoring the supervisee's activities to verify the supervisee is providing services safely and competently;
  3. Verifying in writing that the supervisee provides clients with appropriate written notice of clinical supervision, including the means to obtain the name and telephone number of the supervisee's clinical supervisor;
  4. Contemporaneously written documentation by the clinical supervisor of at least the following for each clinical supervision session:
    - a. Date and duration of the clinical supervision session;
    - b. Description of topics discussed. Identifying information regarding clients is not required;
    - c. Beginning on July 1, 2006, name and signature of the individual receiving clinical supervision;
    - d. Name and signature of the clinical supervisor and the date signed; and
    - e. Whether the clinical supervision occurred on a group or individual basis;
  5. Maintaining the documentation of clinical supervision required under subsection (C)(4) for at least seven years;
  6. Verifying that no conflict of interest exists between the clinical supervisor and the supervisee's clients;
  7. Verifying that clinical supervision was not acquired:
    - a. From a family member or other individual whose objective assessment of the supervisee's performance may be limited by a relationship with the supervisee; or
    - b. In a professional setting in which the supervisee has an ownership interest or operates or manages.
  8. Conducting on-going compliance review of the supervisee's clinical documentation to ensure the supervisee maintains adequate written documentation;
  9. Providing instruction regarding:
    - a. Assessment,
    - b. Diagnosis,
    - c. Treatment plan development, and
    - d. Treatment;
  10. Rating the supervisee's overall performance as at least satisfactory, using a form approved by the Board; and
  11. Complying with the discipline-specific requirements in Articles 4 through 7 regarding clinical supervision.
- D.** The Board shall accept hours of clinical supervision submitted by an applicant for licensure if:
1. At least two hours of the clinical supervision were provided in a face-to-face setting during each six-month period;
  2. No more than 90 hours of the clinical supervision were provided by videoconference and telephone.
  3. No more than 15 of the 90 hours of clinical supervision provided by videoconference and telephone were provided by telephone; and
  4. Each clinical supervision session was at least 30 minutes long.
- E.** Effective July 1, 2006, the Board shall accept hours of clinical supervision submitted by an applicant if at least 10 of the hours involve the clinical supervisor observing the supervisee providing treatment and evaluation services to a client. The clinical supervisor may conduct the observation:
1. In a face-to-face setting,
  2. By videoconference,
  3. By teleconference, or
  4. By review of audio or video recordings.
- F.** The Board shall accept hours of clinical supervision submitted by an applicant from a maximum of six clinical supervisors.
- G.** The Board shall accept hours of clinical supervision obtained by an applicant in both individual and group sessions, subject to the following restrictions:
1. At least 25 of the clinical supervision hours involve individual supervision, and
  2. Of the minimum 100 hours of clinical supervision required for licensure, the Board may accept:
    - a. Up to 75 of the clinical supervision hours involving a group of two supervisees, and
    - b. Up to 50 of the clinical supervision hours involving a group of three to six supervisees.
- H.** If an applicant provides evidence that a catastrophic event prohibits the applicant from obtaining documentation of clinical supervision that meets the standard specified in subsection (C), the Board may consider alternate documentation.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 11 A.A.R. 2713, effective June 27, 2005 (Supp. 05-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4).

**R4-6-212.01. Exemptions to the Clinical Supervision Requirements**

The Board shall accept hours of clinical supervision submitted by an applicant if the clinical supervision meets the requirements specified in R4-6-212 and R4-6-404, R4-6-504, R4-6-604, or R4-6-706, as applicable to the license for which application is made, unless an exemption is granted as follows:

1. An individual using supervised work experience acquired in Arizona may apply to the Board for an exemption from the following requirements:

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- a. Qualifications of the clinical supervisor. The Board may grant an exemption to the supervisor qualification requirements in R4-6-212(A) and R4-6-404, R4-6-504, R4-6-604, or R4-6-706, as applicable to the license for which application is made, if the Board determines the behavioral health professional who provided or will provide the clinical supervision has education, training, and experience necessary to provide clinical supervision and has complied with the educational requirements specified in R4-6-214 and:
- i. A qualified supervisor is not available because of the size and geographic location of the professional setting in which the clinical supervision will occur; or
  - ii. The behavioral health professional who provided or will provide the clinical supervision holds an active and unrestricted license issued under A.R.S. Title 32 as a physician under Chapter 13 or 17 with certification in psychiatry or addiction medicine or as a nurse practitioner under Chapter 15 with certification in mental health;
- b. Employment of clinical supervisor. The Board may grant an exemption to the requirement in R4-6-212(B) regarding employment of the supervisor by the behavioral health entity at which the supervisee obtains hours of clinical supervision if the supervisee provides verification that:
- i. The supervisor and behavioral health entity have a written contract providing the supervisor the same access to the supervisee's clinical records provided to employees of the behavioral health entity, and
  - ii. Supervisee's clients authorized the release of their clinical records to the supervisor; and
- c. Discipline-specific changes. The Board may grant an exemption to a requirement in R4-6-404, R4-6-504, R4-6-604, or R4-6-706, as applicable to the license for which application is made, that changed on November 1, 2015, and had the effect of making the clinical supervision previously completed or completed no later than October 31, 2017, non-compliant with the clinical supervision requirements. If the Board grants an exemption under this subsection, the Board shall evaluate the applicant's clinical supervision using the requirements in existence before November 1, 2015.
2. An individual using supervised work experience acquired outside of Arizona may apply to the Board for an exemption from the supervision requirements in R4-6-404, R4-6-504, R4-6-604, or R4-6-706, as applicable to the license for which application is made. The Board may grant an exemption for supervised work experience acquired outside of Arizona if the Board determines that:
- a. Clinical supervision was provided by a behavioral health professional qualified by education, training, and experience to provide supervision; and
  - b. The behavioral health professional providing the supervision met one of the following:
    - i. Complied with the educational requirements specified in R4-6-214,
    - ii. Complied with the clinical supervisor requirements of the state in which the supervision occurred, or
    - iii. Was approved to provide supervision to the applicant by the state in which the supervision occurred.

**Historical Note**

New Section made by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4).

**R4-6-213. Registry of Clinical Supervisors**

- A.** The Board shall maintain a registry of individuals who have met the educational requirements to provide supervision that are specified in R4-6-214.
- B.** To be included on the registry of clinical supervisors, an individual shall submit the following to the Board:
1. A registration form approved by the Board;
  2. Evidence of being qualified under R4-6-212(A); and
  3. Documentation of having completed the education required under R4-6-214.
- C.** The Board shall include an individual who complies with subsection (B) on the registry of clinical supervisors. To remain on the registry of clinical supervisors, an individual shall submit the following to the Board:
1. A registration form approved by the Board;
  2. Evidence of being qualified under R4-6-212(A); and
  3. Documentation of having completed the continuing education required under R4-6-214.
- D.** If the Board notified an individual before November 1, 2015, that the Board determined the individual was qualified to provide clinical supervision, the Board shall include the individual on the registry maintained under subsection (A). To remain on the registry of clinical supervisors, the individual shall comply with subsection (C).

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 14 A.A.R. 3895, effective September 16, 2008 (Supp. 08-3). Section R4-6-213 renumbered to Section R4-6-215; new Section made final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-214. Clinical Supervisor Educational Requirements**

- A.** The Board shall consider hours of clinical supervision submitted by an applicant only if the individual who provides the clinical supervision is qualified under R4-6-212(A) and complies with the following:
1. Completes one of the following:
    - a. At least 12 hours of training that meets the standard specified in R4-6-802(D), addresses clinical supervision, and includes the following:
      - i. Role and responsibilities of a clinical supervisor;
      - ii. Skills in providing effective oversight of and guidance to supervisees who diagnose, create treatment plans, and treat clients;
      - iii. Supervisory methods and techniques; and
      - iv. Fair and accurate evaluation of a supervisee's ability to plan and implement clinical assessment and treatment;
    - b. An approved clinical supervisor certification from the National Board for Certified Counselors/Center for Credentialing and Education;

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- c. A clinical supervisor certification from the International Certification and Reciprocity Consortium; or
  - d. A clinical member with an approved supervisor designation from the American Association of Marriage and Family Therapy; and
2. Beginning January 1, 2018, completes a three clock hour Board-approved tutorial on Board statutes and rules.
- B.** Through December 31, 2017, the Board shall consider hours of clinical supervision submitted by an applicant if the individual who provided the clinical supervision was licensed at an independent level, qualified under R4-6-212(A), and the supervision was provided during the first two years the individual was licensed at the independent level.
1. For the Board to continue to accept hours of clinical supervision provided by the individual described under subsection (B), the individual shall have obtained at least 12 hours of training described in subsection (A)(1)(a):
    - a. Before the individual's license expired for the first time; or
    - b. Before providing supervision if the 12 hours of training described in subsection (A)(1)(a) were obtained after the individual's license expired;
  2. For the Board to continue to accept hours of clinical supervision provided by the individual described under subsection (B)(1), the individual shall have obtained at least six hours of training described in subsection (A)(1)(a) before the individual's license expires again and during each subsequent license period expiring before January 1, 2018;
  3. For the Board to continue to accept hours of clinical supervision provided by the individual described under subsection (B)(2), the individual shall comply fully with subsection (C) before the individual's license expires for the first time on or after January 1, 2018.
- C.** To continue providing clinical supervision, an individual qualified under subsection (A)(1)(a) shall, at least every three years, complete a minimum of nine hours of continuing training that:
1. Meets the standard specified in R4-6-802(D);
  2. Concerns clinical supervision;
  3. Addresses the topics listed in subsection (A)(1)(a); and
  4. Beginning January 1, 2018, includes three clock hours of a Board-approved tutorial on Board statutes and rules.
- D.** To continue providing clinical supervision, an individual qualified under subsections (A)(1)(b) through (d) shall:
1. Provide documentation that the national certification or designation was renewed before it expired, and
  2. Beginning January 1, 2018, complete a three clock hour Board-approved tutorial on Board statutes and rules.
3. Issuance of license for non-independent level of practice (LBSW, LMSW, LAC, LSAT, LASAC, and LAMFT): \$100;
  4. Issuance of license for independent level of practice (LCSW, LPC, LISAC, and LMFT): \$250;
  5. Application for a temporary license: \$50;
  6. Application for approval of educational program: \$500;
  7. Application for approval of an educational program change: \$250
  8. Biennial renewal of first area of licensure: \$350;
  9. Biennial renewal of each additional area of licensure if all licenses are renewed at the same time: \$175;
  10. Late renewal penalty: \$100 in addition to the biennial renewal fee;
  11. Inactive status request: \$100; and
  12. Late inactive status request: \$100 in addition to the inactive status request fee.
- B.** The Board shall charge the following amounts for the services it provides:
1. Issuing a duplicate license: \$25;
  2. Criminal history background check: \$40;
  3. Paper copy of records: \$.50 per page after the first four pages;
  4. Electronic copy of records: \$25;
  5. Copy of a Board meeting audio recording: \$20;
  6. Verification of licensure: \$20 per discipline or free if downloaded from the Board's web site;
  7. Board's rules and statutes book: \$10 or free if downloaded from the Board's web site;
  8. Mailing list of licensees: \$150, and
  9. Returned check due to insufficient funds: \$50.
- C.** The application fees in subsections (A)(1) and (2) are non-refundable. Other fees established in subsection (A) are non-refundable unless the provisions of A.R.S. § 41-1077 apply.
- D.** The Board shall accept payment of fees and charges as follows:
1. For an amount of \$40 or less, a personal or business check;
  2. For amounts greater than \$40, a certified check, cashier's check, or money order; and
  3. By proof of online payment by credit card for the following:
    - a. All fees in subsection (A);
    - b. The charge in subsection (B)(2) for a criminal history background check; and
    - c. The charge in subsection (B)(8) for a mailing list of licensees.
- E.** An applicant shall make payment for a criminal history background check separate from payment for other fees and charges.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Section R4-6-214 renumbered to Section R4-6-216; new Section made final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4).

**R4-6-215. Fees and Charges**

- A.** Under the authority provided by A.R.S. § 32-3272, the Board establishes and shall collect the following fees:
1. Application for license by examination: \$250;
  2. Application for license by endorsement: \$250;

**Historical Note**

New Section R4-6-215 renumbered from R4-6-213 and amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-216. Foreign Equivalency Determination**

The Board shall accept as qualification for licensure a degree from an institution of higher education in a foreign country if the degree is substantially equivalent to the educational standards required in this Chapter for professional counseling, marriage and family therapy, and substance abuse counseling licensure. To enable the Board to determine whether a foreign degree is substantially equivalent to the educational standards required in this Chapter, the applicant shall, at the applicant's expense, have the foreign degree evaluated by an entity approved by the Board.

**Historical Note**

New Section R4-6-216 renumbered from R4-6-214 and amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**ARTICLE 3. LICENSURE****R4-6-301. Application for a License by Examination**

An applicant for a license by examination shall submit a completed application packet that contains the following:

1. A notarized statement, signed by the applicant, certifying that all information submitted in support of the application is true and correct;
2. Identification of the license for which application is made;
3. The license application fee required under R4-6-215;
4. The applicant's name, date of birth, social security number, and contact information;
5. Each name or alias previously or currently used by the applicant;
6. The name of each college or university the applicant attended and an official transcript for all education used to meet requirements;
7. Verification of current or previous licensure or certification from the licensing or certifying entity as follows:
  - a. Any license or certification ever held in the practice of behavioral health; and
  - b. Any professional license or certification not identified in subsection (7)(a) held in the last 10 years;
8. Background information to enable the Board to determine whether, as required under A.R.S. § 32-3275(A)(3), the applicant is of good moral character;
9. A list of every entity for which the applicant has worked during the last 10 years;
10. If the relevant licensing examination was previously taken, an official copy of the score the applicant obtained on the examination;
11. A report of the results of a self-query of the National Practitioner Data Bank;
12. Documentation required under A.R.S. § 41-1080(A) showing that the applicant's presence in the U.S. is authorized under federal law;
13. A completed and legible fingerprint card for a state and federal criminal history background check and payment as prescribed under R4-6-215 if the applicant has not previously submitted a full set of fingerprints to the Board, or verification that the applicant holds a current fingerprint card issued by the Arizona Department of Public Safety; and
14. Other documents or information requested by the Board to determine the applicant's eligibility.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 11 A.A.R. 2713, effective June 27, 2005 (Supp. 05-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4).

**R4-6-302. Licensing Time Frames**

- A. The overall time frames described in A.R.S. § 41-1072 for each type of license granted by the Board are listed in Table 1. The person applying for a license and the ARC may agree in

writing to extend the substantive review and overall time frames up to 25 percent of the overall time frame.

- B. The administrative completeness review time frame described in A.R.S. § 41-1072 begins when the Board receives an application packet.
  1. If the application packet is not complete, the Board shall send the applicant a written notice specifying the missing document or incomplete information. The administrative completeness review and overall time frames are suspended from the date the notice is served until the date the Board receives the deficient information from the applicant.
  2. An applicant may assume an application packet is complete when the Board sends the applicant a written notice of administrative completeness or when the administrative completeness time frame specified in Table 1 expires.
- C. An applicant shall submit all of the deficient information specified in the notice provided under subsection (B)(1) within 60 days after the deficiency notice is served.
  1. If an applicant cannot submit all deficient information within 60 days after the deficiency notice is served, the applicant may obtain a 60-day extension by submitting a written notice to the Board postmarked or delivered before expiration of the 60 days. The written notice of extension shall document the reasons the applicant is unable to meet the 60-day deadline.
  2. An applicant who requires an additional extension shall submit to the Board a written request that is delivered or postmarked before expiration of the initial extension and documents the reasons the applicant requires an additional extension. The Board shall notify the applicant in writing of its decision to grant or deny the request for an extension.
  3. If an applicant fails to submit all of the deficient information within the required time, the Board shall administratively close the applicant's file with no recourse to appeal. To receive further consideration for licensure, an applicant whose file is administratively closed shall submit a new application and fee.
- D. The substantive review time frame described in A.R.S. § 41-1072 begins on the date the administrative completeness time frame is complete as described under subsection (B)(2).
  1. If an application is referred to the ARC for substantive review and the ARC finds that additional information is needed, the ARC shall provide a comprehensive written request for additional information to the applicant. The substantive review and overall time frames are suspended from the date the comprehensive written request for additional information is served until the applicant provides all information to the Board.
  2. As provided under A.R.S. § 41-1075(A), the ARC and the applicant may agree in writing to allow the ARC to make additional supplemental requests for information. If the ARC issues an additional supplemental request for information, the substantive review and overall time frames are suspended from the date of the additional supplemental request for information until the applicant provides the information to the Board.
  3. An applicant shall submit all of the information requested under subsection (D)(1) within 60 days after the comprehensive request for additional information is served. If the ARC issues an additional comprehensive request for information under subsection (D)(2), the applicant shall submit the additional information within 60 days after the additional comprehensive request for information is served. If the applicant cannot submit all requested infor-



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- A.** A licensee seeking inactive status shall submit:
1. A written request to the Board before expiration of the current license, and
  2. The fee specified in R4-6-215 for inactive status request.
- B.** To be placed on inactive status after license expiration, a licensee shall, within three months after the date of license expiration, comply with subsection (A) and submit the fee specified in R4-6-215 for late request for inactive status.
- C.** The Board shall grant a request for inactive status to a licensee upon receiving a written request for inactive status. The Board shall grant inactive status for a maximum of 24 months.
- D.** The Board shall not grant a request for inactive status that is received more than three months after license expiration.
- E.** Inactive status does not change:
1. The date on which the license of the inactive licensee expires, and
  2. The Board's ability to start or continue an investigation against the inactive licensee.
- F.** To return to active status, a licensee on inactive status shall:
1. Comply with all renewal requirements prescribed under R4-6-801; and
  2. Establish to the Board's satisfaction that the licensee is competent to practice safely and competently. To assist with determining the licensee's competence, the Board may order a mental or physical evaluation of the licensee at the licensee's expense.
- G.** Upon a showing of good cause, the Board shall grant a written request for modification or reduction of the continuing education requirement received from a licensee on inactive status. The Board shall consider the following to show good cause:
1. Illness or disability,
  2. Active military service, or
  3. Any other circumstance beyond the control of the licensee.
- H.** The Board may, upon a written request filed before the expiration of the original 24 months of inactive status and for good cause, as described in subsection (G), permit an inactive licensee to remain on inactive status for one additional period not to exceed 24 months. To return to active status after being placed on a 24-month extension of inactive status, a licensee shall, comply with the requirements in subsection (F) and complete an additional 30 hours of continuing education during the 24-month extension.
- I.** A licensee on inactive status shall not engage in the practice of behavioral health.
- b.** Applying for a license by examination, not currently licensed or certified by a state behavioral health regulatory entity, and:
- i. Within 12 months after obtaining a degree from the education program on which the applicant is relying to meet licensing requirements,
  - ii. Has completed all licensure requirements except passing the required examination, and
  - iii. Has not previously taken the required examination; or
- c.** Applying for a license by examination and currently licensed or certified by another state behavioral health regulatory entity.
- B.** An individual is not eligible for a temporary license if the individual:
1. Is the subject of a complaint pending before any state behavioral health regulatory entity,
  2. Has had a license or certificate to practice a health care profession suspended or revoked by any state regulatory entity,
  3. Has a criminal history or history of disciplinary action by a state behavioral health regulatory entity unless the Board determines the history is not of sufficient seriousness to merit disciplinary action, or
  4. Has been previously denied a license by the Board.
- C.** A temporary license issued to an applicant expires one year after issuance by the Board.
- D.** A temporary license issued to an applicant who has not previously passed the required examination for licensure is revoked immediately if the temporary licensee:
1. Fails to take the required examination by the expiration date of the temporary license; or
  2. Takes but fails the required examination.
- E.** A temporary licensee shall provide written notice and return the temporary license to the Board if the temporary licensee fails the required examination.
- F.** An applicant who is issued a temporary license shall practice as a behavioral health professional only under direct supervision. The temporary license may contain restrictions as to time, place, and supervision that the Board deems appropriate.
- G.** The Board shall issue a temporary license only in the same discipline for which application is made under subsection (A).
- H.** The Board shall not extend the time of a temporary license or grant an additional temporary license based on the application submitted under subsection (A).
- I.** A temporary licensee is subject to disciplinary action by the Board under A.R.S. § 32-3281. A temporary license may be summarily revoked without a hearing under A.R.S. § 32-3279(C)(4).
- J.** If the Board denies a license by examination or endorsement to a temporary licensee, the temporary licensee shall return the temporary license to the Board within five days of receiving the Board's notice of the denial.
- K.** If a temporary licensee withdraws the license application submitted under R4-6-301 for a license by examination or R4-6-304 for a license by endorsement, the temporary license expires.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 11 A.A.R. 2713, effective June 27, 2005 (Supp. 05-2). Amended by final rulemaking at 14 A.A.R. 4516, effective December 2, 2008 (Supp. 08-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-306. Application for a Temporary License**

- A.** To be eligible for a temporary license, an applicant shall:
1. Have applied under R4-6-301 for a license by examination or R4-6-304 for a license by endorsement,
  2. Have submitted an application for a temporary license using a form approved by the Board and paid the fee required under R4-6-215, and
  3. Be one of the following:
    - a. Applying for a license by endorsement;

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 11 A.A.R. 2713, effective June 27, 2005 (Supp. 05-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective

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November 1, 2016 (Supp. 16-4).

**R4-6-307. Approval of an Educational Program**

- A.** To obtain the Board's approval of an educational program, an authorized representative of the regionally accredited college or university shall submit:
1. An application, using a form approved by the Board;
  2. The fee prescribed under R4-6-215; and
  3. Documentary evidence that the educational program is consistent with the curriculum standards specified in A.R.S. Title 32, Chapter 33, and this Chapter.
- B.** The Board shall review the application materials for administrative completeness and determine whether additional information is necessary.
1. If the application packet is incomplete, the Board shall send a written deficiency notice to the applicant specifying the missing or incomplete information. The applicant shall provide the additional information within 60 days after the deficiency notice is served.
  2. The applicant may obtain a 60-day extension of time to provide the deficient information by submitting a written request to the Board before expiration of the time specified in subsection (B)(1).
  3. If an applicant fails to provide the deficient information within the time specified in the written notice or as extended under subsection (B)(2), the Board shall administratively close the applicant's file with no recourse to appeal. To receive further consideration for approval of an educational program, an applicant whose file is administratively closed shall comply with subsection (A).
- C.** When an application for approval of an educational program is administratively complete, the ARC shall substantively review the application packet.
1. If the ARC finds that additional information is needed, the ARC shall provide a written comprehensive request for additional information to the applicant.
  2. The applicant shall provide the additional information within 60 days after the comprehensive request of additional information is served.
  3. If an applicant fails to provide the additional information within the time specified under subsection (C)(2), the Board shall administratively close the applicant's file with no recourse to appeal. To receive further consideration for approval of an educational program, an applicant whose file is administratively closed shall comply with subsection (A).
- D.** After the ARC determines the substantive review is complete:
1. If the ARC finds the applicant's educational program is eligible for approval, the ARC shall recommend to the Board that the educational program be approved.
  2. If the ARC finds the applicant's educational program is ineligible for approval, the ARC shall send written notice to the applicant of the finding of ineligibility with an explanation of the basis for the finding. An applicant may appeal a finding of ineligibility for educational program approval using the following procedure:
    - a. Submit to the ARC a written request for an informal review meeting within 30 days after the notice of ineligibility is served. If the applicant does not request an informal review meeting within the time provided, the ARC shall recommend to the Board that the educational program be denied approval and the applicant's file be closed with no recourse to appeal.
    - b. If the ARC receives a written request for an informal review meeting within the 30 days provided, the ARC shall schedule the informal review meeting and provide at least 30 days' notice of the informal review meeting to the applicant.
- c. At the informal review meeting, the ARC shall provide the applicant an opportunity to present additional information regarding the curriculum of the educational program.
  - d. When the informal review is complete, the ARC shall make a second finding whether the educational program is eligible for approval and send written notice of the second finding to the applicant.
  - e. An applicant that receives a second notice of ineligibility under subsection (D)(2)(d), may appeal the finding by submitting to the Board, within 30 days after the second notice is served, a written request for a formal administrative hearing under A.R.S. Title 41, Chapter 6, Article 10.
  - f. The Board shall either refer a request for a formal administrative hearing to the Office of Administrative Hearings or schedule the hearing before the Board. If no request for a formal administrative hearing is made under subsection (D)(2)(e), the ARC shall recommend to the Board that the educational program be denied approval and the applicant's file be closed with no recourse to appeal.
  - g. If a formal administrative hearing is held before the Office of Administrative Hearings, the Board shall review the findings of fact, conclusions of law, and recommendation of the Administrative Law Judge and issue an order either granting or denying approval of the educational program.
  - h. If a formal administrative hearing is held before the Board, the Board shall issue findings of fact and conclusions of law and issue an order either granting or denying approval of the educational program.
  - i. The Board shall send the applicant a copy of the findings of fact, conclusions of law, and order.
- E.** The Board shall add an approved educational program to the list of approved educational programs that the Board maintains.
- F.** The Board's approval of an educational program is valid for five years unless the accredited college or university makes a change to the educational program that is inconsistent with the curriculum standards specified in A.R.S. Title 32, Chapter 33, and this Chapter.
- G.** An authorized representative of a regionally accredited college or university with a Board-approved educational program shall certify annually, using a form available from the Board, that there have been no changes to the approved educational program.
- H.** If a regionally accredited college or university makes one of the following changes to an approved educational program, the regionally accredited college or university shall notify the Board within 60 days after making the change and request approval of the educational program change under subsection (I):
1. Change to more than 25 percent of course competencies;
  2. Change to more than 25 percent of course learning objectives;
  3. Addition of a course in one of the core content areas specified in R4-6-501, R4-6-601, or R4-6-701; or
  4. Deletion of a course in one of the core content areas specified in R4-6-501, R4-6-601, or R4-6-701.
- I.** To apply for approval of an educational program change, an authorized representative of the regionally accredited college or university shall submit:

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1. An approved educational program change form available from the Board;
  2. The fee prescribed under R4-6-215; and
  3. Documentary evidence that the change to the approved educational program is consistent with the curriculum standards specified in A.R.S. Title 32, Chapter 33, and this Chapter.
- J.** To maintain approved status of an educational program after five years, an authorized representative of the regionally accredited college or university shall make application under subsection (A).
- K.** The Board shall process the materials submitted under subsections (I) and (J) using the procedure specified in subsections (B) through (D).
- L.** Unless an educational program is currently approved by the Board under this Section, the regionally accredited college or university shall not represent that the educational program is Board approved in any program or marketing materials.

**Historical Note**

New Section made by exempt rulemaking at 14 A.A.R. 2714, effective June 6, 2008 (Supp. 08-2). Section repealed; new Section by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**ARTICLE 4. SOCIAL WORK****R4-6-401. Curriculum**

- A.** An applicant for licensure as a baccalaureate social worker shall have a baccalaureate degree in social work from a regionally accredited college or university in a program accredited by the CSWE or an equivalent foreign degree as determined by the Foreign Equivalency Determination Service of the CSWE.
- B.** An applicant for licensure as a master or clinical social worker shall have a master or higher degree in social work from a regionally accredited college or university in a program accredited by the CSWE or an equivalent foreign degree as determined by the Foreign Equivalency Determination Service of the CSWE.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-402. Examination**

- A.** To be licensed as a baccalaureate social worker, an applicant shall receive a passing score on the bachelors, masters, advanced generalist, or clinical examination offered by ASWB.
- B.** To be licensed as a master social worker, an applicant shall receive a passing score on the masters, advanced generalist, or clinical examination offered by ASWB.
- C.** Except as specified in subsection (G)(2), to be licensed as a clinical social worker, an applicant shall receive a passing score on the clinical examination offered by ASWB.
- D.** An applicant for baccalaureate, master, or clinical social worker licensure shall receive a passing score on an approved examination for the level of licensure requested within 12 months after receiving written examination authorization from the Board. An applicant shall not take an approved licensure examination more than twice during the 12-month testing period.
- E.** If an applicant does not receive a passing score on an approved licensure examination within the 12 months referenced in sub-

section (D), the Board shall close the applicant's file with no recourse to appeal. To receive further consideration for licensure, an applicant whose file is closed shall submit a new application and fee.

- F.** The Board may grant a one-time 90-day examination extension request to an applicant who demonstrates good cause as specified under R4-6-305(G).
- G.** To be licensed by endorsement as a clinical social worker, an applicant shall receive a passing score on:
1. The clinical examination offered by ASWB; or
  2. The advanced generalist examination offered by ASWB if the applicant:
    - a. Was licensed as a clinical social worker before July 1, 2004;
    - b. Met the examination requirement of the state being used to qualify for licensure by endorsement; and
    - c. Has been licensed continuously at the same level since passing the examination.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4).

**R4-6-403. Supervised Work Experience for Clinical Social Worker Licensure**

- A.** An applicant for clinical social worker licensure shall demonstrate completion of at least 3200 hours of supervised work experience in the practice of clinical social work in no less than 24 months. Supervised work experience in the practice of clinical social work shall include:
1. At least 1600 hours of direct client contact involving the use of psychotherapy;
  2. No more than 400 of the 1600 hours of direct client contact are in psychoeducation;
  3. At least 100 hours of clinical supervision as prescribed under R4-6-212 and R4-6-404; and
  4. For the purpose of licensure, no more than 1600 hours of indirect client contact related to psychotherapy services.
- B.** For any month in which an applicant provides direct client contact, the applicant shall obtain at least one hour of clinical supervision.
- C.** An applicant may submit more than the required 3200 hours of supervised work experience for consideration by the Board.
- D.** During the period of required supervised work experience specified in subsection (A), an applicant for clinical social worker licensure shall practice behavioral health under the limitations specified in R4-6-210.
- E.** There is no supervised work experience requirement for licensure as a baccalaureate or master social worker.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4).

**R4-6-404. Clinical Supervision for Clinical Social Worker Licensure**

- A.** An applicant for clinical social worker licensure shall demonstrate that the applicant received at least 100 hours of clinical

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supervision that meet the requirements specified in subsection (B) and R4-6-212 during the supervised work experience required under R4-6-403.

- B.** The Board shall accept hours of clinical supervision for clinical social worker licensure if the hours required under subsection (A) meet the following:
1. At least 50 hours are supervised by a clinical social worker licensed by the Board, and
  2. The remaining hours are supervised by an individual qualified under R4-6-212(A), or
  3. The hours are supervised by an individual for whom an exemption was obtained under R4-6-212.01.
- C.** The Board shall not accept hours of clinical supervision for clinical social worker licensure provided by a substance abuse counselor.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 11 A.A.R. 2713, effective June 27, 2005 (Supp. 05-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-405. Repealed****Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Repealed by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**ARTICLE 5. COUNSELING****R4-6-501. Curriculum**

- A.** An applicant for licensure as an associate or professional counselor shall have a master's or higher degree with a major emphasis in counseling from:
1. A program accredited by CACREP or CORE that consists of at least 60 semester or 90 quarter credit hours, including a supervised counseling practicum as prescribed under subsection (E);
  2. An educational program previously approved by the Board under A.R.S. § 32-3253(A)(14) that consists of at least 60 semester or 90 quarter credit hours, including a supervised counseling practicum as prescribed under subsection (E); or
  3. A program from a regionally accredited college or university that consists of at least 60 semester or 90 quarter credit hours, meets the requirements specified in subsections (C) and (D), and includes a supervised counseling practicum as prescribed under subsection (E).
- B.** To assist the Board to evaluate a program under subsection (A)(3), an applicant who obtained a degree from a program under subsection (A)(3) shall attach the following to the application required under R4-6-301:
1. Published college or university course descriptions for the year and semester enrolled for each course submitted to meet curriculum requirements,
  2. Verification, using a form approved by the Board, of completing the supervised counseling practicum required under subsection (E); and
  3. Other documentation requested by the Board.
- C.** The Board shall accept for licensure the curriculum from a program not accredited by CACREP or CORE if the curriculum includes at least 60 semester or 90 quarter credit hours in counseling-related coursework, of which at least three semes-
- ter or 4 quarter credit hours are in each of the following eight core content areas:
1. Professional orientation and ethical practice: Studies that provide a broad understanding of professional counseling ethics and legal standards, including but not limited to:
    - a. Professional roles, functions, and relationships;
    - b. Professional credentialing;
    - c. Ethical standards of professional organizations; and
    - d. Application of ethical and legal considerations in counseling;
  2. Social and cultural diversity: Studies that provide a broad understanding of the cultural context of relationships, issues, and trends in a multicultural society, including but not limited to:
    - a. Theories of multicultural counseling, and
    - b. Multicultural competencies and strategies;
  3. Human growth and development: Studies that provide a broad understanding of the nature and needs of individuals at all developmental stages, including but not limited to:
    - a. Theories of individual and family development across the life-span, and
    - b. Theories of personality development;
  4. Career development: Studies that provide a broad understanding of career development and related life factors, including but not limited to:
    - a. Career development theories, and
    - b. Career decision processes;
  5. Helping relationship: Studies that provide a broad understanding of counseling processes, including but not limited to:
    - a. Counseling theories and models,
    - b. Essential interviewing and counseling skills, and
    - c. Therapeutic processes;
  6. Group work: Studies that provide a broad understanding of group development, dynamics, counseling theories, counseling methods and skills, and other group work approaches, including but not limited to:
    - a. Principles of group dynamics,
    - b. Group leadership styles and approaches, and
    - c. Theories and methods of group counseling;
  7. Assessment: Studies that provide a broad understanding of individual and group approaches to assessment and evaluation, including but not limited to:
    - a. Diagnostic process including differential diagnosis and use of diagnostic classification systems such as the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases,
    - b. Use of assessment for diagnostic and intervention planning purposes, and
    - c. Basic concepts of standardized and non-standardized testing; and
  8. Research and program evaluation: Studies that provide a broad understanding of recognized research methods and design and basic statistical analysis, including but not limited to:
    - a. Qualitative and quantitative research methods, and
    - b. Statistical methods used in conducting research and program evaluation.
- D.** In evaluating the curriculum required under subsection (C), the Board shall assess whether a core content area is embedded or contained in more than one course. The applicant shall provide information the Board requires to determine whether a core content area is embedded in multiple courses. The Board shall not accept a core content area embedded in more than

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two courses unless the courses are succession courses. The Board shall allow subject matter in a course to qualify in only one core content area.

- E.** The Board shall accept a supervised counseling practicum that is part of a master's or higher degree program if the supervised counseling practicum meets the following standards:
1. Consists of at least 700 clock hours in a professional counseling setting,
  2. Includes at least 240 hours of direct client contact,
  3. Provides an opportunity for the supervisee to perform all activities associated with employment as a professional counselor,
  4. Oversight of the counseling practicum is provided by a faculty member, and
  5. Onsite supervision is provided by an individual approved by the college or university.
- F.** The Board shall require that an applicant for professional counselor licensure who received a master's or higher degree before July 1, 1989, from a program that did not include a supervised counseling practicum complete three years of post-master's or higher degree work experience in counseling under direct supervision. One year of a doctoral-clinical internship may be substituted for one year of supervised work experience.
- G.** The Board shall accept for licensure only courses that the applicant completed with a passing grade.
- H.** The Board shall deem that an applicant who holds an active associate counselor license issued by the Board and in good standing meets the curriculum requirements for professional counselor licensure.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 11 A.A.R. 2713, effective June 27, 2005 (Supp. 05-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-502. Examination**

- A.** The Board approves the following examinations for applicants for counselor licensure:
1. National Counselor Examination for Licensure and Certification offered by the National Board for Certified Counselors,
  2. National Clinical Mental Health Counseling Examination offered by the National Board for Certified Counselors, and
  3. Certified Rehabilitation Counselor Examination offered by the Commission on Rehabilitation Counselor Certification.
- B.** An applicant for counselor licensure shall receive a passing score on an approved licensure examination.
- C.** An applicant shall pass an approved examination within 12 months after receiving written examination authorization from the Board. An applicant shall not take an examination more than twice during the 12-month testing period.
- D.** If an applicant does not receive a passing score as required under subsection (B) within the 12 months referenced in subsection (C), the Board shall close the applicant's file with no recourse to appeal. To receive further consideration for licensure, an applicant whose file is closed shall submit a new application and fee.
- E.** The Board may grant a one-time 90-day examination extension request to an applicant who demonstrates good cause as specified under R4-6-305(G).

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4).

**R4-6-503. Supervised Work Experience for Professional Counselor Licensure**

- A.** An applicant for professional counselor licensure shall demonstrate completion of at least 3200 hours of supervised work experience in the practice of professional counseling in no less than 24 months. The applicant shall ensure that the supervised work experience includes:
1. At least 1600 hours of direct client contact involving the use of psychotherapy;
  2. No more than 400 of the 1600 hours of direct client contact are in psychoeducation;
  3. At least 100 hours of clinical supervision as prescribed under R4-6-212 and R4-6-504; and
  4. For the purpose of licensure, no more than 1600 hours of indirect client contact related to psychotherapy services.
- B.** For any month in which an applicant provides direct client contact, the applicant shall obtain at least one hour of clinical supervision.
- C.** An applicant may submit more than the required 3200 hours of supervised work experience for consideration by the Board.
- D.** During the period of supervised work experience specified in subsection (A), an applicant for professional counselor licensure shall practice behavioral health under the limitations specified in R4-6-210.
- E.** There is no supervised work experience requirement for licensure as an associate counselor.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4).

**R4-6-504. Clinical Supervision for Professional Counselor Licensure**

- A.** An applicant for professional counselor licensure shall demonstrate that the applicant received at least 100 hours of clinical supervision that meet the requirements specified in subsection (B) and R4-6-212 during the supervised work experience required under R4-6-503.
- B.** The Board shall accept hours of clinical supervision for professional counselor licensure if:
1. At least 50 hours are supervised by a professional counselor licensed by the Board, and
  2. The remaining hours are supervised by an individual qualified under R4-6-212(A), or
  3. The hours are supervised by an individual for whom an exemption was obtained under R4-6-212.01.
- C.** The Board shall not accept hours of clinical supervision provided by a substance abuse counselor for professional counselor licensure.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 11 A.A.R. 2713, effective June 27,

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2005 (Supp. 05-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-505. Post-degree Programs**

An applicant who has a master's or higher degree with a major emphasis in counseling but does not meet all curriculum requirements specified in R4-6-501 may take post-graduate courses from a regionally accredited college or university to remove the curriculum deficiencies as follows:

1. An applicant whose degree did not consist of 60 semester or 90 quarter credit hours may take graduate or higher level counseling-related courses to meet the curriculum requirement;
2. An applicant whose degree did not include the eight core content areas specified in R4-6-501(C) may take graduate or higher level courses to meet the core content requirement; and
3. An applicant whose practicum did not meet the requirements specified in R4-6-501(E) may obtain additional graduate level supervised practicum hours.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Section repealed; new Section by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**ARTICLE 6. MARRIAGE AND FAMILY THERAPY****R4-6-601. Curriculum**

- A. An applicant for licensure as an associate marriage and family therapist or a marriage and family therapist shall have a master's or higher degree from a regionally accredited college or university in a behavioral health science program that:
  1. Is accredited by COAMFTE;
  2. Was previously approved by the Board under A.R.S. § 32-3253(A)(14); or
  3. Includes at least three semester or four quarter credit hours in each of the number of courses specified in the six core content areas listed in subsection (B).
- B. A program under subsection (A)(3) shall include:
  1. Marriage and family studies: Three courses from a family systems theory orientation that collectively contain at minimum the following elements:
    - a. Introductory family systems theory;
    - b. Family development;
    - c. Family systems, including marital, sibling, and individual subsystems; and
    - d. Gender and cultural issues;
  2. Marriage and family therapy: Three courses that collectively contain at minimum the following elements:
    - a. Advanced family systems theory and interventions;
    - b. Major systemic marriage and family therapy treatment approaches;
    - c. Communications; and
    - d. Sex therapy;
  3. Human development: Three courses that may integrate family systems theory that collectively contain at minimum the following elements:
    - a. Normal and abnormal human development;
    - b. Human sexuality; and
    - c. Psychopathology and abnormal behavior;
  4. Professional studies: One course including at minimum:
    - a. Professional ethics as a therapist, including legal and ethical responsibilities and liabilities; and
    - b. Family law;

5. Research: One course in research design, methodology, and statistics in behavioral health science; and
6. Supervised practicum: Two courses that supplement the practical experience gained under subsection (D).

- C. In evaluating the curriculum required under subsection (B), the Board shall assess whether a core content area is embedded or contained in more than one course. The applicant shall provide information the Board requires to determine whether a core content area is embedded in multiple courses. The Board shall not accept a core content area embedded in more than two courses unless the courses are succession courses. The Board shall allow subject matter in a course to qualify in only one core content area.
- D. A program's supervised practicum shall meet the following standards:
  1. Provides an opportunity for the enrolled student to provide marriage and family therapy services to individuals, couples, and families in an educational or professional setting under the direction of a faculty member or supervisor designated by the college or university;
  2. Includes at least 300 client-contact hours provided under direct supervision;
  3. Has supervision provided by a designated licensed marriage and family therapist.
- E. An applicant may submit a written request to the ARC for an exemption from the requirement specified in subsection (D)(3). The request shall include the name of the behavioral health professional proposed by the applicant to act as supervisor of the practicum, a copy of the proposed supervisor's transcript and curriculum vitae, and any additional documentation requested by the ARC. The ARC shall grant the exemption if the ARC determines the proposed supervisor is qualified by education, experience, and training to provide supervision.
- F. The Board shall deem an applicant who holds an active associate marriage and family therapist license issued by the Board and in good standing meets the curriculum requirements for marriage and family therapist licensure.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 11 A.A.R. 2713, effective June 27, 2005 (Supp. 05-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4).

**R4-6-602. Examination**

- A. The Board approves the marriage and family therapy licensure examination offered by the Association of Marital and Family Therapy Regulatory Boards.
- B. An applicant for associate marriage and family therapist or marriage and family therapist licensure shall receive a passing score on the approved licensure examination.
- C. An applicant shall pass the approved examination within 12 months after receiving written examination authorization from the Board. An applicant shall not take the examination more than twice during the 12-month testing period.
- D. If an applicant does not receive a passing score as required under subsection (B) within the 12 months referenced in subsection (C), the Board shall close the applicant's file with no recourse to appeal. To receive further consideration for licensure, an applicant whose file is closed shall submit a new application and fee.

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- E. The Board may grant a one-time 90-day examination extension request to an applicant who demonstrates good cause as specified under R4-6-305(G).

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt emergency rulemaking at 21 A.A.R. 521, with Attorney General approval effective March 18, 2015 (Supp. 15-1). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4).

**R4-6-603. Supervised Work Experience for Marriage and Family Therapy Licensure**

- A. An applicant for licensure as a marriage and family therapist shall demonstrate completion of at least 3200 hours of supervised work experience in the practice of marriage and family therapy in no less than 24 months. The applicant shall ensure that the supervised work experience includes:
- At least 1600 hours of direct client contact involving the use of psychotherapy:
    - At least 1000 of the 1600 hours of direct client contact are with couples or families; and
    - No more than 400 of the 1600 hours of direct client contact are in psychoeducation and at least 60 percent of psychoeducation hours are with couples or families;
  - At least 100 hours of clinical supervision as prescribed under R4-6-212 and R4-6-604; and
  - For the purpose of licensure, no more than 1600 hours of indirect client contact related to psychotherapy services.
- B. For any month in which an applicant provides direct client contact, the applicant shall obtain at least one hour of clinical supervision.
- C. An applicant may submit more than the required 3200 hours of supervised work experience for consideration by the Board.
- D. During the period of supervised work experience specified in subsection (A), an applicant for marriage and family therapist licensure shall practice behavioral health under the limitations specified in R4-6-210.
- E. There is no supervised work experience requirement for licensure as an associate marriage and family therapist.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4).

**R4-6-604. Clinical Supervision for Marriage and Family Therapy Licensure**

- A. An applicant for marriage and family therapy licensure shall demonstrate that the applicant received at least 100 hours of clinical supervision that meets the requirements specified in subsection (B) and R4-6-212 during the supervised work experience required under R4-6-603.
- B. The Board shall accept hours of clinical supervision for marriage and family therapist licensure if:
- The hours are supervised by an individual who meets the educational requirements under R4-6-214;

- At least 75 of the hours are supervised by a marriage and family therapist licensed by the Board, and
  - The remaining hours are supervised by one or more of the following:
    - A professional counselor licensed by the Board;
    - A clinical social worker licensed by the Board;
    - A marriage and family therapist licensed by the Board; or
    - A psychologist licensed under A.R.S. Title 32, Chapter 19.1; or
  - The hours are supervised by an individual for whom an exemption is obtained under R4-6-212.01.
- C. The Board shall not accept hours of clinical supervision provided by a substance abuse counselor for marriage and family therapy licensure.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 11 A.A.R. 2713, effective June 27, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 1386, effective June 4, 2006 (Supp. 06-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-605. Post-degree Programs**

An applicant who has a master's or higher degree in a behavioral health science but does not meet all curriculum requirements specified in R4-6-601 may take post-graduate courses from a regionally accredited college or university to remove the curriculum deficiencies if:

- The deficiencies constitute no more than 12 semester or 16 quarter credit hours; and
- Courses taken to remove the deficiencies are at a graduate or higher level.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-606. Repealed****Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Repealed by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**ARTICLE 7. SUBSTANCE ABUSE COUNSELING****R4-6-701. Licensed Substance Abuse Technician Curriculum**

- A. An applicant for licensure as a substance abuse technician shall have:
- An associate's or bachelor's degree from a regionally accredited college or university in a program accredited by NASAC;
  - An associate's or bachelor's degree from a regionally accredited college or university in an educational program previously approved by the Board under A.R.S. § 32-3253(A)(14); or
  - An associate's or bachelor's degree from a regionally accredited college or university in a behavioral health science program that includes coursework from the seven core content areas listed in subsection (B).

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- B.** An associate's or bachelor's degree under subsection (A)(3), shall include at least three semester or four quarter credit hours in each of the following core content areas:
1. Psychopharmacology, including but limited to:
    - a. Nature of psychoactive chemicals;
    - b. Behavioral, psychological, physiological, and social effects of psychoactive substance use;
    - c. Symptoms of intoxication, withdrawal, and toxicity;
    - d. Toxicity screen options, limitations, and legal implications; and
    - e. Use of pharmacotherapy for treatment of addiction;
  2. Models of treatment and relapse prevention: Including but not limited to philosophies and practices of generally accepted and scientifically supported models of:
    - a. Treatment,
    - b. Recovery,
    - c. Relapse prevention, and
    - d. Continuing care for addiction and other substance use related problems;
  3. Group work: Group dynamics and processes as they relate to addictions and substance use disorders;
  4. Working with diverse populations: Issues and trends in a multicultural and diverse society as they relate to substance use disorder and addiction;
  5. Co-occurring disorders, including but not limited to:
    - a. Symptoms of mental health and other disorders prevalent in individuals with substance use disorders or addictions;
    - b. Screening and assessment tools used to detect and evaluate the presence and severity of co-occurring disorders; and
    - c. Evidence-based strategies for managing risks associated with treating individuals who have co-occurring disorders;
  6. Ethics, including but not limited to:
    - a. Legal and ethical responsibilities and liabilities;
    - b. Standards of professional behavior and scope of practice;
    - c. Client rights, responsibilities, and informed consent; and
    - d. Confidentiality and other legal considerations in the practice of behavioral health; and
  7. Assessment, diagnosis, and treatment. Use of assessment and diagnosis to develop appropriate treatment interventions for substance use disorders or addictions.
- C.** The Board shall waive the education requirement in subsection (A) for an applicant requesting licensure as a substance abuse technician if the applicant demonstrates all of the following:
1. The applicant provides services under a contract or grant with the federal government under the authority of 25 U.S.C. § 450 – 450(n) or § 1601 – 1683;
  2. The applicant has obtained at least the equivalent of a high school diploma;
  3. Because of cultural considerations, obtaining the degree required under subsection (A) would be an extreme hardship for the applicant; and
  4. The applicant has completed at least 6400 hours of supervised work experience in substance abuse counseling, as prescribed in R4-6-705(C), in no less than 48 months within the seven years immediately preceding the date of application.
- D.** In evaluating the curriculum required under subsection (B), the Board shall assess whether a core content area is embedded or contained in more than one course. The applicant shall provide information the Board requires to determine whether a core content area is embedded in multiple courses. The Board

shall not accept a core content area embedded in more than two courses unless the courses are succession courses. The Board shall allow subject matter in a course to qualify in only one core content area.

- E.** An applicant for licensure as a substance abuse technician who completed the applicant's educational training before the effective date of this Section or no later than October 31, 2017, may request that the Board evaluate the applicant's educational training using the standards in effect before the effective date of this Section.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 11 A.A.R. 2713, effective June 27, 2005 (Supp. 05-2). Amended by exempt rulemaking at 14 A.A.R. 4532, effective January 1, 2009 (Supp. 08-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4). Clerical error correction made to subsection (B)(4); the Office inadvertently did not remove repealed text as filed at 22 A.A.R. 3238; correction made at the request of the Board (Supp. 17-2).

**R4-6-702. Licensed Associate Substance Abuse Counselor Curriculum**

- A.** An applicant for licensure as an associate substance abuse counselor shall have one of the following:
1. A bachelor's degree from a regionally accredited college or university in a program accredited by NASAC and supervised work experience that meets the standards specified in R4-6-705(A);
  2. A master's or higher degree from a regionally accredited college or university in a program accredited by NASAC;
  3. A bachelor's degree from a regionally accredited college or university in a behavioral health science program that meets the core content standards specified in R4-6-701(B) and supervised work experience that meets the standards specified in R4-6-705(A);
  4. A master's or higher degree from a regionally accredited college or university in a behavioral health science program that meets the core content standards specified in R4-6-701(B) and includes at least 300 hours of supervised practicum as prescribed under subsection (C); or
  5. A bachelor's degree from a regionally accredited college or university in an educational program previously approved by the Board under A.R.S. § 32-3253(A)(14) and supervised work experience that meets the standards specified in R4-6-705(A); or
  6. A master's or higher degree from a regionally accredited college or university in an educational program previously approved by the Board under A.R.S. § 32-3253(A)(14) and includes at least 300 hours of supervised practicum as prescribed under subsection (C).
- B.** In evaluating the curriculum required under subsection (A)(3) or (4), the Board shall assess whether a core content area is embedded or contained in more than one course. The applicant shall provide information the Board requires to determine whether a core content area is embedded in multiple courses. The Board shall not accept a core content area embedded in more than two courses unless the courses are succession courses. The Board shall allow subject matter in a course to qualify in only one core content area.

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- C. Supervised practicum. A supervised practicum shall integrate didactic learning related to substance use disorders with face-to-face, direct counseling experience. The counseling experience shall include intake and assessment, treatment planning, discharge planning, documentation, and case management activities.
- D. The Board shall deem an applicant to meet the curriculum requirements for associate substance abuse counselor licensure if the applicant:
1. Holds an active and in good standing substance abuse technician license issued by the Board; and
  2. Met the curriculum requirements with a bachelor's degree when the substance abuse technician license was issued.
- E. An applicant for licensure as an associate substance abuse counselor who completed the applicant's educational training before the effective date of this Section or no later than October 31, 2017, may request that the Board evaluate the applicant's educational training using the standards in effect before the effective date of this Section.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 11 A.A.R. 2713, effective June 27, 2005 (Supp. 05-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4).

**R4-6-703. Licensed Independent Substance Abuse Counselor Curriculum**

- A. An applicant for licensure as an independent substance abuse counselor shall have a master's or higher degree from a regionally accredited college or university in one of the following:
1. A program accredited by NASAC;
  2. A behavioral health science program that meets the core content standards specified in R4-6-701(B) and includes at least 300 hours of supervised practicum as prescribed under subsection (D); or
  3. An educational program previously approved by the Board under A.R.S. § 32-3253(A)(14) that includes at least 300 hours of supervised practicum as prescribed under subsection (D).
- B. In addition to the degree requirement under subsection (A), an applicant for licensure as an independent substance abuse counselor shall complete the supervised work experience requirements prescribed under R4-6-705(B).
- C. In evaluating the curriculum required under subsection (A)(2), the Board shall assess whether a core content area is embedded or contained in more than one course. The applicant shall provide information the Board requires to determine whether a core content area is embedded in multiple courses. The Board shall not accept a core content area embedded in more than two courses unless the courses are succession courses. The Board shall allow subject matter in a course to qualify in only one core content area.
- D. Supervised practicum. A supervised practicum shall integrate didactic learning related to substance use disorders with face-to-face, direct counseling experience. The counseling experience shall include intake and assessment, treatment planning, discharge planning, documentation, and case management activities.

- E. The Board shall deem an applicant to meet the curriculum requirements for independent substance abuse counselor licensure if the applicant:
1. Holds an active and in good standing associate substance abuse counselor license issued by the Board; and
  2. Met the curriculum requirements with a master's degree when the associate substance abuse counselor license was issued.
- F. An applicant for licensure as an independent substance abuse counselor who completed the applicant's educational training before the effective date of this Section or no later than October 31, 2017, may request that the Board evaluate the applicant's educational training using the standards in effect before the effective date of this Section.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 11 A.A.R. 2713, effective June 27, 2005 (Supp. 05-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4).

**R4-6-704. Examination**

- A. The Board approves the following licensure examinations for an applicant for substance abuse technician licensure:
1. Alcohol and Drug Counselor and Advanced Alcohol and Drug Counselor Examinations offered by the International Certification and Reciprocity Consortium, and
  2. Level I or higher examinations offered by the NAADAC, the Association of Addiction Professionals.
- B. The Board approves the following licensure examinations for an applicant for associate or independent substance abuse counselor licensure:
1. Advanced Alcohol and Drug Counselor Examination offered by the International Certification and Reciprocity Consortium,
  2. Level II or higher examinations offered by the NAADAC, the Association of Addiction Professionals, and
  3. Examination for Master Addictions Counselors offered by the National Board for Certified Counselors.
- C. For an applicant for associate or independent substance abuse counselor licensure who received written examination authorization from the Board before the effective date of this Section, the Board shall accept an examination listed in subsection (A) through expiration of the written examination authorization provided by the Board.
- D. The Board shall deem an applicant for independent substance abuse counselor licensure as meeting the examination requirements if all of the following apply:
1. The applicant has an active associate substance abuse counselor license;
  2. The applicant passed a written examination listed in subsection (A) before November 1, 2015; and
  3. The applicant submitted an application to the Board on or after November 1, 2015.
- E. An applicant shall pass an approved examination within 12 months after receiving written examination authorization from the Board. An applicant shall not take an approved examination more than twice during the 12-month testing period.
- F. If an applicant does not receive a passing score on an approved licensure examination within the 12 months referenced in subsection (D), the Board shall close the applicant's file with no recourse to appeal. To receive further consideration for licen-

sure, an applicant whose file is closed shall submit a new application and fee.

- G.** The Board may grant a one-time 90-day examination extension request to an applicant who demonstrates good cause as specified under R4-6-305(G).

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4).

**R4-6-705. Supervised Work Experience for Substance Abuse Counselor Licensure**

- A.** An applicant for associate substance abuse counselor licensure who has a bachelor's degree and is required under R4-6-702(A) to participate in a supervised work experience shall complete at least 3200 hours of supervised work experience in substance abuse counseling in no less than 24 months. The applicant shall ensure that the supervised work experience relates to substance use disorder and addiction and meets the following standards:
1. At least 1600 hours of direct client contact involving the use of psychotherapy related to substance use disorder and addiction issues,
  2. No more than 400 of the 1600 hours of direct client contact are in psychoeducation,
  3. For the purpose of licensure, no more than 1600 hours of indirect client contact related to psychotherapy services,
  4. At least 100 hours of clinical supervision as prescribed under R4-6-212 and R4-6-706, and
  5. At least one hour of clinical supervision in any month in which the applicant provides direct client contact.
- B.** An applicant for independent substance abuse counselor licensure shall demonstrate completion of at least 3200 hours of supervised work experience in substance abuse counseling in no less than 24 months. The applicant shall ensure that the supervised work experience meets the standards specified in subsection (A).
- C.** An applicant for substance abuse technician qualifying under R4-6-701(C) shall complete at least 6400 hours of supervised work experience in no less than 48 months. The applicant shall ensure that the supervised work experience includes:
1. At least 3200 hours of direct client contact;
  2. Using psychotherapy to assess, diagnose, and treat individuals, couples, families, and groups for issues relating to substance use disorder and addiction; and
  3. At least 200 hours of clinical supervision as prescribed under R4-6-212 and R4-6-706.
- D.** An applicant may submit more than the required number of hours of supervised work experience for consideration by the Board.
- E.** During the period of required supervised work experience, an applicant for substance abuse licensure shall practice behavioral health under the limitations specified in R4-6-210.
- F.** There is no supervised work experience requirement for an applicant for licensure as:
1. A substance abuse technician qualifying under R4-6-701(A), or
  2. An associate substance abuse counselor qualifying under R4-6-702(A) with a master's or higher degree.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by

exempt rulemaking at 11 A.A.R. 2713, effective June 27, 2005 (Supp. 05-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R.

2630, effective November 1, 2015 (Supp. 15-4).

Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4).

**R4-6-706. Clinical Supervision for Substance Abuse Counselor Licensure**

- A.** During the supervised work experience required under R4-6-705, an applicant for substance abuse counselor licensure shall demonstrate that the applicant received, for the level of licensure sought, at least the number of hours of clinical supervision specified in R4-6-705 that meets the requirements in subsection (B) and R4-6-212.
- B.** The Board shall accept hours of clinical supervision for substance abuse licensure if the focus of the supervised hours relates to substance use disorder and addiction and:
1. At least 50 hours are supervised by an independent substance abuse counselor licensed by the Board, and
  2. The remaining hours are supervised by an individual qualified under R4-6-212(A), or
  3. The hours are supervised by an individual for whom an exemption was obtained under R4-6-212.01.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 11 A.A.R. 2713, effective June 27, 2005 (Supp. 05-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-707. Post-degree Programs**

An applicant who has a behavioral health science degree from a regionally accredited college or university but does not meet all curriculum requirements specified in R4-6-701, R4-6-702, or R4-6-703 may take post-graduate courses from a regionally accredited college or university to remove the curriculum deficiencies. The Board shall accept a post-graduate course from a regionally accredited college or university to remove a curriculum deficiency if the course meets the following requirement, as applicable:

1. For an applicant who has an associate's or bachelor's degree, an undergraduate or higher level course; or
2. For an applicant who has a master's degree, a graduate or higher level course.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Section repealed; new Section made by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**ARTICLE 8. LICENSE RENEWAL AND CONTINUING EDUCATION**

**R4-6-801. Renewal of Licensure**

- A.** Under A.R.S. § 32-3273, a license issued by the Board under A.R.S. Title 32, Chapter 33 and this Chapter is renewable every two years. A licensee who has more than one license may request in writing that the Board synchronize the expiration dates of the licenses. The licensee shall pay any prorated fees required to accomplish the synchronization.
- B.** A licensee holding an active license to practice behavioral health in this state shall complete 30 clock hours of continuing education as prescribed under R4-6-802 between the date the Board received the licensee's last renewal application and the

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next license expiration date. A licensee may not carry excess continuing education hours from one license period to the next.

- C.** To renew licensure, a licensee shall submit the following to the Board on or before the date of license expiration or as specified in A.R.S. § 32-4301:
1. A renewal application form, approved by the Board. The licensee shall ensure that the renewal form:
    - a. Includes a list of 30 clock hours of continuing education that the licensee completed during the license period;
    - b. If the documentation previously submitted under R4-6-301(12) was a limited form of work authorization issued by the federal government, includes evidence that the work authorization has not expired; and
    - c. Is signed by the licensee attesting that all information submitted is true and correct;
  2. Payment of the renewal fee as prescribed in R4-6-215; and
  3. Other documents requested by the Board to determine that the licensee continues to meet the requirements under A.R.S. Title 32, Chapter 33 and this Chapter.
- D.** The Board may audit a licensee to verify compliance with the continuing education requirements under subsection (B). A licensee shall maintain documentation verifying compliance with the continuing education requirements as prescribed under R4-6-803.
- E.** A licensee whose license expires may have the license reinstated by complying with subsection (C) and paying a late renewal penalty within 90 days of the license expiration date. A license reinstated under this subsection is effective with no lapse in licensure.

#### Historical Note

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 11 A.A.R. 2713, effective June 27, 2005 (Supp. 05-2). Amended by final rulemaking at 14 A.A.R. 4516, effective December 2, 2008 (Supp. 08-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

#### R4-6-802. Continuing Education

- A.** A licensee who maintains more than one license may apply the same continuing education hours for renewal of each license if the content of the continuing education relates to the scope of practice of each license.
- B.** For each license period, a licensee may report a maximum of:
1. Ten clock hours of continuing education for first-time presentations by the licensee that deal with current developments, skills, procedures, or treatments related to the practice of behavioral health. The licensee may claim one clock hour for each hour spent preparing, writing, and presenting information;
  2. Six clock hours of continuing education for attendance at a Board meeting where the licensee is not:
    - a. A member of the Board,
    - b. The subject of any matter on the agenda, or
    - c. The complainant in any matter that is on the agenda; and
  3. Ten clock hours of continuing education for service as a Board or ARC member.
- C.** For each license period, a licensee shall report:

1. A minimum of three clock hours of continuing education sponsored, approved, or offered by an entity listed in subsection (D) in:
    - a. Behavioral health ethics or mental health law, and
    - b. Cultural competency and diversity; and
  2. Beginning January 1, 2018, in addition to the requirement under subsection (C)(1), complete a three clock hour Board-approved tutorial on Board statutes and rules.
- D.** A licensee shall participate in continuing education that relates to the scope of practice of the license held and to maintaining or improving the skill and competency of the licensee. The Board has determined that in addition to the continuing education listed in subsections (B) and (C), the following continuing education meets this standard:
1. Activities sponsored or approved by national, regional, or state professional associations or organizations in the specialties of marriage and family therapy, professional counseling, social work, substance abuse counseling, or in the allied professions of psychiatry, psychiatric nursing, psychology, or pastoral counseling;
  2. Programs in behavioral health sponsored or approved by a regionally accredited college or university;
  3. In-service training, courses, or workshops in behavioral health sponsored by federal, state, or local social service agencies, public school systems, or licensed health facilities or hospitals;
  4. Graduate or undergraduate courses in behavioral health offered by a regionally accredited college or university. One semester-credit hour or the hour equivalent of one semester hour equals 15 clock hours of continuing education;
  5. Publishing a paper, report, or book that deals with current developments, skills, procedures, or treatments related to the practice of behavioral health. For the license period in which publication occurs, the licensee may claim one clock hour for each hour spent preparing and writing materials; and
  6. Programs in behavioral health sponsored by a state superior court, adult probation department, or juvenile probation department.
- E.** The Board has determined that a substance abuse technician, associate substance abuse counselor, or an independent substance abuse counselor shall ensure that at least 20 of the 30 clock hours of continuing education required under R4-6-801(B) are in the following categories:
1. Pharmacology and psychopharmacology,
  2. Addiction processes,
  3. Models of substance use disorder and addiction treatment,
  4. Relapse prevention,
  5. Interdisciplinary approaches and teams in substance use disorder and addiction treatment,
  6. Substance use disorder and addiction assessment and diagnostic criteria,
  7. Appropriate use of substance use disorder and addiction treatment modalities,
  8. Substance use disorder and addiction as it related to diverse populations,
  9. Substance use disorder and addiction treatment and prevention,
  10. Clinical application of current substance use disorder and addiction research, or
  11. Co-occurring disorders.

#### Historical Note

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by

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exempt rulemaking at 11 A.A.R. 2713, effective June 27, 2005 (Supp. 05-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 22 A.A.R. 3238, effective November 1, 2016 (Supp. 16-4).

**R4-6-803. Continuing Education Documentation**

- A.** A licensee shall maintain documentation of continuing education for 24 months following the date of the license renewal.
- B.** The licensee shall retain the following documentation as evidence of participation in continuing education:
1. For conferences, seminars, workshops, and in-service training presentations, a signed certificate of attendance or a statement from the provider verifying the licensee's participation in the activity, including the title of the program, name, address, and telephone number of the sponsoring organization, names of presenters, date of the program, and clock hours involved;
  2. For first-time presentations by a licensee, the title of the program, name, address, and telephone number of the sponsoring organization, date of the program, syllabus, and clock hours required to prepare and make the presentation;
  3. For a graduate or undergraduate course, an official transcript;
  4. For an audited graduate or undergraduate course, an official transcript; and
  5. For attendance at a Board meeting, a signed certificate of attendance prepared by the Board.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-804. Repealed****Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 11 A.A.R. 2713, effective June 27, 2005 (Supp. 05-2). Repealed by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**ARTICLE 9. APPEAL OF LICENSURE OR LICENSURE RENEWAL INELIGIBILITY****R4-6-901. Appeal Process for Licensure Ineligibility**

- A.** An applicant for licensure may be found ineligible because of unprofessional conduct or failure to meet licensure requirements.
- B.** If the ARC finds an applicant is ineligible because of failure to meet licensure requirements:
1. The ARC shall send a written notice of the finding of ineligibility to the applicant with an explanation of the basis for the finding.
  2. An applicant who wishes to appeal the finding of ineligibility shall submit a written request for an informal review meeting to the ARC within 30 days after the notice of ineligibility is served. If an informal review meeting is not requested within the time provided, the ARC shall recommend to the Board that licensure be denied and the licensee's file be closed with no recourse to appeal.

3. If a request for an informal review meeting is received within the 30 days provided under subsection (B)(2), the ARC shall schedule the informal review meeting and provide at least 30-days' notice to the applicant. At the informal review meeting, the ARC shall allow the applicant to present additional information regarding the applicant's qualifications for licensure.
  4. When the review is complete, the ARC shall make a second finding whether the applicant is eligible for licensure. The ARC shall send written notice of this second finding to the applicant with an explanation of the basis for the finding.
  5. If the ARC again finds the applicant is ineligible for licensure, an applicant who wishes to appeal the second finding of ineligibility shall submit a written request to the Board for a formal administrative hearing under the Administrative Procedure Act, A.R.S. Title 41, Chapter 6, Article 10, within 30 days after the second notice of ineligibility is served. The Board shall either refer the request for a formal administrative hearing to the Office of Administrative Hearings or schedule the formal administrative hearing before the Board. If a formal administrative hearing is not requested within 30 days, the ARC shall recommend to the Board that licensure be denied and the applicant's file be closed with no recourse to appeal.
  6. If the formal administrative hearing is held before the Office of Administrative Hearings, the Board shall review the findings of fact, conclusions of law, and recommendation and issue an order either to grant or deny licensure.
  7. If the formal administrative hearing is held before the Board, the Board shall issue the findings of fact and conclusions of law and shall issue an order either to grant or deny licensure.
  8. The Board shall send the applicant a copy of the final findings of fact, conclusions of law, and order. An applicant who is denied licensure following a formal administrative hearing is required to exhaust the applicant's administrative remedies as described in R4-6-1002 before seeking judicial review of the Board's final administrative decision.
- C.** If the Board receives a complaint against an applicant while the applicant is under review for licensure, the Board shall review the complaint in accordance with the procedures in R4-6-1001. The Board shall not take final action on an application while a complaint is pending against the applicant.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-902. Appeal Process for Licensure Renewal Ineligibility**

- A.** A licensee who applies for licensure renewal may be found ineligible because of failure to meet licensure renewal requirements.
- B.** If the Board finds an applicant for licensure renewal is ineligible because of failure to meet licensure renewal requirements:
1. The Board shall send a written notice of the finding of ineligibility to the licensee with an explanation of the basis for the finding.
  2. A licensee who wishes to appeal the finding of ineligibility for licensure renewal shall submit a written request for

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an informal review meeting to the Board within 30 days after the notice of ineligibility is served. If an informal review meeting is not requested within the time provided, the Board shall deny licensure renewal and close the licensee's file with no recourse to appeal.

3. If a request for an informal review meeting is received within the 30 days provided under subsection (B)(2), the Board shall schedule the informal review meeting and provide at least 30-days' notice to the licensee. At the informal review meeting, the Board shall allow the licensee to present additional information regarding the licensee's qualifications for renewal.
4. When the informal review meeting is complete, the Board shall make a second finding whether the licensee meets renewal requirements. The Board shall send written notice of this second finding to the licensee with an explanation of the basis for the finding.
5. If the Board again finds the licensee is ineligible for licensure renewal, a licensee who wishes to appeal the second finding of ineligibility shall submit a written request to the Board for a formal administrative hearing under the Administrative Procedure Act, A.R.S. Title 41, Chapter 6, Article 10, within 30 days after the second notice of ineligibility is served. The Board shall either refer the request for a formal administrative hearing to the Office of Administrative Hearings or schedule the formal administrative hearing before the Board. If a formal administrative hearing is not requested within 30 days, the Board shall deny licensure renewal and close the licensee's file with no recourse to appeal.
6. If the formal administrative hearing is held before the Office of Administrative Hearings, the Board shall review the findings of fact, conclusions of law, and recommendation and issue an order either to grant or deny licensure renewal.
7. If the formal administrative hearing is held before the Board, the Board shall issue the findings of fact and conclusions of law and issue an order either to grant or deny licensure renewal.
8. The Board shall send the licensee a copy of the final findings of fact, conclusions of law, and order. A licensee who is denied licensure renewal following a formal administrative hearing is required to exhaust the licensee's administrative remedies as described in R4-6-1002 before seeking judicial review of the Board's final administrative decision.

#### Historical Note

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

### ARTICLE 10. DISCIPLINARY PROCESS

#### R4-6-1001. Disciplinary Process

- A. If the Board receives a written complaint alleging a licensee is or may be incompetent, guilty of unprofessional practice, or mentally or physically unable to engage in the practice of behavioral health safely, the Board shall send written notice of the complaint to the licensee and require the licensee to submit a written response within 30 days from the date of service of the written notice of the complaint.
- B. The Board shall conduct all disciplinary proceedings according to A.R.S. §§ 32-3281 and 3282 and Title 41, Chapter 6, Article 10.

- C. As provided under A.R.S. § 32-3282(B), a licensee who is the subject of a complaint, or the licensee's designated representative, may review the complaint investigative file at the Board office at least five business days before the meeting at which the Board is scheduled to consider the complaint. The Board may redact confidential information before making the investigative file available to the licensee.
- D. If the Board determines that disciplinary action is appropriate, the Board shall consider factors including, but not limited to, the following when determining the appropriate discipline:
  1. Prior disciplinary offenses;
  2. Dishonest or self-serving motive;
  3. Pattern of misconduct; multiple offenses;
  4. Bad faith obstruction of the disciplinary proceeding by intentionally failing to comply with rules or orders of the Board;
  5. Submission of false evidence, false statements, or other deceptive practices during the investigative or disciplinary process;
  6. Refusal to acknowledge wrongful nature of conduct; and
  7. Vulnerability of the victim.

#### Historical Note

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

#### R4-6-1002. Review or Rehearing of a Board Decision

- A. The Board shall provide for a rehearing or review of its decisions under A.R.S. Title 41, Chapter 6, Article 10 and the rules established by the Office of Administrative Hearings.
- B. Except as provided in subsection (I), a party is required to file a motion for rehearing or review of a Board decision to exhaust the party's administrative remedies. A party that has exhausted the party's administrative remedies may apply for judicial review of the final order issued by the Board in accordance with A.R.S. § 12-901 et seq.
- C. When a motion for rehearing or review is based on affidavits, the affidavits shall be served with the motion. An opposing party may, within 15 days after service, serve opposing affidavits.
- D. A party may amend a motion for rehearing or review at any time before the Board rules on the motion.
- E. An aggrieved party may seek a review or rehearing of a Board decision by submitting a written request for a review or rehearing to the Board within 30 days after service of the decision. The request shall specify the grounds for a review or rehearing. The Board shall grant a request for a review or rehearing for any of the following reasons materially affecting the rights of an aggrieved party:
  1. Irregularity in the administrative proceedings or any abuse of discretion that deprived the aggrieved party of a fair hearing;
  2. Misconduct of the Board, its staff, an administrative law judge, or any party;
  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 penalties;
  6. Decision, findings of fact, or conclusions not justified by the evidence or contrary to law; or

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7. Errors regarding the admission or rejection of evidence or errors of law that occurred at the hearing or during the progress of the proceedings.
- F.** The Board may affirm or modify the decision or grant a rehearing to any party on all or part of the issues for any of the reasons listed in subsection (E). An order modifying a decision or granting a rehearing shall specify with particularity the grounds for the order. The rehearing, if granted, shall be limited to the matters specified by the Board.
- G.** No later than 30 days after a decision is rendered, the Board may order a rehearing or review on its own initiative, for any reason it might have granted relief on motion of a party.
- H.** If the Board grants a request for rehearing, the Board shall hold the rehearing within 60 days after the date on the order granting the rehearing.
- I.** If the Board makes a specific finding that a particular decision needs to be effective immediately to preserve the public health, safety, or welfare, and that a rehearing or review of the decision is impracticable, unnecessary, or contrary to the public interest, the Board may issue the decision as a final order without an opportunity for a rehearing or review.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**ARTICLE 11. STANDARDS OF PRACTICE****R4-6-1101. Consent for Treatment**

A licensee shall:

1. Provide treatment to a client only in the context of a professional relationship based on informed consent for treatment;
2. Document in writing for each client the following elements of informed consent for treatment:
  - a. Purpose of treatment;
  - b. General procedures to be used in treatment, including benefits, limitations, and potential risks;
  - c. The client's right to have the client's records and all information regarding the client kept confidential and an explanation of the limitations on confidentiality;
  - d. Notification of the licensee's supervision or involvement with a treatment team of professionals;
  - e. Methods for the client to obtain information about the client's records;
  - f. The client's right to participate in treatment decisions and in the development and periodic review and revision of the client's treatment plan;
  - g. The client's right to refuse any recommended treatment or to withdraw consent to treatment and to be advised of the consequences of refusal or withdrawal; and
  - h. The client's right to be informed of all fees that the client is required to pay and the licensee's refund and collection policies and procedures; and
3. Obtain a dated and signed informed consent for treatment from a client or the client's legal representative before providing treatment to the client and when a change occurs in an element listed in subsection (2) that might affect the client's consent for treatment; and
4. Obtain a dated and signed informed consent for treatment from a client or the client's legal representative before audio or video taping the client or permitting a third party to observe treatment provided to the client.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-1102. Treatment Plan**

A licensee shall:

1. Work jointly with each client or the client's legal representative to prepare an integrated, individualized, written treatment plan, based on the licensee's provisional or principal diagnosis and assessment of behavior and the treatment needs, abilities, resources, and circumstances of the client, that includes:
  - a. One or more treatment goals;
  - b. One or more treatment methods;
  - c. The date when the client's treatment plan will be reviewed;
  - d. If a discharge date has been determined, the after-care needed;
  - e. The dated signature of the client or the client's legal representative; and
  - f. The dated signature of the licensee;
2. Review and reassess the treatment plan:
  - a. According to the review date specified in the treatment plan as required under subsection (1)(c); and
  - b. At least annually with the client or the client's legal representative to ensure the continued viability and effectiveness of the treatment plan and, where appropriate, add a description of the services the client may need after terminating treatment with the licensee;
3. Ensure that all treatment plan revisions include the dated signature of the client or the client's legal representative and the licensee;
4. Upon written request, provide a client or the client's legal representative an explanation of all aspects of the client's condition and treatment; and
5. Ensure that a client's treatment is in accordance with the client's treatment plan.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-1103. Client Record**

- A.** A licensee shall ensure that a client record is maintained for each client and:
1. Is protected at all times from loss, damage, or alteration;
  2. Is confidential;
  3. Is legible and recorded in ink or electronically recorded;
  4. Contains entries that are dated and include the printed name and signature or electronic signature of the individual making the entry;
  5. Is current and accurate;
  6. Contains original documents and original signature, initials, or authentication; and
  7. Is disposed of in a manner that protects client confidentiality.
- B.** A licensee shall ensure that a client record contains the following, if applicable:
1. The client's name, address, and telephone number;
  2. Information or records provided by or obtained from another person regarding the client;

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3. Written authorization to release the client's record or information;
  4. Progress notes;
  5. Informed consent to treatment;
  6. Contemporaneous documentation of:
    - a. Treatment plan and all revisions to the treatment plan;
    - b. Requests for client records and resolution of the requests;
    - c. Release of any information in the client record;
    - d. Contact with the client or another individual that relates to the client's health, safety, welfare, or treatment; and
    - e. Behavioral health services provided to the client;
  7. Other information or documentation required by state or federal law.
  8. Financial records, including:
    - a. Records of financial arrangements for the cost of providing behavioral health services;
    - b. Measures that will be taken for nonpayment of the cost of behavioral health services provided by the licensee.
- C.** A licensee shall make client records in the licensee's possession promptly available to another health professional and the client or the client's legal representative in accordance with A.R.S. § 12-2293.
- D.** A licensee shall make client records of a minor client in the licensee's possession promptly available to the minor client's parent in accordance with A.R.S. § 25-403.06.
- E.** A licensee shall retain records in accordance with A.R.S. § 12-2297.
- F.** A licensee shall ensure the safety and confidentiality of any client records the licensee creates, maintains, transfers, or destroys whether the records are written, taped, computerized, or stored in any other medium.
- G.** A licensee shall ensure that a client's privacy and the confidentiality of information provided by the client is maintained by subordinates, including employees, supervisees, clerical assistants, and volunteers.
- H.** A licensee shall ensure that each progress note includes the following:
  1. The date a behavioral health service was provided;
  2. The time spent providing the behavioral health service;
  3. If counseling services were provided, whether the counseling was individual, couples, family, or group; and
  4. The dated signature of the licensee who provided the behavioral health service.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-1104. Financial and Billing Records**

A licensee shall:

1. Make financial arrangements with a client or the client's legal representative, third-party payer, or supervisee that are reasonably understandable and conform to accepted billing practices;
2. Before entering a therapeutic relationship, clearly explain to a client or the client's legal representative, all financial arrangements related to professional services, including the use of collection agencies or legal measures for nonpayment;

3. Truthfully represent financial and billing facts to a client or the client's legal representative, third-party payer, or supervisee regarding services rendered; and
4. Maintain billing records, separate from clinical documentation, which correspond with the client record.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-1105. Confidentiality**

- A.** A licensee shall release or disclose client records or any information regarding a client only:
  1. In accordance with applicable federal or state law that authorizes release or disclosure; or
  2. With written authorization from the client or the client's legal representative.
- B.** A licensee shall ensure that written authorization for release of client records or any information regarding a client is obtained before a client record or any information regarding a client is released or disclosed unless otherwise allowed by state or federal law.
- C.** Written authorization includes:
  1. The name of the person disclosing the client record or information;
  2. The purpose of the disclosure;
  3. The individual, agency, or entity requesting or receiving the record or information;
  4. A description of the client record or information to be released or disclosed;
  5. A statement indicating authorization and understanding that authorization may be revoked at any time;
  6. The date or circumstance when the authorization expires, not to exceed 12 months;
  7. The date the authorization was signed; and
  8. The dated signature of the client or the client's legal representative.
- D.** A licensee shall ensure that any written authorization to release a client record or any information regarding a client is maintained in the client record.
- E.** If a licensee provides behavioral health services to multiple members of a family, each legally competent, participating family member shall independently provide written authorization to release client records regarding the family member. Without authorization from a family member, the licensee shall not disclose the family member's client record or any information obtained from the family member.

**Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 2700, effective July 1, 2004 (Supp. 04-2). Amended by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

**R4-6-1106. Telepractice**

- A.** Except as otherwise provided by statute, an individual who provides counseling, social work, marriage and family therapy, or substance abuse counseling via telepractice to a client located in Arizona shall be licensed by the Board.
- B.** Except as otherwise provided by statute, a licensee who provides counseling, social work, marriage and family therapy, or substance abuse counseling via telepractice to a client located outside Arizona shall comply with not only A.R.S. Title 32,

## Board of Behavioral Health Examiners

Chapter 33, and this Chapter but also the laws and rules of the jurisdiction in which the client is located.

- C. An individual who provides counseling, social work, marriage and family therapy, or substance abuse counseling via telepractice shall:
1. In addition to complying with the requirements in R4-6-1101, document the limitations and risks associated with telepractice, including but not limited to the following:
    - a. Inherent confidentiality risks of electronic communication,
    - b. Potential for technology failure,
    - c. Emergency procedures when the licensee is unavailable, and
    - d. Manner of identifying the client when using electronic communication that does not involve video;
  2. In addition to complying with the requirements in R4-6-1103, include the following in the progress note required under R4-6-1103(H):
    - a. Mode of session, whether interactive audio, video, or electronic communication; and
    - b. Physical location of the client during the session.

**Historical Note**

New Section made by final exempt rulemaking pursuant to Laws 2015, Chapter 154, § 10, at 21 A.A.R. 2630, effective November 1, 2015 (Supp. 15-4).

### 32-3253. Powers and duties

A. The board shall:

1. Adopt rules consistent with and necessary or proper to carry out the purposes of this chapter.
2. Administer and enforce this chapter, rules adopted pursuant to this chapter and orders of the board.
3. Issue a license by examination, endorsement or temporary recognition to, and renew the license of, each person who is qualified to be licensed pursuant to this chapter. The board must issue or deny a license within one hundred eighty days after the applicant submits a completed application.
4. Establish a licensure fee schedule annually, by a formal vote at a regular board meeting.
5. Collect fees and spend monies.
6. Keep a record of all persons licensed pursuant to this chapter, actions taken on all applications for licensure, actions involving renewal, suspension, revocation or denial of a license or probation of licensees and the receipt and disbursal of monies.
7. Adopt an official seal for attestation of licensure and other official papers and documents.
8. Conduct investigations and determine on its own motion if a licensee or an applicant has engaged in unprofessional conduct, is incompetent or is mentally or physically unable to engage in the practice of behavioral health.
9. Conduct disciplinary actions pursuant to this chapter and board rules.
10. Establish and enforce standards or criteria of programs or other mechanisms to ensure the continuing competence of licensees.
11. Establish and enforce compliance with professional standards and rules of conduct for licensees.
12. Engage in a full exchange of information with the licensing and disciplinary boards and professional associations for behavioral health professionals in this state and other jurisdictions.

13. Subject to section 35-149, accept, expend and account for gifts, grants, devises and other contributions, money or property from any public or private source, including the federal government. Monies received under this paragraph shall be deposited, pursuant to sections 35-146 and 35-147, in special funds for the purpose specified, which are exempt from the provisions of section 35-190 relating to lapsing of appropriations.

14. Adopt rules regarding the application for and approval of educational curricula of regionally accredited colleges or universities with a program not otherwise accredited by an organization or entity recognized by the board that are consistent with the requirements of this chapter and maintain a list of those programs. Approvals shall be valid for a period of five years if no changes of curricula are made that are inconsistent with the requirements of this chapter or board rule.

15. Maintain a registry of licensees who have met the educational requirements to provide supervision as required pursuant to this chapter to applicants in the same profession.

16. Adopt rules to allow approval of persons who wish to provide supervision pursuant to this chapter and who are not licensed by the board and who are licensed in a profession other than the profession in which the applicant is seeking licensure.

17. Recognize not more than four hundred hours of psychoeducation for work experience required pursuant to sections 32-3293, 32-3301, 32-3311 and 32-3321.

18. Adopt rules regarding the use of telepractice beginning on November 1, 2015.

B. The board may join professional organizations and associations organized exclusively to promote the improvement of the standards of the practice of behavioral health, protect the health and welfare of the public or assist and facilitate the work of the board.

C. The board may enter into stipulated agreements with a licensee for the confidential treatment, rehabilitation and monitoring of chemical dependency or psychiatric, psychological or behavioral health disorders in a program provided pursuant to subsection D of this section. A licensee who materially fails to comply with a program shall be terminated from the confidential program. Any records of the licensee who is terminated from a confidential program are no longer confidential or exempt from the public records law, notwithstanding any law to the contrary. Stipulated agreements are not public records if the following conditions are met:

1. The licensee voluntarily agrees to participate in the confidential program.
2. The licensee complies with all treatment requirements or recommendations including participation in approved programs.
3. The licensee refrains from professional practice until the return to practice has been approved by the treatment program and the board.
4. The licensee complies with all monitoring requirements of the stipulated agreement, including random bodily fluid testing.
5. The licensee's professional employer is notified of the licensee's chemical dependency or medical, psychiatric, psychological or behavioral health disorders and participation in the confidential program and is provided a copy of the stipulated agreement.

D. The board shall establish a confidential program for the monitoring of licensees who are chemically dependent or who have psychiatric, psychological or behavioral health disorders that may impact their ability to safely practice and who enroll in a rehabilitation program that meets the criteria prescribed by the board. The licensee shall be responsible for the costs associated with rehabilitative services and monitoring. The board may take further action if a licensee refuses to enter into a stipulated agreement or fails to comply with the terms of a stipulated agreement. In order to protect the public health and safety, the confidentiality requirements of this subsection do not apply if a licensee does not comply with the stipulated agreement.

E. The board shall audio record all meetings and maintain all audio and video recordings or stenographic records of interviews and meetings for a period of three years from when the record was created.

## **G-1**

### **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (F-17-0903)**

Title 9, Chapter 31, Article 1, Definitions; Article 2, Scope of Services; Article 3, Eligibility and Enrollment; Article 4, KidsCare II Program; Article 5, General Provisions and Standards; Article 6, RFP and Contract Process; Article 7, Standards for Payments; Article 10, First- and Third-Party Liability and Recoveries; Article 11, Civil Monetary Penalties and Assessments; Article 12, Behavioral Health Services; Article 14, Premiums for a Child Determined Eligible Under Article 3; Article 16, Services for American Indians



**GOVERNOR'S REGULATORY REVIEW COUNCIL  
ANALYSIS OF FIVE-YEAR REVIEW REPORT**

**MEETING DATE:** November 7, 2017

**AGENDA ITEM:** G-1

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

**FROM:** Council Staff

**DATE :** October 24, 2017

**SUBJECT:** **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (F-17-0903)**  
Title 9, Chapter 31, Article 1, Definitions; Article 2, Scope of Services; Article 3, Eligibility and Enrollment; Article 4, KidsCare II Program; Article 5, General Provisions and Standards; Article 6, RFP and Contract Process; Article 7, Standards for Payments; Article 10, First- and Third-Party Liability and Recoveries; Article 11, Civil Monetary Penalties and Assessments; Article 12, Behavioral Health Services; Article 14, Premiums For a Child Determined Eligible Under Article 3; Article 16, Services for American Indians.

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**COMMENTS ON THE FIVE-YEAR-REVIEW REPORT**

**Purpose of the Agency and Number of Rules in the Report**

The Arizona Health Care Cost Containment System Administration (AHCCCS or Administration) is reviewing seventy-two rules in A.A.C. Title 9, Chapter 31, Articles 1-17 regarding the operations and administration of KidsCare, Arizona's version of the State Children's Health Insurance Program (SCHIP) authorized by Title XXI of the Social Security Act.

KidsCare provides comprehensive health care coverage for eligible persons under the age of 19 who do not qualify for Arizona's Medicaid program. Arizona instituted an enrollment freeze during the early part of the decade. On May 17, 2016, Governor Ducey signed SB 1475 (Laws 2016, Chapter 112, Section 3) which restored KidsCare coverage. Applications for KidsCare opened on July 26, 2016 for coverage beginning September 1, 2016. Approximately 21,000 individuals were enrolled in KidsCare on June 1, 2017.

The Administration did not follow through with the proposed course of action in its previous Five Year Review Report due to the enrollment freeze in the KidsCare Program and the significant decline in enrollment.

## **Proposed Action**

The Administration intends to initiate the below changes within 180 days of approval of this report:

- R9-31-106: The Administration intends to make general updates to this rule.
- R9-31-116: The Administration intends to update this rule to also reflect the transition of behavioral health responsibilities from Arizona Department of Health Services (ADHS) to AHCCCS.
- R9-31-201: The Administration intends to clarify this rule to include reference to 42 U.S.C. § 438(6).
- R9-31-210: The Administration intends to update this rule through cross-reference to the applicable regulation in A.A.C. Title 9 Chapter 22 Article 2.
- R9-31-401: The Administration intends to repeal this rule.
- R9-31-701: The Administration intends to remove the definition of “tiered per diem” because it is no longer used to determine reimbursement payment methodologies.
- R9-31-1418: The Administration intends to repeal subsection (D) because no persons currently or in the future satisfy the requirements of this rule. Therefore, the rule has no applicability to the current or future operation of the program.
- R9-31-1420: The Administration intends to update this rule to reduce the lock out period from 90 days to 60 days to conform with the flexibility provided to states in federal regulation 42 CFR § 457.570.

### **1. Has the agency analyzed whether the rules are authorized by statute?**

Yes. The Administration cites to A.R.S. § 36-2986 as general authority to adopt rules pertaining to the Children’s Health Insurance Program. Additionally, A.R.S. § 36-2982 provides authority to adopt rules for the collection of copayments and premiums, disenrollment for failure to pay premiums and for granting hardship exemptions from disenrollment.

### **2. Summary of the agency’s economic impact comparison and identification of stakeholders:**

AHCCCS offers health insurance through KidsCare for eligible children age 19 and under, who are not eligible for other AHCCCS health insurance. In 2010, the KidsCare program was frozen shortly before submission of the prior report, with no new enrollment of members beginning January 2010. This action resulted in a significant decrease in eligible members. Therefore, the economic impact discussed in the previous report is not comparable to the current economic impact.

The Agency previously estimated that approximately 33,000 individuals will be eligible for KidsCare by June 2017 with an increase at an annual average rate of 1.5% thereafter, reflecting underlying population growth. In 2016, the KidsCare Program was reopened as a result of legislative action, and approximately 21,000 individuals were enrolled in KidsCare on June 1, 2017. For FY 2018, AHCCCS requested an increase of approximately \$108 million associated with the reopening of enrollment.

Key stakeholders are AHCCCS, third-party payors, health care institutions, health care providers, and the general public.

**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 has determined that the rules impose the least burden and costs. AHCCCS intends to amend several rules by making clarifications to language. AHCCCS plans to submit this rulemaking in summer 2018.

**4. Has the agency received any written criticisms of the rules over the last five years?**

No. The Administration has not received any written criticisms of these rules in the last five years.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?**

Yes. The Administration indicates that the rules are consistent with other rules and statutes and are mostly understandable, except for the provisions mentioned in the Proposed Course of Action section of this memo. The Administration specifically indicates that:

- R9-31-303: Language in R9-31-303(3) regarding premium requirements is not specific enough.
- R9-31-401: This rule is no longer consistent with state statute because the Kids Care II program has been discontinued.
- R9-31-701: The definition of “tiered per diem” is no longer used to determine reimbursement payment methodologies.
- R9-31-1418: Subsection (D) has no applicability to the present or future operation of the program since there are currently no households that meet all four criteria described in the section.
- R9-31-1420: The Administration intends to update this rule to reduce the lock out period from 90 days to 60 days to conform with the flexibility provided to States in federal regulation 42 CFR § 457.570.

**6. Has the agency analyzed the current enforcement status of the rules?**

Yes. The Administration indicates that the rules are enforced with no issues, outside of the consistency issues mentioned above.

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

No. While federal laws relate to the KidsCare program generally, the Administration indicates that no federal laws directly relate to these rules.

8. **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.

9. **Conclusion**

This report meets the requirements of A.R.S. § 41-1056 and R1-6-301. This analyst recommends approval.

June 28, 2017

Ms. Nicole Ong, Chair  
Governor's Regulatory Review Council  
100 N. 15<sup>th</sup> Ave, Suite 305  
Phoenix, AZ 85007

Dear Ms. Ong:

Pursuant to requirements in R1-6-301, attached is a copy of the 5-Year Review Report for Title 9, Chapter 31. 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 Gina Relkin, Office of Administrative Legal Services at (602) 417-4575.

Sincerely,

Matthew Devlin  
Assistant Director

Attachments

**Arizona Health Care Cost Containment System  
(AHCCCS)**

**5 YEAR REVIEW REPORT**

**A.A.C. Title 9, Chapter 31, Articles 1-17**

June 2017

## **I. General Information about 9 A.A.C. 31, Articles 1-17**

### **Overview:**

The Arizona Health Care Cost Containment System Administration (AHCCCS) serves as the State's Medicaid Agency pursuant to Title XIX of the Social Security Act, also administering a variety of health care-related programs, including KidsCare. Operational since 1998, KidsCare is Arizona's version of the State Children's Health Insurance Program (SCHIP) authorized by Title XXI of the Social Security Act. As with Arizona's Title XIX program, Arizona receives partial reimbursement of administrative and program costs from the federal government for the KidsCare program, and both federal and state laws govern its operation and administration.

KidsCare provides comprehensive health care coverage for eligible persons under the age of 19 years of age who do not qualify for Arizona's Medicaid program. Screening for Title XIX eligibility is part of the KidsCare eligibility determination process. Beneficiaries receive coverage through health plans contracted with the AHCCCS Administration. However, American Indians can elect to receive services through Indian Health Services, 638 tribal facilities, or one of the Contractors. The array of health care services available through KidsCare is the same as that offered for Title XIX members. Both medical and behavioral health services are covered. Except under limited circumstances, parents insuring their children in KidsCare pay a monthly premium depending on household income.

As background for the KidsCare program, the federal government approved the State's Title XXI State Plan in 1997, and services for qualifying children became available in 1998. On March 5, 2010, CMS approved an enrollment freeze for the KidsCare Program with an effective date of January 2010. Arizona instituted the freeze as one of several measures to address the budget crisis during the Great Recession. However, on May 17, 2016, Governor Ducey signed SB 1475, (Laws 2016, Chapter 112, Section 3) which restored KidsCare coverage to children from birth to age 19 with household income up to 200% of the Federal Poverty Limit (FPL). Applications for KidsCare opened on July 26, 2016 for coverage beginning September 1, 2016. Approximately 21,000 individuals were enrolled in KidsCare on June 1, 2017.

The administrative regulations in Title 9 Chapter 31 support the operations and administration of the KidsCare program, and they delineate program requirements. Articles 8, 9, 13, and 17 have been repealed in their entirety.

## **II. Five Year Report on 9 A.A.C. 31 Art. 1-17 rules:**

### **General and specific statutes authorizing the rule:**

A.R.S. § 36-2986 general authority to AHCCCS to adopt rules.

A.R.S. §36-2982 provides authority to adopt rules for collection of copayments and premiums, disenrollment for failure to pay premiums and for granting hardship exemptions from disenrollment.

### **Objective of the rule:**

R9-31-101 – The objective of this rule is to define terms used within all articles in the KidsCare Program.

R9-31-102 – The objective of this rule is to define terms used to specifically describe the scope of services provided to an individual.

R9-31-103 – The objective of this rule is to define terms used to specifically describe the eligibility and enrollment process for an individual.

R9-31-106 – The objective of these rules is to define terms applicable to requests for proposals.

R9-31-116 – The objective of this rule is to define terms used within the section describing services for Native Americans.

R9-31-201 – The objective of this rule is to describe the general requirements applicable to the scope of services provided by AHCCCS.

R9-31-204 - The objective of this rule is to describe the services provided by the AHCCCS Program related to Inpatient General Hospital Services.

R9-31-205 - The objective of this rule is to describe the services provided by the AHCCCS Program related to Attending Physician, Practitioner, and Primary Care Provider Services.

R9-31-206 - The objective of this rule is to describe the services provided by the AHCCCS Program related to Organ and Tissue Transplantation Services.

R9-31-207 - The objective of this rule is to describe the services provided by the AHCCCS Program related to Dental Services.

R9-31-208 - The objective of this rule is to describe the services provided by the AHCCCS Program related to Laboratory, Radiology, and Medical Imaging Services.

R9-31-209 - The objective of this rule is to describe the services provided by the AHCCCS Program related to Pharmaceutical Services.

R9-31-210 - The objective of this rule is to describe the services provided by the AHCCCS Program related to Emergency Medical Services.

R9-31-211 – The objective of this rule is to describe the services provided by the AHCCCS Program related to Transportation services.

R9-31-212 - The objective of this rule is to describe the services provided by AHCCCS Program related to Durable Medical Equipment, Orthotic and Prosthetic devices, and Medical Supplies.

R9-31-213 - The objective of this rule is to describe the services provided by the AHCCCS Program related to Health Risk Assessment and Screening Services.

R9-31-215 - The objective of this rule is to describe the services provided by the AHCCCS Program related to Other Medical Professional Services.

R9-31-216 - The objective of this rule is to describe the services provided by the AHCCCS Program related to services provided in a nursing facility (NF), alternative home and community based (HCBS) setting, or HCBS.

R9-31-301 - The objective of this rule is to describe the eligibility and enrollment general requirements necessary to qualify for the KidsCare Program.

R9-31-302 - The objective of this rule is to describe the application requirements necessary to qualify for the KidsCare Program and the waitlist requirements and the timeframes for AHCCCS completing the determination.

R9-31-303 - The objective of this rule is to describe the eligibility criteria that must be met to qualify for the Kids Care Program.

R9-31-304 - The objective of this rule is to describe the income eligibility requirements necessary to qualify for the KidsCare Program.

R9-31-305- The objective of this rule is to describe the verification requirements necessary to qualify for the KidsCare Program.

R9-31-306 - The objective of this rule is to describe the enrollment requirements necessary to qualify for the KidsCare Program.

R9-31-307 - The objective of this rule is to describe the guaranteed enrollment provisions for those who have qualified for the KidsCare Program.

R9-31-308 - The objective of this rule is to describe the changes and redetermination reporting requirements.

R9-31-309 - The objective of this rule is to describe the newborn eligibility.

R9-31-310 - The objective of this rule is to describe the notice requirements for applications and terminations of eligibility.

R9-31-311 – The objective of this rule is to describe the Children’s Rehabilitation Services (CRS) eligibility requirements.

R9-31-401 – The objective of this rule is to describe the KidsCare II Program requirements.

R9-31-501 - The objective of this rule is to describe the definitions applicable to general provisions and standards of the KidsCare Program.

R9-31-502 - The objective of this rule is to describe the pre-existing condition requirements applicable to the KidsCare Program.

R9-31-504 - The objective of this rule is to describe the marketing requirements necessary to advertise enrollment with a contractor for those persons who qualify for the KidsCare Program.

R9-31-509 - The objective of this rule is to describe the transition and coordination of member care requirements for persons who qualify for the KidsCare Program.

R9-31-512 - The objective of this rule is to describe the release of safeguarded information requirements applicable to persons who qualify for the KidsCare Program.

R9-31-518 - The objective of this rule is to describe the information that can be provided to enrolled members who qualify for the KidsCare Program.

R9-31-522 - The objective of this rule is to describe the quality management and utilization management requirements applicable to persons who qualify for the KidsCare Program.

R9-31-601 - The objective of this rule is to describe the general provisions related to contract requirements for the KidsCare Program.

R9-31-602 - The objective of this rule is to describe the request for proposal requirements for the KidsCare Program.

R9-31-603 - The objective of this rule is to describe the contract award process related to the KidsCare Program.

R9-31-604 - The objective of this rule is to describe the contract and proposal protest requirements for the KidsCare Program.

R9-31-605 - The objective of this rule is to describe the waiver of a contractor's subcontract with hospitals for members within the Kids Care Program.

R9-31-606 - The objective of this rule is to describe the contract compliance sanctions applicable to contractors providing services to members of the Kids Care Program.

R9-31-701 - The objective of this rule is to describe the definitions applicable to standards for payment related to the KidsCare Program.

R9-31-701.10 - The objective of this rule is to describe the general requirements applicable to the KidsCare Program.

R9-31-1001 - The objective of this rule is to define terms related to the first-and third-party liability requirements that apply to the KidsCare Program.

R9-31-1002 - The objective of this rule is to describe the general provisions related to first-and third-party liability requirements that apply to the KidsCare Program.

R9-31-1003 -The objective of this rule is to describe the cost avoidance requirements that apply to first-and third-party liability requirements of the KidsCare Program.

R9-31-1004 - The objective of this rule is to describe the member participation requirements that apply to first-and third-party liability requirements of the KidsCare Program.

R9-31-1005 - The objective of this rule is to describe the collection requirements of the first-and third-party liability requirements that apply to the Kids CareProgram.

R9-31-1006 - The objective of this rule is to describe the AHCCCS Monitoring Responsibilities for the first-and third-party liability requirement that apply to the KidsCare Program.

R9-31-1007 - The objective of this rule is to describe the notification and assignment of liens related to first-and third-party liability requirements that apply to the KidsCare Program.

R9-31-1008 - The objective of this rule is to describe the notification information for liens related to first- and third-party liability requirements that apply to the KidsCare Program.

R9-31-1009 - The objective of this rule is to describe the notification of health insurance information related to first-and third-party liability requirements that apply to the KidsCare Program.

R9-31-1101 - The objective of this rule is to provide requirements for imposition of civil penalties and assessments for the KidsCare Program.

R9-31-1201 - The objective of this rule is to provide general requirements related to behavioral health services for the KidsCare Program.

R9-31-1401 - The objective of this rule is to describe the purpose of this article: setting forth premiums for a child determined eligible under Article 3.

R9-31-1402 - The objective of this rule is to describe the premium amount that must be paid for a child determined eligible under Article 3.

R9-31-1404 - The objective of this rule is to describe how a hardship exemption can be obtained for a member who is a child determined eligible under Article 3.

R9-31-1409 - The objective of this rule is to describe the payment due date for the current month of eligibility for a child determined eligible under Article 3.

R9-31-1410 - The objective of this rule is to describe the date payment is considered received with respect to a child determined eligible under Article 3.

R9-31-1411 - The objective of this rule is to describe when a payment is considered past due for a child determined eligible under Article 3.

R9-31-1412 - The objective of this rule is to describe the type of payment that can be made when paying premiums for a child determined eligible under Article 3.

R9-31-1413 - The objective of this rule is to describe the circumstances when the Administration may return a check for a premium payment received for a child determined eligible under Article 3.

R9-31-1414 - The objective of this rule is to describe that a premium payment may be made in advance for a child determined eligible under Article 3.

R9-31-1415 - The objective of this rule is to describe when a premium payment is reimbursable for a child determined eligible under Article 3.

R9-31-1416 - The objective of this rule is to describe how premium payments are allocated first to past due amounts for a child determined eligible under Article 3.

R9-31-1417 - The objective of this rule is to describe how a change in premium amount is processed and applied to the account for a child determined eligible under Article 3.

R9-31-1418 - The objective of this rule is to describe when a child's eligibility could be discontinued due to failure to pay premium for a child determined eligible under Article 3.

R9-31-1419 - The objective of this rule is to describe premium payment responsibility during the appeal and request for hearing process for a child determined eligible under Article 3.

R9-31-1420 - The objective of this rule is to describe the responsibility to pay the past due premium payment before eligibility can be reapproved for a child determined eligible under Article 3.

R9-31-1601 - The objective of this rule is to describe the general requirements applicable to services for American Indians.

**Effectively meets its objectives, including any available data supporting conclusion:**

Except for the provisions mentioned in the Proposed Course of Action section of this report, Articles 1-17 of Chapter 31 meet the objectives listed above.

**Consistent with Statutes, rules, (including Federal, State, Waiver, Policy)**

Except for the provisions mentioned in the Proposed Course of Action section of this report, Articles 1-17 of Chapter 31 are consistent with Federal and State statutes, rules, and state policy and waivers. More specifically, AHCCCS intends to repeal R9-31-401 because it is no longer consistent with state statute since the Kids Care II program has been repealed.

**Is enforced:**

Chapter 31, Articles 1-17 rules are enforced with no issues.

**Clarity, conciseness and understandability of the rule:**

R9-31-303: The Administration intends to clarify language in R9-31-303(3) regarding premium requirements to be more specific.

R9-31-401: The Administration intends to repeal R9-31-401 because the Kids Care II program has been discontinued.

R9-31-701: The Administration intends to remove the definition of “tiered per diem” because it is no longer used to determine reimbursement payment methodologies.

R9-31-1418: The Administration intends to repeal subsection (D) because there are currently no households that meet all four criteria described in the section, and therefore, this rule has no applicability to the present or future operation of the program.

R9-31-1420: The Administration intends to update this rule to reduce the lock out period from 90 days to 60 days to conform with the flexibility provided to States in federal regulation 42 CFR 457.570.

**Had written criticisms in the past five years, including written analyses submitted**

**questioning if the rule is based on valid scientific or reliable principles or methods:**

Written criticisms or written analyses for Chapter 31, Articles 1-17 have not been submitted in the past five years.

**Comparison of estimated economic, small business, and consumer impact.**

In 2010 the KidsCare program was frozen shortly before submission of the prior 5 Year Review Report, with no new enrollment of members beginning January 2010. This action resulted in a significant decrease in eligible members. Less than one year ago, the KidsCare Program was reopened as a result of legislative action. Therefore, the economic impact discussed in the previous 5-year review report is not comparable to the current economic impact. The Agency previously estimated that approximately 33,000 individuals will be eligible for KidsCare by June 2017 with an increase at an annual average rate of 1.5% thereafter, reflecting underlying population growth. For FY 2018, AHCCCS requested an increase of approximately \$108 M associated with the reopening of enrollment.

**Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competitiveness as compared to the competitiveness of businesses in other states:**

No.

**If applicable, has the agency completed the course of action indicated in the agency's previous five-year review:**

Due to the freeze of enrollment in the KidsCare Program that continued for more than five years as well as the significant decline in enrollment resulting from the freeze, the Administration did not complete all recommended courses of action described in the previous 5 year review report. Prior to the reopening of KidsCare for new enrollment, the eligible population had declined considerably from a high of approximately 50,000 members to a few thousand members before reopening the program to new membership in late 2016. Therefore, the continuation of the KidsCare program was unclear in light of the dramatic decrease in membership.

R9-31-101: The recommendation in the previous five-year review to add definitions for "coinsurance", "deductible" and "premium" appears to be misplaced. Coinsurance and deductible are not used in this Chapter, and premium for purposes of KidsCare is defined in Article 14. Pre-existing condition is not defined in Chapter 31 or Chapter 22 so it is recommended that the reference to preexisting condition in R9-31-101 be removed.

R9-31-102: The Administration intends to either revise or remove the definition of "enrollment" as it does not accurately reflect its usage in Article 3. Additionally, the Administration plans to remove the definition of "SSI-MAO" from this section.

R9-31-103: As suggested in the previous five-year review, the Administration believes this rule should be moved to Article 3, for a closer reference to sections related to the definitions described within the Article. The Administration also plans to remove the definition for PSP, because the Premium Sharing Program has been repealed.

R9-31-106: The Administration has not completed the recommended change to move the RFP-related definitions to Title 9 Chapter 22 Article 6.

R9-31-116: The Administration has not completed the recommended change to update the definition to R9-31-101 or R9-22-201

R9-31-201: The Administration has not completed the recommended change regarding clarification of covered services provided to persons residing in institutions for mental diseases under age 22.

R9-31-210: The Administration has not completed the recommended change to clarify Contractor responsibilities for post stabilization services.

R9-31-301: The Administration completed the recommended change with respect to the appropriate citation for the grievance and appeals regulations. Because the Administration has not obtained approval from the federal government to impose the additional eligibility requirement referenced in the prior report, this recommendation will not be implemented.

R9-31-302: The Administration completed the recommended change with final rulemaking at 20 A.A.R. 248, effective January 7, 2014.

R9-31-304: The Administration completed the recommended change with final rulemaking at 20 A.A.R. 248, effective January 7, 2014.

R9-31-310: The Administration updated the cross-reference to Article 8 in final rulemaking at 20 A.A.R. 248, effective January 7, 2014.

R9-31-1201: The Administration completed the recommendation by final rulemaking at 20 A.A.R. 3128, effective January 4, 2015.

R9-31-1202: The Administration completed the recommendation by final rulemaking at 20 A.A.R. 3128, effective January 4, 2015.

R9-31-1204: The Administration completed these recommendations by final rulemaking 20 A.A.R. 3128, effective January 4, 2015.

R9-31-1207: The Administration repealed this section, per previous recommendation, by final rulemaking at 20 A.A.R. 3128, effective January 4, 2015.

R9-31-1413: The change recommended in the previous five-year review has been included in R9-22-1412.

R9-31-1702: The Administration repealed this rule by final rulemaking at 20 A.A.R. 248, effective January 7, 2014.

R9-31-1720: This Administration repealed this rule by final rulemaking at 20 A.A.R. 248, effective January 7, 2014.

**Has there been 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 persons regulated 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.

**A determination after analysis that the rule is not more stringent than a corresponding federal law. Are the rules more stringent than a corresponding federal law? Is there a statutory authority that exceeds the requirements of that federal law?:**

The rule is not more stringent than corresponding federal law.

**Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization?**

Not applicable, the Administration does not issue permits, license or agency authorization for the imposition the definitions section of Chapter 31.

**Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend repeal or make a rule:**

The Administration intends to initiate the below changes within 180 days following GRRC's approval of this 5YRR.

R9-31-106: The Administration intends to update this rule.

R9-31-116-The Administration intends to update this rule to also reflect the transition of behavioral health responsibilities from ADHS to AHCCCS.

R9-31-201-The Administration intends to clarify this rule to include reference to 42 U.S.C. 438(6).

R9-31-210-The Administration intends to update this rule through cross-reference to the applicable regulation in Title 9 Chapter 22 Article 2.

R9-31-401: The Administration intends to repeal this rule.

R9-31-701: The Administration intends to update this rule.

R9-31-1418(D): The Administration intends to repeal this rule because no persons currently or in the future satisfy the requirements of this rule. Therefore, the rule has no applicability to the current or future operation of the program. The Administration intends to repeal this rule.

R9-31-1420: The Administration intends to update this rule to reduce the lock out period from 90 days to 60 days within 180 days of GRRC's approval of this report to conform with the flexibility provided to States in federal regulation 42 CFR 457.570.

## TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM  
CHILDREN’S HEALTH INSURANCE PROGRAM

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

*Editor’s Note: Articles 1 through 13, and Article 16 were adopted under an exemption from the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session. Although exempt from certain provisions of the rulemaking process, AHCCCS submitted a notice of docket opening with the Secretary of State for publication in the Arizona Administrative Register. Exemption from A.R.S. Title 41, Chapter 6 means AHCCCS was not required to submit these rules to the Governor’s Regulatory Review Council for review; they did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and they were not required to hold public hearings on these rules. Because this Chapter contains rules that are exempt from the regular rulemaking process, it is printed on blue paper.*

## ARTICLE 1. DEFINITIONS

*Article 1, consisting of Sections R9-31-101 thru R9-31-116, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).*

## Section

R9-31-101.	Location of Definitions
R9-31-102.	Scope of Services-related Definitions
R9-31-103.	Eligibility and Enrollment Related Definitions
R9-31-104.	Reserved
R9-31-105.	Repealed
R9-31-106.	Request for Proposal (RFP) Related Definitions
R9-31-107.	Repealed
R9-31-108.	Repealed
R9-31-109.	Reserved
R9-31-110.	Repealed
R9-31-111.	Reserved
R9-31-112.	Repealed
R9-31-113.	Repealed
R9-31-114.	Reserved
R9-31-115.	Reserved
R9-31-116.	Services for Native Americans Related Definitions

## ARTICLE 2. SCOPE OF SERVICES

*Article 2, consisting of Sections R9-31-201 thru R9-31-216, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).*

## Section

R9-31-201.	General Requirements
R9-31-202.	Reserved
R9-31-203.	Reserved
R9-31-204.	Inpatient General Hospital Services
R9-31-205.	Attending Physician, Practitioner, and Primary Care Provider Services
R9-31-206.	Organ and Tissue Transplantation Services
R9-31-207.	Dental Services
R9-31-208.	Laboratory, Radiology, and Medical Imaging Services
R9-31-209.	Pharmaceutical Services
R9-31-210.	Emergency Medical Services
R9-31-211.	Transportation Services
R9-31-212.	Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies
R9-31-213.	Health Risk Assessment and Screening Services
R9-31-214.	Reserved
R9-31-215.	Other Medical Professional Services
R9-31-216.	NF, Alternative HCBS Setting, or HCBS

## ARTICLE 3. ELIGIBILITY AND ENROLLMENT

*Article 3, consisting of Sections R9-31-301 thru R9-31-310, adopted effective October 23, 1998, under an exemption from the Arizona Administrative Procedure Act. (Supp. 98-4).*

## Section

R9-31-301.	Expenditure Limit and Enrollment
R9-31-302.	General Requirements
R9-31-303.	Eligibility Criteria
R9-31-304.	Income Eligibility
R9-31-305.	Verification
R9-31-306.	Enrollment
R9-31-307.	Guaranteed Enrollment
R9-31-308.	Changes and Redeterminations
R9-31-309.	Newborn Eligibility
R9-31-310.	Notice Requirements
R9-31-311.	Children’s Rehabilitative Services (CRS) Eligibility Requirements

## ARTICLE 4. KIDSCARE II PROGRAM

*Article 4, consisting of Section R9-31-401, made by exempt rulemaking at 18 A.A.R. 1141, effective May 1, 2012 (Supp. 12-2).*

*Article 4, consisting of Sections R9-31-401 through R9-31-407, repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).*

*Article 4, consisting of Sections R9-31-401 thru R9-31-407, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).*

## Section

R9-31-401.	KidsCare II Program
R9-31-402.	Repealed
R9-31-403.	Repealed
R9-31-404.	Repealed
R9-31-405.	Repealed
R9-31-406.	Repealed
R9-31-407.	Repealed

## ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

*Article 5, consisting of Sections R9-31-501 thru R9-31-529, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).*

## Section

R9-31-501.	General Provisions and Standards – Related Definitions
R9-31-502.	Pre-existing Conditions
R9-31-503.	Repealed
R9-31-504.	Marketing; Prohibition Against Inducements; Misrepresentations; Discrimination; Sanctions
R9-31-505.	Repealed
R9-31-506.	Reserved
R9-31-507.	Repealed
R9-31-508.	Repealed
R9-31-509.	Transition and Coordination of Member Care
R9-31-510.	Repealed
R9-31-511.	Repealed
R9-31-512.	Release of Safeguarded Information

- R9-31-513. Repealed
- R9-31-514. Repealed
- R9-31-515. Reserved
- R9-31-516. Reserved
- R9-31-517. Reserved
- R9-31-518. Information to Enrolled Members
- R9-31-519. Reserved
- R9-31-520. Repealed
- R9-31-521. Repealed
- R9-31-522. Quality Management/Utilization Management (QM/UM) Requirements
- R9-31-523. Repealed
- R9-31-524. Repealed
- R9-31-525. Reserved
- R9-31-526. Reserved
- R9-31-527. Reserved
- R9-31-528. Reserved
- R9-31-529. Reserved

**ARTICLE 6. RFP AND CONTRACT PROCESS**

Article 6, consisting of Section R9-31-601, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

- Section
- R9-31-601. General Provisions
  - R9-31-602. RFP
  - R9-31-603. Contract Award
  - R9-31-604. Contract or Proposal Protests; Appeals
  - R9-31-605. Waiver of Contractor’s Subcontract with Hospitals
  - R9-31-606. Contract Compliance Sanction

**ARTICLE 7. STANDARDS FOR PAYMENTS**

Article 7, consisting of Sections R9-31-701 thru R9-31-717, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

- Section
- R9-31-701. Standards for Payments Related Definitions
  - R9-31-701.10. General Requirements
  - R9-31-702. Repealed
  - R9-31-703. Repealed
  - R9-31-704. Repealed
  - R9-31-705. Repealed
  - R9-31-706. Reserved
  - R9-31-707. Repealed
  - R9-31-708. Reserved
  - R9-31-709. Repealed
  - R9-31-710. Repealed
  - R9-31-711. Repealed
  - R9-31-712. Reserved
  - R9-31-713. Repealed
  - R9-31-714. Repealed
  - R9-31-715. Repealed
  - R9-31-716. Repealed
  - R9-31-717. Repealed
  - R9-31-718. Repealed
  - R9-31-719. Repealed

**ARTICLE 8. REPEALED**

Article 8, consisting of Sections R9-31-801 through R9-31-803 and Exhibit A, repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).

Article 8, consisting of Sections R9-31-801 thru R9-31-804, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

- Section
- R9-31-801. Repealed
  - R9-31-802. Repealed
  - R9-31-803. Repealed
  - R9-31-804. Repealed
  - Exhibit A. Repealed

**ARTICLE 9. REPEALED**

Article 9, consisting of Section R9-31-901, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

- Section
- R9-31-901. Repealed

**ARTICLE 10. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES**

Article 10, consisting of Sections R9-31-1001 and R9-31-1002, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

- Section
- R9-31-1001. Definitions
  - R9-31-1002. General Provisions
  - R9-31-1003. Cost Avoidance
  - R9-31-1004. Member Participation
  - R9-31-1005. Collections
  - R9-31-1006. AHCCCS Monitoring Responsibilities
  - R9-31-1007. Notification for Perfection, Recording, and Assignment of Title XXI Liens
  - R9-31-1008. Notification Information for Liens
  - R9-31-1009. Notification of Health Insurance Information

**ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS**

Article 11, consisting of Sections R9-31-1101 thru R9-31-1104, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

- Section
- R9-31-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims
  - R9-31-1102. Repealed
  - R9-31-1103. Repealed
  - R9-31-1104. Repealed

**ARTICLE 12. BEHAVIORAL HEALTH SERVICES**

Article 12, consisting of Sections R9-31-1201 through R9-31-1207, repealed; new Article 12, consisting of Sections R9-31-1201 through R9-31-1208, adopted by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4).

Article 12, consisting of Sections R9-31-1201 through R9-31-1207, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

- Section
- R9-31-1201. Requirements
  - R9-31-1202. Repealed
  - R9-31-1203. Repealed
  - R9-31-1204. Repealed
  - R9-31-1205. Repealed
  - R9-31-1206. Repealed
  - R9-31-1207. Repealed
  - R9-31-1208. Repealed

**ARTICLE 13. REPEALED**

Article 13, consisting of Sections R9-31-1301 through R9-31-1309, repealed by final rulemaking at 10 A.A.R. 822, effective April

## Arizona Health Care Cost Containment System – Children’s Health Insurance Program

3, 2004. The subject matter of Article 13 is now in 9 A.A.C. 34 (Supp. 04-1).

Article 13, consisting of Sections R9-31-1301 thru R9-31-1309, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

## Section

R9-31-1301. Repealed  
 R9-31-1302. Repealed  
 R9-31-1303. Repealed  
 R9-31-1304. Repealed  
 R9-31-1305. Repealed  
 R9-31-1306. Repealed  
 R9-31-1307. Repealed  
 R9-31-1308. Repealed  
 R9-31-1309. Repealed

#### ARTICLE 14. PREMIUMS FOR A CHILD DETERMINED ELIGIBLE UNDER ARTICLE 3

Article 14, consisting of Sections R9-31-1401 through R9-31-1406, adopted effective September 10, 1999, under an exemption from the Administrative Procedure Act (Supp. 99-3).

## Section

R9-31-1401. Purpose  
 R9-31-1402. Premium Amount for a Member who is a Child Determined Eligible Under Article 3 of this Chapter  
 R9-31-1403. Repealed  
 R9-31-1404. Hardship Exemption for a Member who is a Child Determined Eligible Under Article 3 of This Chapter  
 R9-31-1405. Repealed  
 R9-31-1406. Repealed  
 R9-31-1407. Repealed  
 R9-31-1408. Repealed  
 R9-31-1409. Payment Due Date for Current Month  
 R9-31-1410. Payment Received Date  
 R9-31-1411. Past Due Payment  
 R9-31-1412. Payment Type  
 R9-31-1413. Returned Check  
 R9-31-1414. Payment In Advance  
 R9-31-1415. Reimbursement of a Premium  
 R9-31-1416. Allocation of Payment for an Eligible Member  
 R9-31-1417. Change in Premium Amount  
 R9-31-1418. Discontinuance for Failure to Pay Premium  
 R9-31-1419. Premium Payment During the Appeal and Request for Hearing Process  
 R9-31-1420. Payment of a Premium

#### ARTICLE 15. RESERVED

#### ARTICLE 16. SERVICES FOR AMERICAN INDIANS

Article 16, consisting of Sections R9-31-1601 thru R9-31-1625, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

## Section

R9-31-1601. General Requirements  
 R9-31-1602. Repealed  
 R9-31-1603. Repealed  
 R9-31-1604. Repealed  
 R9-31-1605. Repealed  
 R9-31-1606. Repealed  
 R9-31-1607. Repealed  
 R9-31-1608. Repealed  
 R9-31-1609. Repealed  
 R9-31-1610. Repealed  
 R9-31-1611. Repealed  
 R9-31-1612. Repealed

R9-31-1613. Repealed  
 R9-31-1614. Repealed  
 R9-31-1615. Repealed  
 R9-31-1616. Repealed  
 R9-31-1617. Repealed  
 R9-31-1618. Repealed  
 R9-31-1619. Repealed  
 R9-31-1620. Repealed  
 R9-31-1621. Repealed  
 R9-31-1622. Repealed  
 R9-31-1623. Repealed  
 R9-31-1624. Repealed  
 R9-31-1625. Repealed

#### ARTICLE 17. REPEALED

Article 17, consisting of Sections R9-31-1701 through R9-31-1713 and Sections R9-31-1716 through R9-31-1732, repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

Article 17, consisting of Sections R9-31-1701 through R9-31-1724, made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

## Section

R9-31-1701. Repealed  
 R9-31-1702. Repealed  
 R9-31-1703. Repealed  
 R9-31-1704. Repealed  
 R9-31-1705. Repealed  
 R9-31-1706. Repealed  
 R9-31-1707. Repealed  
 R9-31-1708. Repealed  
 R9-31-1709. Repealed  
 R9-31-1710. Repealed  
 R9-31-1711. Repealed  
 R9-31-1712. Repealed  
 R9-31-1713. Repealed  
 R9-31-1714. Repealed  
 R9-31-1715. Repealed  
 R9-31-1716. Repealed  
 R9-31-1717. Repealed  
 R9-31-1718. Repealed  
 R9-31-1719. Repealed  
 R9-31-1720. Repealed  
 R9-31-1721. Repealed  
 R9-31-1722. Repealed  
 R9-31-1723. Repealed  
 R9-31-1724. Repealed  
 R9-31-1725. Repealed  
 R9-31-1726. Repealed  
 R9-31-1727. Repealed  
 R9-31-1728. Repealed  
 R9-31-1729. Repealed  
 R9-31-1730. Repealed  
 R9-31-1731. Repealed  
 R9-31-1732. Repealed  
 R9-31-1733. Repealed  
 R9-31-1734. Repealed  
 R9-31-1735. Repealed

#### ARTICLE 1. DEFINITIONS

##### R9-31-101. Location of Definitions

A. Location of definitions. Definitions applicable to 9 A.A.C. 31 are found in the following.

Definition	Section or Citation
“ADHS”	R9-22-102

## Arizona Health Care Cost Containment System – Children’s Health Insurance Program

“Administration”	A.R.S. § 36-2901	“Information”	R9-31-103
“Adverse action”	R9-34-102	“Institution for Mental Diseases” or “IMD”	
“Aggregate”	R9-22-701	42 CFR 435.1010 and	R9-22-102
“AHCCCS”	R9-31-101	“Inmate of a public institution”	42 CFR 435.1010
“AHCCCS registered provider”	R9-22-101	“Inpatient hospital services”	R9-31-101
“Ambulance”	A.R.S. § 36-2201	“License” or “licensure”	R9-22-101
“Applicant”	R9-31-101	“Medical record”	R9-22-101
“Application”	R9-31-101	“Medical review”	R9-31-107
“Behavior management service”	R9-31-1201	“Medical services”	R9-22-101
“Behavioral health evaluation”	R9-31-1201	“Medical supplies”	R9-22-102
“Behavioral health medical practitioner”	R9-31-1201	“Member”	A.R.S. § 36-2981
“Behavioral health professional”	R9-31-1201	“Mental disorder”	A.R.S. § 36-501
“Behavioral health service”	R9-31-1201	“Native American”	R9-31-101
“Behavioral health technician”	R9-31-1201	“New hospital”	R9-22-701
“Billed charges”	R9-22-701	“NF” or “nursing facility”	42 U.S.C. 1396r(a)
“Capital costs”	R9-22-701	“NICU”	R9-22-701
“Certified nurse practitioner”	R9-31-102	“Noncontracting provider”	A.R.S. § 36-2981
“Certified psychiatric nurse practitioner”	R9-31-1201	“Occupational therapy”	R9-22-102
“Child”	42 U.S.C. 1397jj	“Offeror”	R9-31-106
“Chronically ill”	A.R.S. § 36-2983	“Operating costs”	R9-22-701
“Clean claim”	A.R.S. § 36-2904	“Outlier”	R9-31-107
“Clinical supervision”	R9-22-102	“Outpatient hospital service”	R9-22-701
“CMDP”	R9-31-103	“Ownership change”	R9-22-701
“Continuous stay”	R9-22-101	“Partial care”	R9-22-1201
“Contract”	R9-22-101	“Peer group”	R9-22-701
“Contractor”	A.R.S. § 36-2901	“Pharmaceutical service”	R9-22-102
“Contract year”	R9-31-101	“Physical therapy”	R9-22-102
“Cost avoid”	R9-22-1201	“Physician”	A.R.S. § 36-2981
“Cost-to-Charge”	R9-22-701	“Post stabilization care services”	42 CFR 438.114
“Covered charges”	R9-31-107	“Practitioner”	R9-22-102
“Covered services”	R9-22-102	“Pre-existing condition”	R9-31-501
“CPT”	R9-22-701	“Prepaid capitated”	A.R.S. § 36-2981
“CRS”	R9-31-103	“Prescription”	R9-22-102
“Date of eligibility posting”	R9-22-701	“Primary care physician”	A.R.S. § 36-2981
“Day”	R9-22-101	“Primary care practitioner”	A.R.S. § 36-2981
“De novo hearing”	42 CFR 431.201	“Primary care provider (PCP)”	R9-22-102
“Dentures” and “Denture services”	R9-22-102	“Primary care provider services”	R9-22-102
“DES”	R9-31-103	“Prior authorization”	R9-22-102
“Determination”	R9-31-103	“Program”	A.R.S. § 36-2981
“Diagnostic services”	R9-22-102	“Proposal”	R9-31-106
“Director”	A.R.S. § 36-2981	“Prospective rates”	R9-22-701
“DME”	R9-22-102	“Provider”	A.R.S. § 36-2931
“DRI inflation factor”	R9-22-701	“Psychiatrist”	A.R.S. § 36-501
“Emergency medical condition”	42 U.S.C. 1396b(v)	“Psychologist”	A.R.S. § 36-501
“Emergency medical services for the non-FES”		“Psychosocial rehabilitation”	R9-22-102
member	R9-22-102	“Qualified alien”	A.R.S. § 36-2903.03
“Encounter”	R9-22-701	“Qualifying plan”	A.R.S. § 36-2981
“Enrollment”	R9-31-103	“Quality management”	R9-22-501
“Experimental services”	R9-22-101	“Radiology”	R9-22-102
“Facility”	R9-22-101	“Rebase”	R9-22-701
“Factor”	R9-22-101	“Redetermination”	R9-31-103
“Federal Poverty Level” or “FPL”	A.R.S. § 36-2981	“Referral”	R9-22-101
“First-party liability”	R9-22-1001	“Regional Behavioral Health Authority” or	
“Grievance”	R9-34-202	“RBHA”	A.R.S. § 36-3401
“Group Health Plan”	42 U.S.C. 1397jj	“Rehabilitation services”	R9-22-102
“GSA”	R9-22-101	“Reinsurance”	R9-22-701
“Head of Household”	R9-31-103	“Remittance advice”	R9-22-701
“Health care practitioner”	R9-31-1201	“RFP”	R9-31-106
“Hearing aid”	R9-22-102	“Respiratory therapy”	R9-22-102
“Home health services”	R9-22-102	“Scope of services”	R9-22-102
“Hospital”	R9-22-101	“Seriously ill”	R9-31-101
“Household income”	R9-31-103	“Service location”	R9-22-101
“ICU”	R9-22-701	“Service site”	R9-22-101
“IGA”	R9-31-116	“SMI” or “Seriously mentally ill”	A.R.S. § 36-550
“IHS”	R9-31-116	“Specialist”	R9-22-102
“IHS” or “Tribal Facility Provider”	R9-31-116	“Speech therapy”	R9-22-102

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“Spouse”	R9-31-103
“SSI-MAO”	R9-31-103
“Stabilize”	42 U.S.C. 1395dd
“Standard of care”	R9-22-101
“Sterilization”	R9-22-102
“Subcontract”	R9-22-101
“Subcontractor”	R9-31-101
“Third-party”	R9-22-1001
“Third-party liability”	R9-22-1001
“Tier”	R9-22-701
“Tiered per diem”	R9-31-107
“TRBHA” or “Tribal Regional Behavioral Health Authority”	R9-31-1201
“Tribal facility”	A.R.S. § 36-2981
“Utilization management”	R9-22-501

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

“ADHS” has the same meaning as in A.A.C. R9-22-102.

“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.

“Applicant” means a person who submits, or whose representative submits, a written, signed, and dated application for Title XXI medical coverage.

“Application” means an official request for Title XXI medical coverage made under this Chapter.

“Contract year” means the period beginning on October 1 and continuing until September 30 of the following year.

“Inpatient hospital services” means medically necessary services that require an inpatient stay in an acute care hospital and that are provided by or under the direction of a physician or other health care practitioner upon referral from a member’s primary care provider.

“Native American” means Indian as specified in 42 CFR 137.10.

“Seriously ill” means a medical or psychiatric condition manifesting itself by acute symptoms that left untreated may result in:

- Death,
- Disability,
- Disfigurement, or
- Dysfunction.

“Subcontractor” means a person, agency, or organization that enters into an agreement with a contractor or subcontractor to provide services.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Amended by

final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 1103, effective May 5, 2007 (Supp. 07-1).

**R9-31-102. Scope of Services-related Definitions**

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

“Certified nurse practitioner” means a registered nurse practitioner as certified by the Arizona Board of Nursing according to A.R.S. Title 32, Ch. 15.

“Psychosocial rehabilitation services” means the same as in R9-22-102.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 13 A.A.R. 1103, effective May 5, 2007 (Supp. 07-1).

**R9-31-103. Eligibility and Enrollment Related Definitions**

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

“CMDP” means Comprehensive Medical and Dental Program.

“CRS” means Children’s Rehabilitative Services.

“DES” means the Department of Economic Security.

“Determination” means the process by which an applicant is approved or denied for coverage.

“Enrollment” means the process by which a person is determined eligible for and enrolled in the program.

“Head of household” means the household member who assumes the responsibility for providing eligibility information for the household unit.

“Household income” means the total gross amount of all money received by or directly deposited into a financial account of a member of the household income group as defined in R9-31-304.

“Information” means the knowledge received or communicated in written or oral form regarding a circumstance or proof of a circumstance.

“PSP” means Premium Sharing Program, established according to A.R.S. § 36-2923.01.

“Redetermination” means the periodic review of a member’s continued Title XXI eligibility.

“Spouse” means the husband or wife of a Title XXI applicant or household member, who has entered into a contract of marriage, recognized as valid by Arizona.

“SSI-MAO” means Supplemental Security Income-Medical Assistance Only.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final

rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-104. Reserved****R9-31-105. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4).

**R9-31-106. Request for Proposal (RFP) Related Definitions**

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

1. “Offeror” means a person or other entity that submits a proposal to the Administration in response to an RFP.
2. “Proposal” means all documents including best and final offers submitted by an offeror in response to a Request for Proposals by the Administration.
3. “RFP” means Request for Proposals including all documents, whether attached or incorporated by reference, which are used by the Administration for soliciting a proposal according to this Article.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3).

**R9-31-107. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-108. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-109. Reserved****R9-31-110. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

**R9-31-111. Reserved****R9-31-112. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended

by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 13 A.A.R. 1103, effective May 5, 2007 (Supp. 07-1).

**R9-31-113. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3).

**R9-31-114. Reserved****R9-31-115. Reserved****R9-31-116. Services for Native Americans Related Definitions**

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

“IGA” means intergovernmental agreement.

“IHS” means Indian Health Service.

“IHS or Tribal Facility Provider” means a person who is authorized by the IHS or Tribal Facility to provide covered services to members and:

Is an AHCCCS registered provider, and

Is certified by the IHS or Tribal Facility as meeting all applicable federal and state requirements.

“TRBHA” means a Tribal Regional Behavioral Health Authority operated by a tribal government through an IGA with ADHS for the provision of behavioral health services to a Native American member residing on reservation.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3).

**ARTICLE 2. SCOPE OF SERVICES****R9-31-201. General Requirements**

- A. The Administration shall administer the Children’s Health Insurance Program under A.R.S. § 36-2982.
- B. Scope of services for American Indian fee-for-service members is under Article 16 of this Chapter.
- C. A contractor or RBHA shall provide behavioral health services under Articles 12 and 16.
- D. 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. The Administration or a contractor may waive the covered services referral requirements of this Article.
  3. Except as authorized by a contractor, a primary care provider, practitioner, or 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.
  4. A contractor shall offer a female member direct access to preventive and routine services from gynecology provid-

ers within the contractor’s network without a referral from a primary care provider.

5. A member may receive behavioral health services as specified in 9 A.A.C. 22, Articles 2 and 12.
  6. A member may receive treatment that is considered the standard of care, or that is approved by the AHCCCS Chief Medical Officer after appropriate input from providers who are considered experts in the field by the professional medical community.
  7. An AHCCCS registered provider shall provide covered services within the provider’s scope of practice.
  8. 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 in R9-31-212.
  9. Medical or behavioral health services are not covered if provided to:
    - a. An inmate of a public institution;
    - b. A person who is a resident of an institution for the treatment of tuberculosis; or
    - c. A person who is in an IMD at the time of application, unless provided under Article 12 of this Chapter.
- E.** The Administration or a contractor may deny payment if a provider fails to obtain prior authorization as specified in this Article and Article 7 of this Chapter for non-emergency services. 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.
- F.** Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition.
- G.** Under A.R.S. § 36-2989, a member shall receive covered services outside of the GSA only if one of the following applies:
1. A member is referred by a primary care provider for medical specialty care out of the contractor’s area. If the member is referred outside of the GSA to receive an authorized medically necessary service, a 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; or
  3. The contractor authorizes placement in a nursing facility located outside of the GSA;
- H.** 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.
- I.** A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.
- J.** The restrictions, limitations, and exclusions in this Article do not apply to a contractor if the contractor elects 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.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 3246, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 3276, effective September 11, 2007 (Supp. 07-3). Amended by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

#### R9-31-202. Reserved

#### R9-31-203. Reserved

#### R9-31-204. Inpatient General Hospital Services

A contractor, fee-for-service provider, or noncontracting provider shall render inpatient general hospital services including:

1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
  - a. Maternity care, including labor, delivery, recovery room, birthing center, and newborn nursery;
  - b. Neonatal intensive care unit (NICU);
  - c. Intensive care unit (ICU);
  - d. Surgery, including surgery room and recovery room;
  - e. Nursery and related services;
  - f. Routine care; and
  - g. Emergency behavioral health services under 9 A.A.C. 31, Article 12.
2. Ancillary services as specified by the Director and included in contract:
  - a. Laboratory services;
  - b. Radiological and medical imaging services;
  - c. Anesthesiology services;
  - d. Rehabilitation services;
  - e. Pharmaceutical services and prescription drugs;
  - f. Respiratory therapy;
  - g. Blood and blood derivatives; and
  - h. Central supply items, appliances, and equipment not ordinarily furnished to all patients which are customarily reimbursed as ancillary services.
3. Providers are not required to obtain prior authorization from the Administration for the following inpatient hospital services:
  - a. Dialysis shunt placement,
  - b. Arteriovenous graft placement for dialysis,
  - c. Angioplasties or thrombectomies of dialysis shunts,
  - d. Angioplasties or thrombectomies of arteriovenous graft for dialysis,
  - e. Hospitalization for vaginal delivery that does not exceed 48 hours,
  - f. Hospitalization for cesarean section delivery that does not exceed 96 hours, and
  - g. Other services identified by the Administration through the Provider Participation Agreement.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

**R9-31-205. Attending Physician, Practitioner, and Primary Care Provider Services**

- A.** A primary care provider 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 or equipment,
  5. Referral to a specialist or other health care professional if medically necessary as specified in A.R.S. § 36-2989,
  6. Patient education,
  7. Home visits if medically necessary,
  8. Covered immunizations, and
  9. Covered preventive health services.
- B.** As specified in A.R.S. § 36-2989, a second opinion procedure may be required to determine coverage for surgery. Under this procedure, documentation must be provided by at least two physicians as to the need for the proposed surgery for the member.
- C.** The following limitations and exclusions apply to 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 are limited to the services or conditions for which the referral is made, or for which authorization is given by the contractor;
  2. A member’s physical examination is not a covered service if the physical examination is to obtain 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 (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. The following services are excluded from AHCCCS coverage:
    - a. Infertility services, reversal of surgically induced infertility (sterilization), and gender reassignment surgery;
    - b. Pregnancy termination counseling services;
    - c. A pregnancy termination, unless authorized under federal law;
    - d. A service or item furnished solely for cosmetic purposes;
    - e. A hysterectomy, unless determined to be medically necessary; and
    - f. Licensed midwife services for prenatal care and home birth.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-206. Organ and Tissue Transplantation Services**

The following organ and tissue transplantation services shall be covered for a member as specified in A.R.S. § 36-2989 if prior authorized and coordinated with a member’s contractor:

1. Kidney transplantation;
2. Simultaneous Kidney/Pancreas transplant;
3. Cornea transplantation;
4. Heart transplantation;
5. Liver transplantation;
6. Autologous and allogeneic bone marrow transplantation;
7. Lung transplantation;
8. Heart-lung transplantation;
9. Other organ transplantation if the transplantation is required by federal law and if other statutory criteria are met; and
10. Immunosuppressant medications, chemotherapy, and other related services.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

**R9-31-207. Dental Services**

Medically necessary dental services are provided for children under age 19 under A.R.S. § 36-2989 and R9-22-213.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-208. Laboratory, Radiology, and Medical Imaging Services**

An AHCCCS-registered provider shall provide laboratory, radiology, and medical imaging services for children under age 19, under A.R.S. § 36-2989 and R9-22-208.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-209. Pharmaceutical Services**

Pharmaceutical services are provided for children under age 19 under R9-22-209.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

**R9-31-210. Emergency Medical Services**

- A.** Emergency medical services shall be provided based on the prudent layperson standard to a member by licensed providers registered with AHCCCS to provide services under A.R.S. § 36-2989.
- B.** The provider of emergency services shall verify eligibility and enrollment status through the Administration to determine the need for notification to a contractor or a RBHA for a member and to determine the party responsible for payment of services rendered.
- C.** Access to an emergency room and emergency medical services shall be available 24 hours per day, seven days per week in

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each contractor’s service area. The use of examining or treatment rooms shall be available when required by a physician or practitioner for the provision of emergency services.

- D. Behavioral Health Evaluation provided by a psychiatrist or psychologist shall be covered as an emergency service, so long as it meets the requirements of 9 A.A.C. 31, Article 12.
- E. Emergency services do not require prior authorization but providers shall comply with the following notification requirements:
  1. Providers and noncontracting providers furnishing emergency services to a member shall notify the member’s contractor within 12 hours of the time the member presents for services;
  2. If a member’s medical condition is determined not to be an emergency medical condition under Article 1 of this Chapter, the provider shall notify the member’s contractor before initiation of treatment and follow the prior authorization requirements and protocol of the contractor regarding treatment of the member’s nonemergent condition. Failure to provide timely notice or comply with prior authorization requirements of the contractor constitutes cause for denial of payment.
- F. A provider and a noncontracting provider shall request authorization from a contractor for post stabilization services. A contractor shall pay for the post stabilization services if:
  1. The service is pre-approved by a contractor, or
  2. A contractor does not respond to an authorization request within the time-frame under 42 CFR 438.114.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3).

**R9-31-211. Transportation Services**

The Administration shall provide transportation services under A.A.C. R9-22-211.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-212. Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies**

As specified in A.R.S. § 36-2989, DME, orthotic and prosthetic devices, and medical supplies, including incontinence briefs, are covered services if provided in compliance with requirements of this Chapter and A.A.C. R9-22-212. For purposes of this Section, where the term “AHCCCS services” is used in R9-22-212, it is replaced with the term “Title XXI services.”

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3276, effective September 11, 2007 (Supp. 07-3).

**R9-31-213. Health Risk Assessment and Screening Services**

- A. As authorized by A.R.S. § 36-2989, the following services shall be covered for a member:
  1. Screening services, including:
    - a. Comprehensive health, behavioral health and developmental histories;
    - b. Comprehensive unclothed physical examination;
    - c. Appropriate immunizations according to age and health history; and
    - d. Health education, including anticipatory guidance.
  2. Vision services including:
    - a. Diagnosis and treatment for defects in vision,
    - b. Eye examinations for the provision of prescriptive lenses, and
    - c. Provision of prescriptive lenses.
  3. Hearing services, including:
    - a. Diagnosis and treatment for defects in hearing,
    - b. Testing to determine hearing impairment, and
    - c. Provision of hearing aids.

- B. All providers of services shall meet the following standards:
  1. Provide services by or under the direction of, the member’s primary care provider or dentist.
  2. Perform tests and examinations as specified in contract and under 42 CFR 441, Subpart B, January 29, 1985, which is incorporated by reference and on file with the Office of the Secretary of State and the Administration. This incorporation by reference contains no future editions or amendments.
  3. Refer members as necessary for dental diagnosis and treatment, and necessary specialty care.
  4. Refer members as necessary for behavioral health evaluation and treatment services as specified in 9 A.A.C. 31, Article 12.
- C. A contractor shall meet the following additional conditions for members:
  1. Provide information to members and their parents or guardians concerning services; and
  2. Notify members and their parents or guardians regarding the initiation of screening and subsequent appointments according to the AHCCCS Administration Periodicity Schedule.
- D. A contractor, primary care provider, attending physician, or practitioner shall refer a member with special health care needs under A.A.C. R9-7-301 to CRS.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

**R9-31-214. Reserved****R9-31-215. 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 setting:
  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, medication, 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; and

- b. Natural family planning education or referral;
  4. Midwifery services provided by a nurse practitioner certified in midwifery;
  5. Podiatry services if ordered by a member’s primary care provider as specified in A.R.S. § 36-2989;
  6. Respiratory therapy;
  7. Ambulatory and outpatient surgery facilities services;
  8. Home health services in A.R.S. § 36-2989;
  9. Private or special duty nursing services;
  10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology provided under this Article;
  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);
  12. Inpatient chemotherapy;
  13. Outpatient chemotherapy; and
  14. Hospice care under R9-22-213.
- B.** Prior authorization from the Administration for a member is required for services listed in subsections (A)(4) through (11) and (14); except for:
1. Dialysis shunt placement,
  2. Arteriovenous graft placement for dialysis,
  3. Angioplasties or thrombectomies of dialysis shunts,
  4. Angioplasties or thrombectomies of arteriovenous grafts for dialysis,
  5. Eye surgery for the treatment of diabetic retinopathy,
  6. Eye surgery for the treatment of glaucoma,
  7. Eye surgery for the treatment of macular degeneration,
  8. Home health visits following an acute hospitalization (limited up to five visits),
  9. 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),
  10. Physical therapy subject to the limitation in subsection A.A.C. R9-22-215(C),
  11. Facility services related to wound debridement,
  12. Apnea management and training for premature babies up to the age of 1, and
  13. Other services identified by the Administration through the Provider Participation Agreement.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

#### R9-31-216. NF, Alternative HCBS Setting, or HCBS

Services provided in a NF, including room and board, alternative HCBS setting, or HCBS shall be covered as specified in A.A.C. R9-22-216.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3276, effective September 11, 2007 (Supp. 07-3).

## ARTICLE 3. ELIGIBILITY AND ENROLLMENT

### R9-31-301. Expenditure Limit and Enrollment

Expenditure limit and enrollment

1. Title XXI will accept enrollees subject to the availability of funds. If the Director determines that monies may be insufficient for the program, the Administration shall stop processing applications for the program as specified in A.R.S. § 36-2985.
2. After the Administration has verified that funding is sufficient, it will resume processing applications as specified in A.R.S. § 36-2985.
3. The Administration shall immediately stop processing all applications and shall provide advance notice to a member that the program will terminate under A.R.S. § 36-2985.
4. A child is not entitled to a hearing under Chapter 34, if the program is suspended or terminated.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

### R9-31-302. General Requirements

- A.** Administration. The Administration or its designee shall administer the program as specified in A.R.S. § 36-2982. The requirements described under Chapter 22, Article 3, except for R9-22-303, R9-22-305(1), R9-22-306(A)(4)(a) and (b), R9-22-306(B)(2)(b) and (c), R9-22-306(B)(3)(c)(iv), (vii) and (xi), R9-22-306(B)(4), R9-22-306(B)(5) and R9-22-307, apply to this Chapter.
- B.** Eligibility determination processing time. When an application is complete, the Administration or its designee shall mail notification to the applicant regarding the eligibility determination no more than 30 days from the date of application except when there is an emergency beyond the Administration’s or its designee’s control.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 9 A.A.R. 5150, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1). Amended by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

### R9-31-303. Eligibility Criteria

Eligibility. To be eligible for the program, an applicant shall meet all the following eligibility requirements in addition to R9-31-302:

1. Age. Is less than 19 years of age. A child’s coverage shall continue through the month in which a child turns age 19 if the child is otherwise eligible;
2. Income. Meets the income requirements in R9-31-304;
3. Cost sharing. Pays the cost sharing premium amount when premiums are required as specified in A.R.S. §§ 36-2982 and 36-2903.01;
4. Other federal program. Is not eligible for Medicaid or other federally operated or financed health care insurance program, except the Indian Health Service as specified in A.R.S. § 36-2983;

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5. Patient in an institution for mental disease. Is not a patient in an institution for mental disease at the time of application, or at the time of redetermination, as specified in A.R.S. § 36-2983;
6. Other health coverage. Is not covered under:
  - a. An employer’s group health insurance plan,
  - b. Family or individual health insurance, or
  - c. Other health insurance;
7. State health benefits. Is not eligible for health benefits coverage under a state health benefit plan based on a family member’s employment with a public agency in the state of Arizona;
8. Prior health insurance coverage. Has not been covered by health insurance during the previous 90 days unless that health insurance was discontinued due to the involuntary loss of employment or other involuntary reason as specified in A.R.S. § 36-2983. The 90 days of ineligibility due to previous insurance coverage shall not apply to a child if:
  - a. Following the loss of eligibility for and enrollment in Medicaid or another insurance affordability program;
  - b. The premium paid by the family for coverage of the child under the group health plan exceeded 5 percent of household income;
  - c. The child’s parent is determined eligible for advance payment of the premium tax credit for enrollment in a QHP through the Exchange because the ESI in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B-2(c)(3)(v);
  - d. The cost of family coverage that includes the child exceeds 9.5 percent of the household income;
  - e. The employer stopped offering coverage of dependents (or any coverage) under an employer-sponsored health insurance plan;
  - f. A change in employment, including involuntary separation, resulted in the child’s loss of employer-sponsored insurance (other than through full payment of the premium by the parent under COBRA);
  - g. The child has special health care needs; or
  - h. The child lost coverage due to the death or divorce of a parent.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by exempt rulemaking at 9 A.A.R. 4560, effective October 1, 2003 (Supp. 03-4). Amended by final rulemaking at 9 A.A.R. 5150, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-304. Income Eligibility**

- A. Income standard. The combined gross income of the household income group members as specified in subsection (C) shall not exceed the percentage of the appropriate FPL under A.R.S. § 36-2981 for the Title XXI household income group size.
- B. Calculating monthly income. The Administration or its designee shall calculate monthly income under R9-22-1423.

- C. The Administration or its designee shall include the income of persons described under R9-22-1420(B).
- D. Income disregards. When determining gross income of the household, the Administration or its designee shall disregard income as described under R9-22-1421(A).
- E. Effective date of initial eligibility.
  1. For an eligibility determination completed by the 25th day of the month, eligibility shall begin on the first day of the month following the determination of eligibility.
  2. For an eligibility determination completed after the 25th day of the month, eligibility shall begin on the first day of the second month following the determination of eligibility.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 9 A.A.R. 5150, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-305. Verification**

Verification. An applicant or a member shall provide the Administration or its designee with verification or authorize the release of verification to the Administration or its designee of all information necessary to complete the determination of eligibility as described under R9-22-304.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-306. Enrollment**

Enrollment requirements applicable to the KidsCare program are described under Chapter 22, Article 17.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-307. Guaranteed Enrollment**

- A. Guaranteed Enrollment. A child who is determined eligible for Title XXI shall be guaranteed a one-time, 12-month period of continuous coverage unless a child:
  1. Attains age 19,
  2. Is no longer a resident of the state,
  3. Is an inmate of a public institution,
  4. Is determined to have been ineligible at the time of approval,
  5. Obtains private or group health coverage,
  6. Is adopted and the new household does not meet the qualifications of this program,
  7. Is a patient in an institution for mental diseases,
  8. Has whereabouts that are unknown, or
  9. Has a head of household who:
    - a. Does not pay cost sharing premium amount when premiums are required as specified in A.R.S. §§ 36-

2982 and 36-2903.01 and as specified in this Chapter,

- b. Voluntarily withdraws from the program, or
  - c. Fails to cooperate in meeting the requirements of the program.
- B.** The 12-month guaranteed period shall begin with the month an applicant is initially enrolled.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by exempt rulemaking at 9 A.A.R. 4560, effective October 1, 2003 (Supp. 03-4).

**R9-31-308. Changes and Redeterminations**

- A.** Reporting Changes. A member or a member's parent or guardian shall report the following changes to the Administration or its designee:
- 1. Any increase in income that will begin or continue into the following month,
  - 2. Any change of address,
  - 3. The addition or departure of a household member,
  - 4. Any health coverage under private or group health insurance,
  - 5. Employment of a member or a parent with a state agency,
  - 6. Incarceration of a member, and
  - 7. Any other changes that may impact eligibility or premiums.
- B.** Verification. If required verification is needed and requested as a result of a change specified in subsection (A) of this Section to determine the impact on eligibility or premiums and is not received within 10 days, the Administration or its designee shall send a notice to discontinue eligibility for a member unless a member is within the guaranteed enrollment period as specified in R9-31-307.
- C.** Redeterminations. The renewal eligibility requirements described under R9-22-306 for a KidsCare program member shall be followed.
- D.** Termination. The termination notice requirements as described under R9-22-307 for a KidsCare program member shall be followed.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-309. Newborn Eligibility**

- A.** Eligibility. A child born to a Title XXI member, is eligible for 12 months of coverage without filing an application under Title XXI provided:
- 1. The child continues to live with the child's mother during the 12-month period; and
  - 2. One of the events as specified in R9-31-307(A) does not occur.
- B.** Deemed Coverage. A newborn's deemed newborn coverage shall begin effective with a newborn's date of birth and end with the last day of the month in which a newborn turns age 1. Deemed newborn status does not preclude a child from being approved for Title XIX.

- C.** Enrollment choice for a newborn. A newborn shall be enrolled with a mother's enrollment choice as specified in contract.
- D.** Notification of enrollment. The Administration or its designee shall notify a mother of a newborn's enrollment and provide a mother an opportunity to select an enrollment choice as specified in Chapter 22, Article 17.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-310. Notice Requirements**

Notice Requirements. The notice requirements as described in R9-22-312 apply to this Chapter.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-311. Children’s Rehabilitative Services (CRS) Eligibility Requirements**

Beginning October 1, 2013, an enrolled KidsCare member who is determined to need active treatment for one or more of the qualifying medical condition(s) in R9-22-1303 shall be enrolled with the CRS contractor as described under Chapter 22, Article 13.

**Historical Note**

New Section R9-31-311 made by final rulemaking at 19 A.A.R. 2965, effective November 10, 2013 (Supp. 13-3).

**ARTICLE 4. KIDSCARE II PROGRAM**

**R9-31-401. KidsCare II Program**

- A.** Subject to CMS approval and the availability of funding under the special terms and conditions of the 1115 Waiver, the Administration shall establish the KidsCare II program.
- B.** Subject to the availability of funding, the following children are potentially eligible under this Section notwithstanding the closure of new enrollment under Article 3 on December 21, 2009, due to a lack of available funding:
- 1. Children with household income at or below 175% of FPL, who are discontinued for eligibility under 9 A.A.C. 22, Article 14, effective on or after May 1, 2012, due to age.
  - 2. Children with household income at or below 175% of FPL, whose application for assistance was denied or discontinued as ineligible under 9 A.A.C. 22 on or after December 21, 2009, but who were determined potentially eligible for KidsCare as of the date of that denial or discontinuance and whose eligibility for KidsCare was not determined because the Administration stopped processing applications due to insufficient funding pursuant to R9-31-301(C).
  - 3. Children not described in subsection (B)(2) with household income at or below 175% of FPL.
- C.** Beginning on or before May 1, 2012, the Administration shall send notice of potential eligibility under this Section to as many households with children described in subsection (B)(2) as is estimated by the Administration as likely to result in the

return of a sufficient number of applications to increase enrollment under this Section to the extent of available funding under this Section.

- D.** Notice of potential eligibility:
1. Children who were placed on the waiting list established under R9-31-302(F) on an earlier date shall receive notice before children placed on the waiting list on a later date.
  2. Notwithstanding subsection (D)(1), all children in the household will receive notice and be determined for eligibility based on the child in the household with the earliest applicable date.
  3. Households shall have 30 days to return an application to the Department.
  4. If notices that are initially sent under subsection (C) do not result in sufficient applications to enroll as many children as allowed by available funding, the Administration shall send out additional notices as described in subsection (C).
- E.** The Department shall review all applications for a determination of eligibility under 9 A.A.C. 22. If the Department determines that a child is not eligible under 9 A.A.C. 22 but has income at or below 175% of FPL and meets all other eligibility criteria under R9-31-303, the Department shall refer the application to the Administration.
- F.** The Administration shall accept the Department’s determinations regarding eligibility criteria without requiring the household to submit a new application under this Section or to reverify information verified by the Department.
- G.** Upon referral of an application from the Department, the Administration shall:
1. Determine whether the application referred by the Department was from a household with a child described in subsection (B)(1) or from a household that received a notice under subsection (D) that submitted an application to the Department within 30 days of the Administration’s request for a new application;
  2. Process applications for children described in subsection (B)(3) beginning June 25, 2012;
  3. Determine whether the household has any unpaid premiums as described in R9-31-1420 and, if so, the Administration shall require the household to pay the past due premium within 20 days from notification as a condition of determining a child eligible under this Section;
  4. Enroll children under this Section based on the date that the Administration determines the child eligible; and
  5. Stop processing applications and determining eligibility under this Section once the Administration has enrolled the maximum number of children consistent with funding made available under this Section.
- H.** Effective date of initial enrollment.
1. For an eligibility determination completed by the 25th day of the month, enrollment shall begin on the first day of the month following the determination of eligibility.
  2. For an eligibility determination completed after the 25th day of the month, enrollment shall begin on the first day of the second month following the determination of eligibility.
- I.** Any child who is not determined eligible under subsection (G) shall remain on the waiting list described in R9-31-302(F).
- J.** Eligibility for children under this Section ends on December 31, 2013.
- K.** Except as otherwise provided by this Section, eligibility shall be determined in accordance with the provisions of this Chapter.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1). New Section made by exempt rulemaking at 18 A.A.R. 1141, effective May 1, 2012 (Supp. 12-2). Amended by exempt rulemaking at 18 A.A.R. 1975, effective August 1, 2012 (Supp. 12-3).

#### R9-31-402. Repealed

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

#### R9-31-403. Repealed

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

#### R9-31-404. Repealed

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

#### R9-31-405. Repealed

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

#### R9-31-406. Repealed

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

#### R9-31-407. Repealed

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

### ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

#### R9-31-501. General Provisions and Standards – Related Definitions

Definitions. In this Chapter, unless the context explicitly requires another meaning terms are defined in R9-31-101 or cross-referenced to the location of the definition.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4408, effective January 3, 2009 (Supp. 08-4).

**R9-31-502. Pre-existing Conditions**

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

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4). Error to Section heading corrected to reflect amendment made at 11 A.A.R. 4295 (Supp. 08-3). Amended by final rulemaking at 14 A.A.R. 4408, effective January 3, 2009 (Supp. 08-4).

**R9-31-503. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Section repealed by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3).

**R9-31-504. Marketing; Prohibition Against Inducements; Misrepresentations; Discrimination; Sanctions**

A contractor or any person or entity acting as the contractor’s marketing representative shall follow the requirements in A.A.C. R9-22-504.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4).

**R9-31-505. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4).

**R9-31-506. Reserved****R9-31-507. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4).

**R9-31-508. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4).

**R9-31-509. Transition and Coordination of Member Care**

The Administration or a contractor shall conduct transition and coordination of member care as described in A.A.C. R9-22-509.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4).

**R9-31-510. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4).

**R9-31-511. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4).

**R9-31-512. Release of Safeguarded Information**

The Administration, a contractor, provider, and noncontracting provider shall meet the requirements specified in A.A.C. R9-22-512 regarding release of safeguarded information for an applicant or member.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4).

**R9-31-513. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4).

**R9-31-514. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section

repealed by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4).

**R9-31-515. Reserved****R9-31-516. Reserved****R9-31-517. Reserved****R9-31-518. Information to Enrolled Members**

A contractor shall provide information to enrolled members as described under R9-22-518.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4).

**R9-31-519. Reserved****R9-31-520. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4).

**R9-31-521. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4).

**R9-31-522. Quality Management/Utilization Management (QM/UM) Requirements**

A contractor shall comply with Quality Management/Utilization Management (QM/UM) requirements as described under A.A.C. R9-22-522.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4).

**R9-31-523. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4).

**R9-31-524. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 11 A.A.R. 4295, effective December 5, 2005 (Supp. 05-4).

**R9-31-525. Reserved****R9-31-526. Reserved****R9-31-527. Reserved****R9-31-528. Reserved****R9-31-529. Reserved****ARTICLE 6. RFP AND CONTRACT PROCESS****R9-31-601. General Provisions**

- A.** The Director has full operational authority to adopt rules and to use the appropriate rules for contract administration and oversight of contractors under A.R.S. § 36-2986. The Administration shall administer the program under A.R.S. § 36 - 2982.
- B.** The Administration shall award contracts under A.R.S. § 36-2986 to provide services under A.R.S. § 36-2989.
- C.** The Administration shall follow the provisions under 9 A.A.C. 22, Article 6 for members, unless otherwise specified in this Chapter.
- D.** The Administration is exempt from the procurement code under A.R.S. § 36-2988 and § 41-2501.
- E.** The Administration and contractors shall retain all contract records for five years under A.R.S. § 36-2986 and dispose of the records under A.R.S. § 41-2550.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-602. RFP**

The RFP for a contractor serving members who qualify for the program shall be under A.R.S. § 36-2986 and A.A.C. R9-22-602.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-603. Contract Award**

The contract award shall be under A.R.S. § 36-2986 and A.A.C. R9-22-603.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-604. Contract or Proposal Protests; Appeals**

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

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-605. Waiver of Contractor’s Subcontract with Hospitals**

A waiver of a contractor’s subcontract with a hospital shall be under A.A.C. R9-22-605.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**R9-31-606. Contract Compliance Sanction**

The Administration shall follow sanction provisions under A.A.C. R9-22-606.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

**ARTICLE 7. STANDARDS FOR PAYMENTS****R9-31-701. Standards for Payments Related Definitions**

Definitions. The words and phrases in this Article have the following meanings unless the context explicitly requires another meaning:

“Covered charges” means billed charges that represent medically necessary, reasonable, and customary items of expense for Title XXI-covered services that meet medical review criteria of the Administration or contractor.

“Medical review” means a review involving clinical judgment of a claim or a request for a service before or after it is paid or rendered to ensure that the services provided to the member are medically necessary and covered services and that the provider obtains required authorizations. The criteria for medical review are established by the contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

“Outlier” means a hospital claim or encounter in which the Title XXI inpatient hospital days of care have operating costs per day that meet the criteria in A.A.C. R9-22-712.

“Tiered per diem” means a payment structure in which payment is made on a per-day basis depending upon the tier into which the Title XXI inpatient hospital day of care is assigned.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1). Section repealed; new Section made by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-701.10. General Requirements**

The following Sections of A.A.C. Chapter 22, Articles 2 and 7 are applicable to reimbursement for AHCCCS-covered services provided to a member under the KidsCare program, except that the term “Children’s Health Insurance Program Fund” shall be substituted for “AHCCCS fund” and “A.R.S. § 36-2986” shall be substituted for “A.R.S. § 36-2903:”

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 and Payments by Contractors, R9-22-703 and R9-22-705;
4. Payments for Newborns, R9-22-707;
5. Contractor’s Liability to Hospitals for the Provision of Emergency and Post-stabilization Care, R9-22-709;
6. Payments for Non-hospital Services, R9-22-710;
7. Copayments, R9-22-711;
8. Specialty Contracts, R9-22-712(G)(3), R9-22-712.01(10) and Article 2;
9. Overpayment and Recovery of Indebtedness, R9-22-713;
10. Payments to Providers, R9-22-714;
11. Hospital Rate Negotiations, R9-22-715;
12. Contractor Performance Measure Outcomes, R9-22-719; and
13. Reinsurance, R9-22-720.

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-702. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 3246, effective October 1, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-703. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-704. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-705. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 11 A.A.R. 3171, effective October 1, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-706. Reserved****R9-31-707. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-708. Reserved****R9-31-709. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

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**R9-31-710. Repealed****Historical Note**

New Section made by final rulemaking at 11 A.A.R. 3854, effective November 12, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-711. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3). Amended by exempt rulemaking at 9 A.A.R. 4560, effective October 1, 2003 (Supp. 03-4). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-712. Reserved****R9-31-713. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-714. Repealed****Historical Note**

New Section made by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-715. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 11 A.A.R. 3171, effective October 1, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-716. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-717. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Section repealed by final

rulemaking at 11 A.A.R. 3171, effective October 1, 2005 (Supp. 05-3).

**R9-31-718. Repealed****Historical Note**

New Section made by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-719. Repealed****Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**ARTICLE 8. REPEALED**

*Article 8, consisting of Sections R9-31-801 through R9-31-803 and Exhibit A, repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).*

**R9-31-801. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-802. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-803. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-804. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3).

**Exhibit A. Repealed****Historical Note**

New Exhibit adopted by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Exhibit

repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

#### **ARTICLE 9. REPEALED**

##### **R9-31-901. Repealed**

###### **Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 12 A.A.R. 4494, effective January 6, 2007 (Supp. 06-4).

#### **ARTICLE 10. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES**

##### **R9-31-1001. Definitions**

The definitions in A.R.S. § 36-2981, A.A.C. R9-22-1001, and A.A.C. R9-31-101 apply to this Article.

###### **Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

##### **R9-31-1002. General Provisions**

AHCCCS is the payor of last resort unless specifically prohibited by applicable state or federal law.

###### **Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

##### **R9-31-1003. Cost Avoidance**

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

1. Replace the reference to “Article 2,” with 9 A.A.C. 31, Article 2; and
2. This Section applies to Title XXI covered services.

###### **Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

##### **R9-31-1004. Member Participation**

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

###### **Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

##### **R9-31-1005. Collections**

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

1. Replace the reference to “Article 2,” with 9 A.A.C. 31, Article 2;
2. This Section applies to Title XXI fee-for-service and reinsurance payments.

###### **Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

##### **R9-31-1006. AHCCCS Monitoring Responsibilities**

With the exception of long-term care insurance, the provisions in A.A.C. R9-22-1006 apply to this Section.

###### **Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

##### **R9-31-1007. Notification for Perfection, Recording, and Assignment of Title XXI liens**

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

###### **Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

##### **R9-31-1008. Notification Information for Liens**

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

###### **Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

##### **R9-31-1009. Notification of Health Insurance Information**

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

###### **Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

#### **ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS**

##### **R9-31-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims**

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

###### **Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 10 A.A.R. 3067, effective September 11, 2004 (Supp. 04-3).

##### **R9-31-1102. Repealed**

###### **Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 10 A.A.R. 3067, effective September 11, 2004 (Supp. 04-3).

##### **R9-31-1103. Repealed**

###### **Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 10 A.A.R. 3067, effective September 11, 2004 (Supp. 04-3).

##### **R9-31-1104. Repealed**

###### **Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 10 A.A.R. 3067, effective September 11, 2004 (Supp. 04-3).

#### **ARTICLE 12. BEHAVIORAL HEALTH SERVICES**

##### **R9-31-1201. Requirements**

The requirements, services and definitions under Chapter 22, Article 2 and Article 12 apply to behavioral health services provided under this Article.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 1103, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3128, effective January 4, 2015 (Supp. 14-4).

**R9-31-1202. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 1103, effective May 5, 2007 (Supp. 07-1). Section repealed by final rulemaking at 20 A.A.R. 3128, effective January 4, 2015 (Supp. 14-4).

**R9-31-1203. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 1103, effective May 5, 2007 (Supp. 07-1). Section repealed by final rulemaking at 20 A.A.R. 3128, effective January 4, 2015 (Supp. 14-4).

**R9-31-1204. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 1103, effective May 5, 2007 (Supp. 07-1). Section repealed by final rulemaking at 20 A.A.R. 3128, effective January 4, 2015 (Supp. 14-4).

**R9-31-1205. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 13 A.A.R. 1103, effective May 5, 2007 (Supp. 07-1). Section repealed by final rulemaking at 20 A.A.R. 3128, effective January 4, 2015 (Supp. 14-4).

**R9-31-1206. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 1103, effective May 5, 2007 (Supp. 07-1). Section repealed by final rulemaking at 20 A.A.R. 3128, effective January 4, 2015 (Supp. 14-4).

**R9-31-1207. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed; new Section adopted by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 13 A.A.R. 1103, effective May 5, 2007 (Supp. 07-1). Section repealed by final rulemaking at 20 A.A.R. 3128, effective January 4, 2015 (Supp. 14-4).

**R9-31-1208. Repealed****Historical Note**

New Section adopted by exempt rulemaking at 6 A.A.R. 282, effective December 16, 1999 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 13 A.A.R. 1103, effective May 5, 2007 (Supp. 07-1).

**ARTICLE 13. REPEALED**

*Article 13, consisting of Sections R9-31-1301 through R9-31-1309, repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004. The subject matter of Article 13 is now in 9 A.A.C. 34 (Supp. 04-1).*

**R9-31-1301. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-1302. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-1303. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August

4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-1304. Repealed**

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-1305. Repealed**

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-1306. Repealed**

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-1307. Repealed**

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-1308. Repealed**

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**R9-31-1309. Repealed**

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 6 A.A.R. 3205, effective August 4, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

**ARTICLE 14. PREMIUMS FOR A CHILD DETERMINED ELIGIBLE UNDER ARTICLE 3**

**R9-31-1401. Purpose**

This Article contains the requirements for the payment of a premium for a child determined eligible under Article 3 of this Chapter to the Administration by a member and the processing of a premium by the Administration.

**Historical Note**

New Section adopted by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Section repealed; new Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4).

**R9-31-1402. Premium Amount for a Member who is a Child Determined Eligible Under Article 3 of this Chapter**

- A. For the purposes of this Article, a premium is a monthly amount that an enrolled member pays to the Administration to remain eligible for Title XXI.
- B. When the household income is greater than the income limit described under R9-22-1427(D) and less than or equal to 150 percent of the FPL, the monthly premium is \$10 for one eligible child and \$15 for two or more eligible children.
- C. When household income is greater than 150 percent of the FPL and less than or equal to 175 percent of the FPL, the monthly premium payment is \$40 for one eligible child and \$60 for two or more eligible children.
- D. When household income is greater than 175 percent of the FPL and less than or equal to 200 percent of the FPL, the monthly premium is \$50 for one eligible child and \$70 for two or more eligible children.
- E. A household’s premium payments as specified in this Section shall not exceed five percent of a household’s gross income.
- F. A member’s newborn is enrolled immediately upon the Administration receiving notification of the child’s birth. Upon enrollment, the household’s premium is redetermined.
- G. To remain eligible, the premium amount shall be paid according to this Article.
- H. American Indians are exempt from paying premiums.

**Historical Note**

New Section adopted by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 9 A.A.R. 4560, effective October 1, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 504, effective February 1, 2004 (Supp. 04-1). Amended by exempt rulemaking at 10 A.A.R. 2887, effective July 1, 2004 (Supp. 04-2). Amended by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Amended by exempt rulemaking at 12 A.A.R. 4900, effective January 1, 2007 (Supp. 06-4). Amended by exempt rulemaking at 15 A.A.R. 876, effective June 1, 2009 (Supp. 09-2). Amended by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1403. Repealed**

**Historical Note**

New Section adopted by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1404. Hardship Exemption for a Member who is a Child Determined Eligible Under Article 3 of This Chapter**

- A. Definitions. The following definitions apply to this Section:
  1. “Major expense” means the expense is more than 10 percent of the household’s countable income under R9-31-304.

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2. “Medically necessary” has the same meaning as defined in A.A.C. R9-22-101.
- B. Hardship exemption.** The Administration shall provide information to the head of household regarding the request for a hardship exemption. The Administration shall grant a hardship exemption from the disenrollment requirements under A.R.S. § 36-2982 for a household who:
1. Is no longer able to pay the premium due to one of the hardship criteria in subsection (C), and
  2. Submits a written request for a hardship exemption and provides all necessary written information at the time of request.
- C. Hardship criteria.** To be eligible for a hardship exemption, a household shall have:
1. Medically necessary expenses or health insurance premiums that:
    - a. Are not covered under Medicaid or other insurance, and
    - b. Exceed 10 percent of the household’s countable income under R9-31-304;
  2. Unanticipated major expense, related to maintaining a residence for the household or transportation for work;
  3. A combination of medically necessary expenses under subsection (C)(1) and unanticipated major expenses under subsection (C)(2) that exceed 10 percent of the household’s countable income under R9-31-304; or
  4. Experienced the death of a household member during the month the premium was not paid.
- D. Written hardship exemption request.** The Administration shall not consider a hardship exemption unless the Administration receives the written request and information under subsection (C) by the due date specified in the Administration’s notice that explains the undue hardship exemption requirements.
- E. Notification.** The Administration shall notify the head of household of the approval or denial of the request for exemption and discontinuance under R9-31-310, no later than 10 days from the date the Administration received the request.
- F. Appeal and Request for hearing.** The head of household may appeal and request a hearing concerning the discontinuance and denial of the hardship exemption.

**Historical Note**

New Section adopted by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Former Section R9-31-1404 renumbered to R9-31-1405; new Section R9-31-1404 made by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4).

**R9-31-1405. Repealed****Historical Note**

New Section adopted by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Former Section R9-31-1405 renumbered to R9-31-1406; new Section R9-31-1405 renumbered from R9-31-1404 and amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1406. Repealed****Historical Note**

New Section adopted by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Former

Section R9-31-1406 renumbered to R9-31-1407; new Section R9-31-1406 renumbered from R9-31-1405 and amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1407. Repealed****Historical Note**

Renumbered from R9-31-1406 and amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1408. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Section repealed by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4).

**R9-31-1409. Payment Due Date for Current Month**

The monthly premium payment is due on the 15th day of the month for coverage of that month. This would be considered a current payment.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4).

**R9-31-1410. Payment Received Date**

A payment is considered received on the date that the Administration receives and credits the payment to the member’s account.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1411. Past Due Payment**

- A. Past due payment date. A payment is considered past due if the Administration receives the payment after the 15th day of the month.
- B. Payment not received. If payment for a month is not received in full by the last working day of the month in which the payment is due, the Administration shall include the past and current due amounts in the next billing statement.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4).

**R9-31-1412. Payment Type**

A premium shall be paid to the Administration by a:

1. Cashier’s check,
2. Personal check,
3. Money order,
4. Electronic debit, or
5. Other form approved by the Administration.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4).

**R9-31-1413. Returned Check**

The Administration shall not accept a personal check when the premium has been previously paid with a personal check that was returned to the Administration because of insufficient funds.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1414. Payment In Advance**

A premium may be paid in advance.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

**R9-31-1415. Reimbursement of a Premium**

- A. A premium paid in advance is nonrefundable, unless the member is disenrolled at least 15 days prior to the month of coverage.
- B. A premium paid during an appeal and request for hearing process is applied as specified in R9-31-1419.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 9 A.A.R. 4560, effective October 1, 2003 (Supp. 03-4). Amended by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4).

**R9-31-1416. Allocation of Payment for an Eligible Member**

Except for payments specified in R9-31-1419 of this Article, all payments received for eligible members shall first be applied to any past due amounts for prior months owed to the Administration for a child determined eligible under Article 3 of this Chapter. Any remaining amounts shall then be applied to the amount due for the current month for a child eligible under Article 3 of this Chapter.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Amended by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1417. Change in Premium Amount**

- A. When there is a decrease in the premium amount and the change is processed by the 25th day of the month, then the effective date of the change shall begin on first day following the month in which the amount of the premium change is processed.
- B. When there is a decrease in the premium amount and the change is processed after the 25th day of the month, then the effective date of the change shall begin on the first day of the second month in which the amount of the premium change is processed.
- C. When there is an increase in the premium amount, the effective date of the change shall begin with the first month following advance notice of at least ten days.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4).

**R9-31-1418. Discontinuance for Failure to Pay Premium**

- A. Discontinuance notice. The Administration shall send an adverse action notice to discontinue eligibility if the Administration does not receive the past and current due premium

amounts by the 15th day of the current month. The Administration shall follow the discontinuance notice requirements under R9-31-310(B).

- B. Discontinuance rescinded. The Administration shall rescind the discontinuance and continue eligibility if the past due amount for at least one prior month is received by the Administration in full before the effective date of the discontinuance.
- C. Discontinuance of eligibility. Except as provided in R9-31-1419, the Administration shall discontinue eligibility on the effective date of the discontinuance if the past due amount for at least one prior month is not received by the Administration in full before the effective date of the discontinuance.
- D. Notwithstanding subsection (A), the Administration shall not discontinue eligibility for the enrolled members of the household until the Administration has not received, by the 15th day of the month in which the Administration sends the adverse action notice, premium amounts due for the past two months and the current month for persons who:
  1. Have been continuously eligible since June 2004,
  2. Were required to pay a premium under R9-31-1402(B) for the month of July 2004,
  3. Were required to pay any premium under R9-31-1402 for the month of August 2004, and
  4. As of August 31, 2004, had not paid the premiums required for July 2004 and August 2004.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 10 A.A.R. 3895, effective August 30, 2004 (Supp. 04-3). Amended by exempt rulemaking at 10 A.A.R. 4268, effective October 1, 2004 (Supp. 04-3). Amended by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4).

**R9-31-1419. Premium Payment During the Appeal and Request for Hearing Process**

- A. Discontinuance of eligibility. To receive coverage from the time an appeal and request for hearing is filed for a discontinuance of eligibility until a Director’s decision is made.
  1. A member shall:
    - a. File an appeal and request for hearing prior to the effective date of the discontinuance.
    - b. Submit the full monthly premium amount to the Administration prior to the date of the discontinuance, and
    - c. Continue to pay the full monthly premium amount each month during the hearing process.
  2. Failure of the member to pay the full premium shall result in the loss of eligibility effective the first of the next month.
  3. If the decision is upheld, the Administration shall not refund any premium amounts that have been paid during the hearing process.
- B. Increase in premium amount. To stop the Administration from increasing the premium amount from the time an appeal and request for hearing is filed until a Director’s decision is made.
  1. A member shall file an appeal and request for hearing prior to the effective date of the action. The member shall pay the lower premium amount until the decision is made.
  2. If the decision to increase the premium is upheld, the member shall be responsible for paying the higher premium retroactively from the proposed effective date of the increase in the premium amount that is being appealed.

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- C. Imposition of a premium. To receive coverage from the time an appeal and request for hearing is filed for an imposition of a premium until a Director’s decision is made.
1. A member shall file an appeal and request for hearing in accordance with the time-frame as specified in R9-34-107.
  2. A member shall pay the premium as billed by the Administration.
  3. If the decision determines the imposition of the premium is incorrect then the premium will be refunded to the member.
- D. Method of payment. To continue coverage a member shall pay the premium by:
1. Cashier’s check,
  2. Money order, or
  3. Other form approved by the Administration.

**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4).

**R9-31-1420. Payment of a Premium**

When a member was discontinued with an unpaid premium, the parent or other responsible person shall pay the past due premium amounts for a child to the Administration or the child will remain ineligible for 90 days before the person can attain eligibility again.

**Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Amended by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**ARTICLE 15. RESERVED****ARTICLE 16. SERVICES FOR AMERICAN INDIANS****R9-31-1601. General Requirements**

- A. An American Indian who is a member may receive:
1. Covered acute care services specified in this Chapter from:
    - a. Indian Health Service (IHS) under A.R.S. § 36-2982 if IHS has a signed agreement with the Administration,
    - b. A Tribal Facility under A.R.S. § 36-2982,
    - c. A contractor under A.R.S. § 36-2901, or
    - d. An AHCCCS registered provider.
  2. Covered behavioral health care services as specified in this Chapter from:
    - a. IHS under A.R.S. § 36-2982 if IHS has a signed agreement with the Administration,
    - b. A Tribal Facility under A.R.S. § 36-2982, or
    - c. A RBHA or TRBHA.
- B. IHS, a Tribal facility, or a referred provider shall meet the requirements in this Chapter and A.A.C. Chapter 22, Articles 2 and 7 to receive reimbursement for AHCCCS-covered services. Title 9 A.A.C. 22, Articles 2 and 7 are applicable to reimbursement for AHCCCS-covered services provided to an American Indian member under the KidsCare program, except that the term “IHS,” “Tribal facility,” or “referred provider” is substituted for “provider.”

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking

at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

**R9-31-1602. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

**R9-31-1603. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

**R9-31-1604. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Subsection labeling in subsection (A) amended to correct manifest typographical error (Supp. 01-3). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

**R9-31-1605. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

**R9-31-1606. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

**R9-31-1607. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

**R9-31-1608. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

**R9-31-1609. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

**R9-31-1610. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

**R9-31-1611. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3276, effective September 11, 2007 (Supp. 07-3). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

**R9-31-1612. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

**R9-31-1613. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

**R9-31-1614. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 4195, effective November 6, 2007 (Supp. 07-4). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

**R9-31-1615. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section

repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

**R9-31-1616. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 10 A.A.R. 4660, effective January 1, 2005 (04-4). Amended by final rulemaking at 11 A.A.R. 3854, effective November 12, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-1617. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-1618. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-1619. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 11 A.A.R. 3171, effective October 1, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-1620. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 3246, effective October 1, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-1621. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-1622. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

**R9-31-1623. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Section repealed by final rulemaking at 8 A.A.R. 3350, effective July 15, 2002 (Supp. 02-3).

**R9-31-1624. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

**R9-31-1625. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

**ARTICLE 17. REPEALED**

*Article 17, consisting of Sections R9-31-1701 through R9-31-1713 and Sections R9-31-1716 through R9-31-1732, repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).*

*Article 17, consisting of Sections R9-31-1701 through R9-31-1724, made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).*

**R9-31-1701. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Amended by exempt rulemaking at 12 A.A.R. 4900, effective January 1, 2007 (Supp. 06-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1702. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 5150, effective January 3, 2004 (Supp. 03-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1703. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1704. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Amended by exempt rulemaking at 12 A.A.R. 4900, effective January 1, 2007 (Supp. 06-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1705. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1706. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1707. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1708. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1709. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1710. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1711. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1712. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1713. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1714. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Section repealed by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4).

**R9-31-1715. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 9 A.A.R. 730, effective March 1, 2003 (Supp. 03-1). Section repealed by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4).

**R9-31-1716. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1717. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1718. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1719. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1720. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Repealed

by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1721. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1722. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1723. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1724. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Amended by exempt rulemaking at 12 A.A.R. 4900, effective January 1, 2007 (Supp. 06-4). Amended by exempt rulemaking at 15 A.A.R. 876, effective June 1, 2009 (Supp. 09-2). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1725. Repealed****Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1726. Repealed****Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1727. Repealed****Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1728. Repealed****Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

## Arizona Health Care Cost Containment System – Children’s Health Insurance Program

**R9-31-1729. Repealed****Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1730. Repealed****Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1731. Repealed****Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1732. Repealed****Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Repealed by

final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1733. Repealed****Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1734. Repealed****Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

**R9-31-1735. Repealed****Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4). Repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

36-2982. Children's health insurance program; administration; nonentitlement; enrollment; eligibility

A. The children's health insurance program is established for children who are eligible pursuant to section 36-2981, paragraph 6. The administration shall administer the program. All covered services shall be provided by health plans that have contracts with the administration pursuant to section 36-2906, by a qualifying plan or by either tribal facilities or the Indian health service for Native Americans who are eligible for the program and who elect to receive services through the Indian health service or a tribal facility.

B. This article does not create a legal entitlement for any applicant or member who is eligible for the program.

C. The director shall take all steps necessary to implement the administrative structure for the program and to begin delivering services to persons within sixty days after approval of the state plan by the United States department of health and human services.

D. The administration shall perform eligibility determinations for persons applying for eligibility and annual redeterminations for continued eligibility pursuant to this article.

E. The administration shall adopt rules for the collection of copayments from members whose income does not exceed one hundred fifty percent of the federal poverty level and for the collection of copayments and premiums from members whose income exceeds one hundred fifty percent of the federal poverty level. The director shall adopt rules for disenrolling a member if the member does not pay the premium required pursuant to this section. The director shall adopt rules to prescribe the circumstances under which the administration shall grant a hardship exemption to the disenrollment requirements of this subsection for a member who is no longer able to pay the premium.

F. Before enrollment, a member, or if the member is a minor, that member's parent or legal guardian, shall select an available health plan in the member's geographic service area or a qualifying health plan offered in the county, and may select a primary care physician or primary care practitioner from among the available physicians and practitioners participating with the contractor in which the member is enrolled. The contractors shall only reimburse costs of services or related services provided by or under referral from a primary care physician or primary care practitioner participating in the contract in which the member is enrolled, except for emergency services that shall be reimbursed pursuant to section 36-2987. The director shall establish requirements as to the minimum time period that a member is assigned to specific contractors.

G. Eligibility for the program is creditable coverage as defined in section 20-1379.

H. Notwithstanding section 36-2983, the administration may purchase for a member employer-sponsored group health insurance with state and federal monies available pursuant to this article, subject to any restrictions imposed by the centers for medicare and medicaid services. This subsection does not apply to members who are eligible for health benefits coverage under a state health benefits plan based on a family member's employment with a public agency in this state.

36-2986. Administration: powers and duties of director

A. The director has full operational authority to adopt rules or to use the appropriate rules adopted for article 1 of this chapter to implement this article, including any of the following:

1. Contract administration and oversight of contractors.
2. Development of a complete system of accounts and controls for the program, including provisions designed to ensure that covered health and medical services provided through the system are not used unnecessarily or unreasonably, including inpatient behavioral health services provided in a hospital.
3. Establishment of peer review and utilization review functions for all contractors.
4. Development and management of a contractor payment system.
5. Establishment and management of a comprehensive system for assuring quality of care.
6. Establishment and management of a system to prevent fraud by members, contractors and health care providers.
7. Development of an outreach program. The administration shall coordinate with public and private entities to provide outreach services for children under this article. Priority shall be given to those families who are moving off welfare. Outreach activities shall include strategies to inform communities, including tribal communities, about the program, ensure a wide distribution of applications and provide training for other entities to assist with the application process.
8. Coordination of benefits provided under this article for any member. The director 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 director may require members to assign to the administration rights to all types of medical benefits to which the person is entitled, including first party medical benefits under automobile insurance policies. The state has a right of subrogation against any other person or firm to enforce the assignment of medical benefits. The provisions of this paragraph are controlling over the provisions of any insurance policy that provides benefits to a member if the policy is inconsistent with this paragraph.
9. Development and management of an eligibility, enrollment and redetermination system including a process for quality control.
10. Establishment and maintenance of an encounter claims system that ensures that ninety percent of the clean claims are paid within thirty days after receipt and ninety-nine percent of the remaining clean claims are paid within ninety days after receipt by the administration or contractor unless an alternative payment schedule is agreed to by the contractor and the provider. For the purposes of this paragraph, "clean claims" has the same meaning prescribed in section 36-2904, subsection G.
11. Establishment of standards for the coordination of medical care and member transfers.
12. Requiring contractors to submit encounter data in a form specified by the director.

13. Assessing civil penalties for improper billing as prescribed in section 36-2903.01, subsection K.

B. Notwithstanding any other law, if Congress amends title XXI of the social security act and the administration is required to make conforming changes to rules adopted pursuant to this article, the administration shall request a hearing with the joint health committee of reference for review of the proposed rule changes.

C. The director may subcontract distinct administrative functions to one or more persons who may be contractors within the system.

D. 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 administration and that these records be maintained by the contractor for five years. The director shall also require that these records are available by a contractor on request of the secretary of the United States department of health and human services.

E. 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 this information may be used or released, including requirements for physician-patient confidentiality. Notwithstanding any other law, these rules shall be designed to provide for the exchange of necessary information for the purposes of eligibility determination under this article. Notwithstanding any other law, a member's medical record shall be released without the member's consent in situations of suspected cases of fraud or abuse relating to the system to an officer of this state's certified Arizona health care cost containment system fraud control unit who has submitted a written request for the medical record.

F. The director shall provide for the transition of members between contractors and noncontracting providers and the transfer of members who have been determined eligible from hospitals that do not have contracts to care for these persons.

G. To the extent that services are furnished pursuant to this article, a contractor is not subject to title 20 unless the contractor is a qualifying plan and has elected to provide services pursuant to this article.

H. As a condition of a contract, the director shall require contract terms that are necessary to ensure adequate performance by the contractor. Contract provisions required by the director include 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 who have posted other security, equal to or greater than that required by the administration, with a state agency for the performance of health service contracts if monies would be available from that security for the system on default by the contractor.

I. The director shall establish solvency requirements in contract that may include withholding or forfeiture of payments to be made to a contractor by the administration for the failure of the contractor to comply with a provision of the contract with the administration. 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 to accomplish the orderly transition of members to other 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 providing 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.

J. For the sole purpose of matters concerning and directly related to this article, the administration is exempt from section 41-192.

K. The director may withhold payments to a noncontracting provider if the noncontracting provider does not comply with this article or adopted rules that relate to the specific services rendered and billed to the administration.

L. The director shall:

1. Prescribe uniform forms to be used by all contractors and furnish uniform forms and procedures, including methods of identification of members. The rules shall include requirements that an applicant personally complete or assist in the completion of eligibility application forms, except in situations in which the person has a disability.

2. By rule, establish a grievance and appeal procedure that conforms with the process and the time frames specified in article 1 of this chapter. If the program is suspended pursuant to section 36-2985, an applicant or member is not entitled to contest the denial, suspension or termination of eligibility for the program.

3. Apply for and accept federal monies available under title XXI of the social security act. Available state monies appropriated to the administration for the operation of the program shall be used as matching monies to secure federal monies pursuant to this subsection.

M. The administration is entitled to all rights provided to the administration for liens and release of claims as specified in sections 36-2915 and 36-2916 and shall coordinate benefits pursuant to section 36-2903, subsection F and be a payor of last resort for persons who are eligible pursuant to this article.

N. The director shall follow the same procedures for review committees, immunity and confidentiality that are prescribed in article 1 of this chapter.

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (F-17-1001)**  
Title 9, Chapter 22, Article 6, RFP and Contract Process



**GOVERNOR'S REGULATORY REVIEW COUNCIL  
ANALYSIS OF FIVE-YEAR REVIEW REPORT**

**MEETING DATE:** November 7, 2017

**AGENDA ITEM:** G-2

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

**FROM:** Council Staff

**DATE :** October 24, 2017

**SUBJECT: ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (F-17-1001)**  
Title 9, Chapter 22, Article 6, RFP and Contract Process

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**COMMENTS ON THE FIVE-YEAR-REVIEW REPORT**

**Purpose of the Agency and Number of Rules in the Report**

The purpose of the Arizona Health Care Cost Containment System (AHCCCS) is "to promote a comprehensive health care system to eligible citizens of this state." Laws 2013, 1st S.S., Ch. 10, § 53. This system is managed by the Director of the AHCCCS Administration (Administration), which is established under A.R.S. § 36-2902(A). The Director has the powers and duties prescribed in A.R.S. §§ 36-2903 and 2903.01.

This five-year-review report covers six rules in A.A.C. Title 9, Chapter 22, Article 6. As of July 2017, AHCCCS provides, directly or through contracts, health care coverage for approximately 2 million Arizonans. The rules in article 6 govern the Request for Proposal (RFP) process, specifically with regards to the methods the Administration may employ to procure contracts with health care organizations to provide health care services to qualified candidates. These rules relate to the Medicaid program administered through AHCCCS.

In the previous five-year-review report, approved by the Council in 2012, the Administration proposed action on sections 601, 604, 605, and 606. The Administration complied with the plan and amended the rules by final rulemaking in November 2012. The remaining two rules, sections 602 and 603, were last amended in 2002.

**Proposed Action**

The Administration does not propose a course of action, as no issues have been identified with the rules.

**1. Has the agency analyzed whether the rules are authorized by statute?**

Yes. The Administration cites to A.R.S. § 36-2903.01(F) as general authority for the rules. Under A.R.S. § 36-2903.01(F), in relevant part, “[i]n addition to the rules otherwise specified in this article [Arizona Health Care Cost Containment System], the [Administration] may adopt necessary rules pursuant to [T]itle 41, [C]hapter 6 to carry out this article.”

The Administration cites to A.R.S. § 36-2906 as specific authority for the Administration to adopt rules regarding the request for proposal process as specified in A.R.S. § 36-2904.

**2. Summary of the agency’s economic impact comparison and identification of stakeholders:**

Key stakeholders that are impacted by these rules are the Administration, health care-service providers and the general public. Currently, approximately 1.7 million Arizonans are enrolled in one of several managed care entities under contract with AHCCCS.

The Administration believes that the economic impact has generally been as predicted in the prior EIS for the rules.

**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?**

Yes. The Administration indicates that the rules as written impose the least burden and cost to the regulated community.

**4. Has the agency received any written criticisms of the rules over the last five years?**

No. The Administration indicates that it has not received any written criticisms of the rules during the last five years.

**5. Has the agency analyzed the rules’ clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?**

Yes. The Administration indicates that the rules are clear, concise, and understandable, are consistent with other rules and statutes, and are effective in achieving their objectives.

**6. Has the agency analyzed the current enforcement status of the rules?**

Yes. The Administration indicates that the rules are enforced as written.

**7. 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 Administration indicates that the rules are not more stringent than federal law.

**8. 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?**

No. The rules do not require issuance of a permit, license, or agency authorization.

**9. Conclusion**

The Administration has not identified any issues with the rules. Hence, there is no proposed course of action. The report meets the requirements of A.R.S. § 41-1056 and R1-6-301. Staff recommends that the report be approved.

July 25, 2017

Ms. Nicole Ong, Chair  
Governor's Regulatory Review Council  
100 N. 15<sup>th</sup> Ave, Suite 305  
Phoenix, AZ 85007

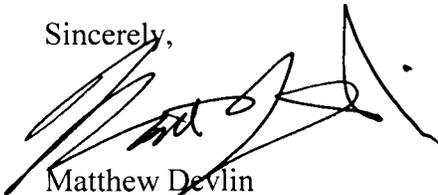
Dear Ms. Ong:

Pursuant to requirements in R1-6-301, attached is a copy of the 5-Year Review Report for Title 9, Chapter 22, Article 6. 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 Gina Relkin, Office of Administrative Legal Services at (602) 417-4575.

Sincerely,



Matthew Devlin  
Assistant Director

Attachments

**Arizona Health Care Cost Containment System  
(AHCCCS)**

**5 YEAR REVIEW REPORT**

**A.A.C. Title 9, Chapter 22, Article 6**

July 2017

## **I. General Information about 9 A.A.C. 22, Article 6**

### **Overview:**

The Arizona Health Care Cost Containment System Administration (AHCCCS) serves as the State's Medicaid Agency pursuant to Title XIX of the Social Security Act, also administering a variety of health care-related programs, including KidsCare, Arizona's version of the State Children's Health Insurance Program (SCHIP) authorized by Title XXI of the Social Security Act.

ARS §36-2904 provides that the Administration "shall execute prepaid capitated health services contracts, pursuant to 36-2906... for health and medical services to be provided under contract with contractors." Although the AHCCCS Administration is exempt from the requirements of the Arizona Procurement Code with respect to "prepaid capitated health service contracts" and with respect to contracts for "health and medical services" pursuant to A.R.S. §§ 41-2501(H) and 36-2904(A), the AHCCCS Director is required to adopt rules for the request for proposal (RFP) process and the award of contracts pursuant to A.R.S. § 36-2906. These rules address that statutory requirement. Accordingly, the rules reviewed in this Report describe the methods by which the AHCCCS Administration procures contracts for these services. In 2012, all rules in Article 6 were amended except for A.A.A. R9-22-602 and 603.

As of July 2017, AHCCCS, directly or through contracts, provides health care coverage for approximately 2 million Arizonans. Most beneficiaries receive coverage through managed care organizations (known as "health plans" and "program contractors") that contract with the AHCCCS Administration to provide covered physical and behavioral health services. In excess of 1.5 million persons are enrolled in one of several health plans under contract with the AHCCCS Administration to provide acute care services. In addition, almost 60,000 individuals are enrolled with program contractors serving as managed care organization coordinating delivery of both acute and long-term care services to persons whose level of care meet criteria for care in an institutional setting and who are age 65 years or older, have a physical disability, or have a developmental disability. A few hundred thousand persons eligible for AHCCCS benefits receive health services on a fee-for-service basis, including American Indians who elect not to

receive services through managed care organizations, and persons who are eligible only for emergency services.

## **II. Five Year Report on 9 A.A.C. 22, Article 6 rules:**

### **General and specific statutes authorizing the rule:**

A.R.S. § 36-2903.01(F) provides general authority to AHCCCS to adopt rules.

A.R.S. § 36-2906 specifically authorizes the AHCCCS Administration to establish rules for the request for proposal process as specified in A.R.S. §36-2904 (A).

### **Objective of the rule:**

R9-22-601 – The objective of the 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 this rule 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.

### **Effectively meets its objectives, including any available data supporting conclusion:**

Chapter 22, Article 6 rule meets the objective listed above. No data was attained.

### **Consistent with Statutes, rules, (including Federal, State, Waiver, Policy)**

Chapter 22, Article 6 rules are consistent with statutes and federal regulations.

### **Is enforced:**

Chapter 22, Article 6 rules are enforced with no issues.

### **Clarity, conciseness and understandability of the rule:**

The rules are clear, concise, and understandable.

**Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods:**

Written criticisms or written analyses for Chapter 22, Article 6 have not been submitted in the past five years.

**Comparison of estimated economic, small business, and consumer impact.**

The economic impact estimated at the time of rule promulgation has not been significantly different than the actual economic impact.

**Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competitiveness as compared to the competitiveness of businesses in other states:**

No.

**If applicable, has the agency completed the course of action indicated in the agency's previous five-year review:**

The Administration completed the courses of action indicated in the previous five-year review.

**Has there been 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 persons regulated 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.

**A determination after analysis that the rule is not more stringent than a corresponding federal law. Are the rules more stringent than a corresponding federal law? Is there a statutory authority that exceeds the requirements of that federal law?:**

The rules are not more stringent than corresponding federal law.

**Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization?**

Not applicable, the Administration does not issue permits, license or agency authorization for the imposition the definitions section of Chapter 22.

**Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend repeal or make a rule:**

The Agency has not identified any necessary courses of action for the rules in Article 6.



Within the stated calendar quarter, this Title 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.

**TITLE 9. Health Services**

**Chapter 22. Arizona Health Care Cost Containment System - Administration**

Sections, Parts, Exhibits, Tables or Appendices modified  
R9-22-730

REMOVE Supp. 16-4  
Pages: 1 - 120

REPLACE with Supp. 17-2  
Pages: 1 - 121

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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.*

**PUBLISHER**  
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## 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  
ADMINISTRATIVE RULES DIVISION  
June 30, 2017

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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 2017 is cited as Supp. 17-1.

### **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 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION**

*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), pursuant to 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.*

**ARTICLE 1. DEFINITIONS**

*New Article 1, consisting of Sections R9-22-101 through R9-22-103, R9-22-105, and R9-22-106 through R9-22-112 adopted effective December 8, 1997 (Supp. 97-4).*

*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 R9-22-604, adopted 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 R9-22-605, 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 8, consisting of Sections 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).*

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*Article 22, consisting of Sections R9-22-901 through R9-22-908, adopted effective August 29, 1985.*

*Former Article 22, consisting of Section R9-22-901, repealed effective October 1, 1983.*

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Article 10, consisting of Section R9-22-1001 through R9-22-1002, repealed effective November 7, 1997 (Supp. 97-4).

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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).

Article 13, consisting of Sections R9-22-1301 through R9-22-1309, adopted effective September 9, 1998 (Supp. 98-3).

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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

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## ARTICLE 1. DEFINITIONS

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

Definition	Section or Citation	Definition	Section or Citation
"Accommodation"	R9-22-701	"Cost-To-Charge Ratio" or "CCR"	R9-22-701 or R9-22-712
"Active treatment"	R9-22-1301	"Court-ordered evaluation"	R9-22-1201
"ADHS"	R9-22-101	"Court-ordered pre-petition screening"	R9-22-1201
"Administration"	A.R.S. § 36-2901	"Court-ordered treatment"	R9-22-1201
"Adult behavioral health therapeutic home"	9 A.A.C. 10, Article 1	"Covered charges"	R9-22-701
"Adverse action"	R9-22-101	"Covered services"	R9-22-101
"Affiliated corporate organization"	R9-22-101	"CPT"	R9-22-701
"Aged"	42 U.S.C. 1382c(a)(1)(A) and R9-22-1501	"Creditable coverage"	R9-22-2003 and 42 U.S.C. 300gg(c)
"Agency"	R9-22-1201	"Crisis services"	R9-22-1201
"Aggregate"	R9-22-701	"Critical Access Hospital"	R9-22-701
"AHCCCS"	R9-22-101	"CRS application"	R9-22-1301
"AHCCCS inpatient hospital day or days of care"	R9-22-701	"CRS condition"	R9-22-1301
"AHCCCS registered provider"	R9-22-101	"CRS provider"	R9-22-1301
"Ambulance"	A.R.S. § 36-2201	"Cryotherapy"	R9-22-2001
"Ancillary service"	R9-22-101	"Customized DME"	R9-22-212
"Anticipatory guidance"	R9-22-201	"Day"	R9-22-101 and R9-22-1101
"Annual enrollment choice"	R9-22-1701	"Date of the Notice of Adverse Action"	R9-22-1441
"APC"	R9-22-701	"DBHS"	R9-22-101
"Applicant"	R9-22-101 or R9-22-301	"DCSS"	R9-22-301
"Application"	R9-22-101	"Department"	A.R.S. § 36-2901
"Assessment"	R9-22-1101 or R9-22-1201	"Dependent child"	A.R.S. § 46-101 or R9-22-1401
"Assignment"	R9-22-101	"DES"	R9-22-101
"Attending physician"	R9-22-101 or R9-22-202	"Diagnostic services"	R9-22-101
"Authorized representative"	R9-22-101	"Direct graduate medical education costs" or "direct program costs"	R9-22-701
"Authorization"	R9-22-202	"Direct supervision"	R9-22-1201
"Auto-assignment algorithm"	R9-22-1701	"Director"	R9-22-101
"AZ-NBCCEDP"	R9-22-2001	"Disabled"	R9-22-1501
"Behavior management services"	R9-22-1201	"Discussion"	R9-22-101
"Behavioral health therapeutic home care services"	R9-22-1201	"Disenrollment"	R9-22-1701
"Behavioral health paraprofessional"	R9-22-101	"DME"	R9-22-101
"Behavioral health professional"	R9-22-101	"DRI inflation factor"	R9-22-701
"Behavioral health recipient"	R9-22-201	"E.P.S.D.T. services"	42 CFR 440.40(b)
"Behavioral health services"	R9-22-1201	"Eligibility posting"	R9-22-701
"Behavioral health technician"	R9-22-1201	"Eligible person"	A.R.S. § 36-2901
"Benefit year"	R9-22-201	"Emergency behavioral health condition for a non-FES member"	R9-22-201
"BHS" R9-22-301		"Emergency behavioral health services for a non-FES member"	R9-22-201
"Billed charges"	R9-22-701	"Emergency medical condition for a non-FES member"	R9-22-201
"Blind"	R9-22-1501	"Emergency medical services for a non-FES member"	R9-22-201
"Burial plot"	R9-22-1401	"Emergency medical services provider"	R9-22-1201
"Business agent"	R9-22-701	"Emergency medical or behavioral health condition for a FES member"	R9-22-217
"Calculated inpatient costs"	R9-22-712.07	"Emergency services costs"	A.R.S. § 36-2903.07
"Capital costs"	R9-22-701	"Emergency services for a FES member"	R9-22-217
"Capped fee-for-service"	R9-22-101	"Encounter"	R9-22-701
"Caretaker relative"	R9-22-1401	"Enrollment"	R9-22-1701
"Case management"	R9-22-1201	"Equity"	R9-22-101
"Case record"	R9-22-101	"Experimental services"	R9-22-203
"Cash assistance"	R9-22-1401	"Existing outpatient service"	R9-22-701
"Certified psychiatric nurse practitioner"	R9-22-1201	"Expansion funds"	R9-22-701
"Charge master"	R9-22-712	"FAA"	R9-22-301
"Child"	R9-22-1503	"Facility"	R9-22-101
"Children's Rehabilitative Services" or "CRS"	R9-22-101 or R9-22-301	"Factor"	R9-22-701 and 42 CFR 447.10
"Chronic"	R9-22-1301	"FBR"	R9-22-101
"Claim"	R9-22-1101	"Federal financial participation" or "FFP"	42 CFR 400.203
"Claims paid amount"	R9-22-712.07	"Federal poverty level" or "FPL"	A.R.S. § 36-2981
"Clean claim"	A.R.S. § 36-2904	"Fee-For-Service" or "FFS"	R9-22-101
"Clinical oversight"	9 A.A.C. 10	"FES member"	R9-22-101
"CMDP"	R9-22-1701	"FESP"	R9-22-101
"CMS"	R9-22-101	"First-party liability"	R9-22-1001
"Continuous stay"	R9-22-101	"File"	R9-22-1101
"Contract"	R9-22-101	"Fiscal agent"	R9-22-210
"Contract year"	R9-22-101	"Fiscal intermediary"	R9-22-701
"Contractor"	A.R.S. § 36-2901 or R9-22-210.01	"Foster care maintenance payment"	42 U.S.C. 675(4)(A)
"Copayment"	R9-22-701	"FQHC"	R9-22-101
"Cost avoid"	R9-22-1201	"Freestanding Children's Hospital"	R9-22-701
		"Functionally limiting"	R9-22-1301
		"Fund"	R9-22-712.07
		"Graduate medical education (GME) program"	R9-22-701

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“GME program approved by the Administration” or “approved GME program”	R9-22-701	“Person”	R9-22-1101
“Grievance”	A.A.C. Chapter 34	“Pharmaceutical service”	R9-22-201
“GSA”	R9-22-101	“Physical therapy”	R9-22-201
“HCAC”	R9-22-701	“Physician”	R9-22-101
“HCPCS”	R9-22-701	“Physician assistant”	R9-22-1201
“Health care institution”	A.R.S. § 36-401	“Post-stabilization services”	R9-22-201 or 42 CFR 422.113
“Health care practitioner”	R9-22-1201	“PPS bed”	R9-22-701
“Hearing aid”	R9-22-201	“Practitioner”	R9-22-101
“HIPAA”	R9-22-701	“Pre-enrollment process”	R9-22-301
“Home health services”	R9-22-201	“Prescription”	R9-22-101
“Hospital”	R9-22-101	“Primary care provider” or “PCP”	R9-22-101
“ICU”	R9-22-701	“Primary care provider services”	R9-22-201
“IHS”	R9-22-101	“Prior authorization”	R9-22-101
“IHS enrolled” or “enrolled with IHS”	R9-22-708	“Prior period coverage” or “PPC”	R9-22-101
“IMD” or “Institution for Mental Diseases”	42 CFR 435.1010 and R9-22-101	“Procedure code”	R9-22-701
“Income”	R9-22-301	“Procurement file”	R9-22-601
“Indirect program costs”	R9-22-701	“Proposal”	R9-22-101
“Individual”	R9-22-211	“Prospective rates”	R9-22-701
“In-kind income”	R9-22-1420	“Psychiatrist”	R9-22-1201
“Inmate of a public institution”	42 CFR 435.1010	“Psychologist”	R9-22-1201
“Inpatient covered charges”	R9-22-712.07	“Psychosocial rehabilitation services”	R9-22-201
“Intermediate Care Facility for the Mentally Retarded” or “ICF-MR”	42 U.S.C. 1396d(d)	“Public hospital”	R9-22-701
“Intern and Resident Information System”	R9-22-701	“Qualified alien”	A.R.S. § 36-2903.03
“LEEP”	R9-22-2001	“Qualified behavioral health service provider”	R9-22-1201
“Legal representative”	R9-22-101	“Quality management”	R9-22-501
“Level I trauma center”	R9-22-2101	“Radiology”	R9-22-101
“License” or “licensure”	R9-22-101	“RBHA” or “Regional Behavioral Health Authority”	R9-22-201
“Licensee”	R9-22-1201	“Reason to know” or “had reason to know”	R9-22-1101
“MAGI-based income”	R9-22-1401	“Rebase”	R9-22-701
“Mailing date”	R9-22-101	“Redetermination”	R9-22-1301
“Medical education costs”	R9-22-701	“Referral”	R9-22-101
“Medical expense deduction” or “MED”	R9-22-1401	“Rehabilitation services”	R9-22-101
“Medical practitioner”	R9-22-1201	“Reinsurance”	R9-22-701
“Medical record”	R9-22-101	“Remittance advice”	R9-22-701
“Medical review”	R9-22-701	“Resident”	R9-22-701
“Medical services”	A.R.S. § 36-401	“Residual functional deficit”	R9-22-201
“Medical supplies”	R9-22-101	“Resources”	R9-22-301
“Medical support”	R9-22-301	“Respiratory therapy”	R9-22-201
“Medically eligible”	R9-22-1301	“Respite”	R9-22-1201
“Medically necessary”	R9-22-101	“Responsible offeror”	R9-22-101
“Medicare claim”	R9-22-101	“Responsive offeror”	R9-22-101
“Medicare Urban or Rural Cost-to-Charge Ratio (CCR)”	R9-22-701	“Revenue Code”	R9-22-701
“Member”	A.R.S. § 36-2901 or R9-22-301	“Review”	R9-22-101
“Mental disorder”	A.R.S. § 36-501	“Review month”	R9-22-101
“Milliman study”	R9-22-712.07	“RFP”	R9-22-101
“Monthly equivalent”	R9-22-1401	“Rural Contractor”	R9-22-718
“Monthly income”	R9-22-1401	“Rural Hospital”	R9-22-712.07 and R9-22-718
“National Standard code sets”	R9-22-701	“Scope of services”	R9-22-201
“New hospital”	R9-22-701	“Section 1115 Waiver”	A.R.S. § 36-2901
“NICU”	R9-22-701	“Service location”	R9-22-101
“Noncontracted Hospital”	R9-22-718	“Service site”	R9-22-101
“Noncontracting provider”	A.R.S. § 36-2901	“SOBRA”	R9-22-101
“Non-FES member”	R9-22-101	“Specialist”	R9-22-101
“Non-IHS Acute Hospital”	R9-22-701	“Specialty facility”	R9-22-701
“Nursing facility” or “NF”	42 U.S.C. 1396r(a)	“Speech therapy”	R9-22-201
“Observation day”	R9-22-701	“Spendthrift restriction”	R9-22-1401
“Occupational therapy”	R9-22-201	“Sponsor”	R9-22-301
“Offeror”	R9-22-101	“Sponsor deemed income”	R9-22-301
“Operating costs”	R9-22-701	“Sponsoring institution”	R9-22-701
“OPPC”	R9-22-701	“Spouse”	R9-22-101
“Organized health care delivery system”	R9-22-701	“SSA”	42 CFR 1000.10
“Outlier”	R9-22-701	“SSI”	42 CFR 435.4
“Outpatient hospital service”	R9-22-701	“SSN”	R9-22-101
“Ownership change”	R9-22-701	“Stabilize”	42 U.S.C. 1395dd
“Ownership interest”	42 CFR 455.101	“Standard of care”	R9-22-101
“Partial Care”	R9-22-1201	“Sterilization”	R9-22-201
“Participating institution”	R9-22-701	“Subcontract”	R9-22-101
“Peer group”	R9-22-701	“Submitted”	A.R.S. § 36-2904
“Peer-reviewed study”	R9-22-2001	“Substance abuse”	R9-22-201
“Penalty”	R9-22-1101	“SVES”	R9-22-301
		“Tax dependent”	42 CFR 435.4
		“Taxi”	A.R.S. § 28-101(53)
		“Taxpayer”	R9-22-1401

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“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.

“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.

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“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, whichever 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.

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“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 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,

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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****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

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(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:

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.

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“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, practi-

tioner, 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.
- 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.

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- 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 10, 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.
  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.

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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.
- C.** 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 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).
- 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

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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:
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).

**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**

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- 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.
- 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).

**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:
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

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(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 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.

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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.
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.

**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), paragraph (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.
  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 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.**

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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.
- 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.
  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

**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

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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 travelling 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.
- 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 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;

**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.

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- 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), para-

graph (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 (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

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- 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;
  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

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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 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. Reserved****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).

**R9-22-302. Reserved****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).

**R9-22-303. Prior Quarter Eligibility**

- A.** Prior Quarter eligibility shall be effective no earlier than January 1, 2014. An applicant may be eligible during any of the three months prior to application if the applicant:
1. 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
  2. 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.
- B.** The Prior Quarter requirements do not apply to:
1. Qualified Medicare Beneficiaries
  2. KidsCare

**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).

**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, effective 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 cooperat-

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- ing 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 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.
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

**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, effective 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:

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- 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.
      - 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 Adminis-

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tration 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), 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, effective 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 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 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, effective 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).

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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, effective 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). 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, effective 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, effective 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, effective 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, effective 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 withdrawal 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 Pro-

cedure 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, effective 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, effective 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.

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**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 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, effective 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
  - f. The victim does not currently live with the perpetrator.
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

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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 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, effective 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, effective 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

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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).

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.

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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).

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. 97-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-340. Repealed**

**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.
- 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 informa-

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tion 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 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 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;

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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**

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**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

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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.
- 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

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- 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 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 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

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(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 AHCCCS 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 AHCCCS or a contractor.

“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 by a hospital 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.

“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 provide 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 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 hospital experiences as a result of having an approved graduate medical education program and that is not accounted for by the hospital’s direct program costs.

“Intern and Resident Information System” means a software program used by teaching hospitals and the provider community for collecting and reporting information on resident training in hospital and non-hospital settings.

“Medical education costs” means direct hospital 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,

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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.

“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 UB-04 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).

**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 contractor. 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

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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 or electronic claim to be submitted on the date that it is received by the Administration. The Administration shall do one or more of the following for each claim it 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 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 IHS 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,

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- 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.
  - 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).

**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**

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- 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.
  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.

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- 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,
    - 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.

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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****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 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 publi-*

*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.*

**R9-22-710. 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 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.

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- 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 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;

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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) 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.

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- 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 provider 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 subse-*

*quently 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 or before September 30, 2014, at the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article.
  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

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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.
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

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(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 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

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- 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 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

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- 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 revenue 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.

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- 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 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.

**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 rulemaking 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:

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- i. The program name and number assigned by the accrediting organization;
- ii. The original date of accreditation;
- 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):
    - 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

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- 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 Medicaid share by dividing the AHCCCS inpatient hospital days of care by the total inpatient hospital days from the Medicare Cost Report. For this purpose, the Administration shall use the information described by subsection (B)(4)(c) for adjusting allocated residents for Arizona Medicaid utilization.
      - ii. Calculate each hospital's Medicare share by dividing the Medicare inpatient days on the Medicare Cost Report by the total inpatient hospital days on the Medicare Cost Report.
      - iii. Divide the Medicaid share by the Medicare share and multiply the resulting ratio by the indirect medical education payment calculated on the Medicare Cost Report.
      - iv. Total the results for all hospitals, divide the result by the total allocated residents determined under subsection (B)(4)(b)(ii) for these 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)(b)(ii) by 12 by the per resident per month conversion factor determined under subsection (D)(4)(b);
      2. The amount calculated for the hospital at subsection (D)(4)(b)(iii); or
      3. The median of all amounts calculated at subsection (D)(4)(b)(iii) if the hospital does not have an indirect medical education payment calculated on the Medicare Cost Report.

**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).

**R9-22-712.06. Reserved****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

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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. 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.
- B.** 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. 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. Reserved**

**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

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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**

- 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.

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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 subsection (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:
1. By 48 percent for public hospitals on July 1, 2005, and hospitals that were public anytime during the calendar year 2004;
  2. 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;
  3. 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;
  4. By 115 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been design-

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- nated as Critical Access Hospitals but meet the criteria during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
5. 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
  6. 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:
1. By 73 percent for public hospitals;
  2. 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;
  3. 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;
  4. 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;
  5. By 78 percent for a Freestanding Children's Hospital with at least 110 pediatric beds as of October 1 of that contract year; or
  6. 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, 2016 through September 30, 2017, 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, 2016. To qualify, a hospital providing outpatient hospital services must meet the following criteria:
1. By June 1, 2016, the hospital must have executed an agreement with and electronically submitted admission, discharge, and transfer information, as well as data from the hospital emergency department, to a qualifying health information exchange organization, and
  2. No sooner than January 4, 2016, and no later than February 29, 2016, CMS must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015; or, for a children's hospital that does not participate in the Medicare electronic health record incentive program, no sooner than January 4, 2016, and no later than the date established by CMS, the administration must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015.
- F.** Fee adjustments made under subsection (A), (B), (C), (D), and (E) are on file with AHCCCS and current adjustments are 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 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).

**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.
- 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.:

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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.

**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 sections 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 version 31 of the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health Information Systems. If version 31 of the APR-DRG classification system will no longer support assigning DRG codes and relative weights to claims, and 3M Health Information Systems issues a newer version of the APR-DRG classification system using updated DRG codes and/or updated relative weights, then an updated version established by 3M Health Information Systems will be used; however, if the version employs updated relative weights, those weights will be adjusted using a single adjustment factor applied to all relative weights to ensure that the statewide weighted average of the updated relative weights does not increase or decrease from the statewide weighted average of the relative weights used under version 31.
- 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.

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- 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 version 31 of 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).

**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 701 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.

**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).

**R9-22-712.62. 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 adjustors.
- 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, where the standardized amount is \$5,295.40, and the hospital's labor share and the hospital's wage index are those used in the Medicare inpatient prospective payment system for the fiscal year beginning October 1, 2013.
- 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).

**R9-22-712.63. DRG Base Payments Not Based on the Statewide Standardized Amount**

Notwithstanding section R9-22-712.62, the amount of \$3,436.08 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.

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**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**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 \$5,184.75.

**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, 2010.****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).

**R9-22-712.65.DRG Provider Policy Adjustor****A. After calculating the DRG base payment as required in sections 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 of 1.055.****B. A hospital is a high-utilization hospital if the hospital had:**

1. At least 46,112 AHCCCS-covered inpatient days using adjudicated claim and encounter data during the fiscal year beginning October 1, 2010, which is equal to at least four hundred percent of the statewide average number of AHCCCS-covered inpatient days at all hospitals of 11,528 days; and,
2. A Medicaid inpatient utilization rate greater than 30% 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 2011.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.66.DRG Service Policy Adjustor**

In addition to subsection 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 following service policy adjustors:

1. Normal newborn DRG codes: 1.55
2. Neonates DRG codes: 1.10

3. Obstetrics DRG codes: 1.55
4. Psychiatric DRG codes: 1.65
5. Rehabilitation DRG codes: 1.65
6. Claims for members under age 19 assigned DRG codes other than listed above:
  - a. 1.25 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. 1.25 for dates of discharge on or after January 1, 2016 for severity of illness levels 1 and 2,
  - c. 1.60 for dates of discharge on or after January 1, 2016 for severity of illness levels 3 and 4.

**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).

**R9-22-712.67.DRG Reimbursement: Transfers**

- 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

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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 is \$5,000 for critical access hospitals and \$65,000 for all other hospitals.
- 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 is 90% for claims assigned DRG codes associated with the treatment of burns and 80% for all other claims.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**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 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**

The final DRG payment is the sum of the final DRG base payment, the final DRG outlier add-on payment, and the Inpatient Value Based Purchasing (VBP) Differential Adjusted Payment.

1. 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.
2. 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.
3. 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 701 E. Jefferson Street, Phoenix, Arizona.
4. For inpatient services with a date of discharge from October 1, 2016 through September 30, 2017, the Inpatient VBP 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, 2016. To qualify for the Inpatient VBP

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Differential Adjusted Payment, a hospital providing inpatient hospital services must meet the following criteria:

- a. By June 1, 2016, the hospital must have executed an agreement with and electronically submitted admission, discharge, and transfer information, as well as data from the hospital emergency department, to a qualifying health information exchange organization, and
- b. No sooner than January 4, 2016, and no later than February 29, 2016, CMS must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015; or, for a children's hospital that does not participate in the Medicare electronic health record incentive program, no sooner than January 4, 2016, and no later than the date established by CMS, the administration must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 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 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4).

**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. The claim may include all surgical procedures performed during the entire inpatient stay, but the hospital shall only include revenue codes, service units, and charges for services performed on or after the date of enrollment.
- 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).

**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. 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.
  1. 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.
  2. 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.
  3. 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.
- B. 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.
- 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.
- E. Administrative days 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 (e.g., as nursing facility days).

**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).

**R9-22-712.76.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

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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 section R9-22-712.62(B) because the hospital was not in operation, the DRG base rate described in section R9-22-712.62(B) shall be calculated as the statewide standardized amount of \$5,295.40 after adjusting that amount for the labor-related share and the wage index published by CMS as described in section R9-22-712.62(B) that is appropriate to the location of the hospital published by CMS as described in section 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 section 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 section 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).

**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 adjust the statewide standardized amount in section R9-22-712.62, the base payments in sections R9-22-712.63 and R9-22-712.64, the provider policy adjustor in section R9-22-712.65, service policy adjustors section R9-22-712.66, and the fixed loss amounts and marginal cost percentages used to calculate the outlier threshold in section 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 to the general population in the geographic area.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.90. Reimbursement of Hospital-based Free-standing 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 sections R9-22-712.20 through R9-22-712.30. All other covered codes shall be reimbursed in accordance with sections R9-22-712.20 through R9-22-712.30 without a percentage reduction.
  1. 60% for a level 1 emergency department visit as indicated by CPT 99281.
  2. 80% for a level 2 emergency department visit as indicated by CPT 99282.
  3. 90% for a level 3 emergency department visit as indicated by CPT 99283.
  4. 100% 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

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city or town operating an emergency department closed on or after January 1, 2015, shall be reimbursed under sections 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;
    - 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,

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- 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.*

**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 adopted 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 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.*

**R9-22-718. Urban Hospital Inpatient Reimbursement Program**

- A. Definitions. The following definitions apply to this Section:
  1. "Noncontracted Hospital" means an urban hospital which does not have a contract under this Section with an urban contractor in the same county.
  2. "Rural Contractor" means a contractor or program contractor as defined in A.R.S. Title 36, Chapter 29 that does not provide services to members residing in either Maricopa or Pima County.
  3. "Urban Contractor" means a contractor or program contractor as defined in A.R.S. Title 36, Chapter 29, that provides services to members residing in Maricopa or Pima County and may also provide services to members who reside in other counties. An urban contractor does not include ADHS/BHS, or a TRBHA.
  4. "Rural Hospital" means a hospital, as defined in R9-22-712.07, that is physically located in Arizona but in a county other than Maricopa and Pima County.
  5. "Urban Hospital" means a hospital that is not a rural hospital and 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. An urban 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 urban contractor.
  5. A noncontracted urban hospital shall be reimbursed for inpatient services by an urban contractor at 95% of the

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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 urban 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).

**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 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. Reserved****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).*

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*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**

- A.** For purposes of this Section, the following terms are defined as provided below unless the context specifically requires another meaning:
1. "2011 Medicare Cost Report" means:
    - a. The Medicare Cost Report for the hospital fiscal year ending in calendar year 2011 as reported in the CMS Healthcare Provider Cost Reporting Information System (HCRIS) release dated December 31, 2012; or
    - b. For hospitals not included in that CMS HCRIS report, the "as filed" Medicare Cost Report for the hospital fiscal year ending in calendar year 2011 submitted by the hospital to the Administration.
  2. "2011 Uniform Accounting Report" means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of December 19, 2012.
  3. "2012 Uniform Accounting Report" means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of August 2, 2013.
  4. "Quarter" means the three month period beginning January 1, April 1, July 1, and October 1 of each year.
- B.** Beginning January 1, 2014, 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 July 1, 2017, the assessment shall be calculated by multiplying the number of discharges reported on the hospital's 2011 Medicare Cost Report, excluding discharges reported on the Medicare Cost Report as "Other Long Term Care Discharges" by the following rates based on the hospital's peer group:
1. \$483.00 per discharge for hospitals located in a county with a population less than 500,000 that are designated as type: hospital, subtype: short-term.
  2. \$483.00 per discharge for hospitals designated as type: hospital, subtype: critical access hospital.
  3. \$120.75 per discharge for hospitals designated as type: hospital, subtype: long term.
  4. \$120.75 per discharge for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the 2011 Medicare Cost Report.
  5. \$386.50 per discharge 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 2012 Uniform Accounting Report.
  6. \$434.75 per discharge 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 2012 Uniform Accounting Report.
  7. \$483.00 per discharge for hospitals designated as type: hospital, subtype: short-term not included in another peer group.
- C.** Peer groups for the four quarters beginning July 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 April 1, 2017.
- D.** Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's 2011 Medicare Cost Report, are assessed a rate of \$120.75 for each discharge from the psychiatric sub-provider as reported in the 2011 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 2011 Medicare Cost Report, are assessed a rate of \$0 for each discharge from the rehabilitative sub-provider as reported in the 2011 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 28,200 discharges on the hospital's 2011 Medicare Cost Report, discharges in excess of 28,200 are assessed a rate of \$48.25 for each discharge in excess of 28,200. The initial 28,200 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 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:
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 2011 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 April 1, 2017:
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 2011 Medicare Cost Report.
  4. Hospitals designated as type: hospital, subtype; rehabilitation.
  5. Hospitals designated as type: hospital, subtype: children's.
  6. Hospitals designated as type: med-hospital, subtype: special hospitals.
  7. 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 2011 Medicare Cost Report are reimbursed by Medicare.
- J.** New hospitals. For hospitals that did not file a 2011 Medicare Cost Report because of the date the hospital began operations:

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1. If the hospital was open on the April 1 preceding the July assessment start date, the hospital assessment will begin on July 1 following the date the hospital began operating.
  2. If the hospital began operating between April 2 and June 30, the assessment will begin on July 1 of the following calendar year.
  3. A hospital is not considered a new hospital based on a change in ownership.
  4. Until the first full year of data is available, the assessment will be based on the annualized number of discharges from the date hospital operations began through April 30 preceding the July assessment start date. The hospital shall submit the discharge data and all other data requested by the Administration necessary to determine the appropriate assessment to the Administration no later than May 15 preceding the assessment start date for the new hospitals. Thereafter, 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; however, when 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. No later than August 15, 2017, new hospitals shall also submit to the Administration discharge data and all other data requested by the Administration necessary to determine the appropriate assessment beginning July 1, 2018.
  5. For hospitals providing self-reported data:
    - 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 any hospital that has not filed a 2011 Medicare Cost report, or if the 2011 Medicare Cost report does not include the reliable information sufficient for the Administration to calculate the assessment, the Administration shall use data reported on the 2011 Uniform Accounting Report filed by the hospital in place of the 2011 Medicare Cost report to calculate the assessment. If the 2011 Uniform Accounting Report filed by the hospital does not include reliable information sufficient for the Administration to calculate the assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2011 Medicare Cost report to calculate the assessment.
- N.** 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.
- O.** 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).

**ARTICLE 8. REPEALED**

*Article 8, consisting of Sections 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 subsections (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).

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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 (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).

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 rulemaking 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

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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.
- 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) 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**

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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,
  - 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.

#### 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
  - 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).

#### 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.
  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.

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“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.

“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 AHCCCS 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;

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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 behavioral 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

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- 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.
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;

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- ix. A medical practitioner; and
  - 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;
  8. 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**

**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 enrolled with the CRS contractor. An American Indian member shall obtain CRS services through the CRS contractor. A member enrolled in CMDP shall also obtain CRS services through the CRS contractor. Initial enrollment with the CRS contractor is limited to individuals under the age of 21. The CRS contractor shall provide covered services necessary to treat the CRS condition(s) and other services described within the CRS contract. The effective date of enrollment in CRS 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).

**R9-22-1303. Medical Eligibility**

The following lists identify those medical condition(s) that do qualify for the CRS program as well as those that do not qualify for the CRS program. The list of condition(s) that qualify for CRS medical eligibility is all inclusive. The list of condition(s) that do not qualify for CRS medical eligibility 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,
    - v. Hyperparathyroidism,
    - vi. Hyperthyroidism,

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- 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. Arthrogyposis (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,
    - v. Deformity and dysfunction secondary to trauma or injury,
    - vi. Ehlers Danlos,
    - vii. Flat foot,
    - viii. Fracture,
    - ix. Ganglion cyst,
    - x. Ingrown toenail,

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- 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, dermamyositis, 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.
  - 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:
- i. Amino acid or organic acidopathy,

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- ii. Biotinidase deficiency,
  - iii. Homocystinuria,
  - iv. Inborn error of metabolism,
  - v. Maple syrup urine disease,
  - vi. Phenylketonuria, and
  - vii. 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).

**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 the CRS program shall be redetermined by verifying active treatment status of the CRS qualifying medical condition(s) as follows:
- 1. The CRS Contractor is responsible for notifying the AHCCCS Administration of the date when a CRS member is no longer in active treatment for the CRS qualifying condition(s).
  - 2. The Administration may request, at any time, that the CRS contractor submit the medical documentation requested in the CRS medical redetermination form within the specified time-frames in contract.
  - 3. The Administration shall notify the CRS member or authorized representative of the redetermination process.
- B. If the Administration determines that a CRS member is no longer medically eligible for CRS, the Administration shall provide the CRS member or authorized representative a written notice that informs the CRS member that the Administration is transitioning the CRS member's enrollment according to R9-22-1306. The member may appeal the redetermination under Chapter 34.
- C. Upon reaching his or her 21st birthday, the CRS member will be enrolled with a non-CRS contractor unless the member requests to continue enrollment with the CRS contractor.

**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).

**R9-22-1306. Transition or Termination**

- A. The Administration shall transition a CRS member from the CRS contractor when the Administration determines the CRS member does not meet the medical eligibility requirements under this Article.
- B. The Administration shall terminate a CRS member from the CRS contractor and the AHCCCS program when the Administration determines the CRS member does not meet the AHCCCS eligibility requirements. The member may appeal the termination under Chapter 34.
- C. If the Administration transitions a CRS member from the CRS contractor, the Administration shall provide the CRS member, or authorized representative a written notice of transition. The member may appeal the transition under Chapter 34.

**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).

**R9-22-1307. Covered Services**

The Administration will cover medically necessary services as described within Article 2 unless otherwise specified in contract.

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**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). 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).

**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

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tive December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective 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, effective 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, effective 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, effective 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, effective January 7, 2014 (Supp. 14-1).

**R9-22-1407. Deceased Applicants**

- A. If an applicant dies while an application is pending, the Administration or Administration's designee shall complete an eligibility determination for all applicants listed on the application, including the deceased applicant.
- B. The Administration or Administration's designee shall complete an eligibility determination on an application filed on behalf of a deceased applicant.

**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, effective January 7, 2014 (Supp. 14-1). Amended by final rulemaking at 19 A.A.R. 3309, November 30, 2013 (Supp. 13-4).

**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, effective 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, effective 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. 192, effective 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, effective 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

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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, effective 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, effective 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, effective 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, effective 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, effective 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, effective 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, effective 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, effective 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

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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.
  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, effective 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

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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, effective 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.
  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, effective 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, effective 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 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, effective 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, effective January 7, 2014 (Supp. 14-1).

**R9-22-1426. Repealed**

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**Historical Note**

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**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;
  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, effective 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, effective 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, effective 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, effective 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, effective 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, effective 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, effective 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 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:

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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 presumed 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

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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 time-frames 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 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. Closing New Eligibility for Persons Not Covered under the State Plan**

- A.** Definition. For purposes of this Section, "AHCCCS Care" refers to the eligibility category that includes individuals encompassed within the expanded definition of "eligible person" under A.R.S. § 36-2901.01 and R9-22-1428(4), but who do not meet eligibility criteria for an optional or mandatory Title XIX coverage group described in the Arizona State Plan for Medicaid.
- B.** General Rule. Except as provided by this Section, neither the Department nor the Administration shall approve an individual for AHCCCS Care with an effective date of eligibility on or after July 8, 2011.
- C.** Exception for pending applications. With respect to any applications that are pending as of July 8, 2011, the Department and the Administration shall approve any individual as eligible for AHCCCS Care who has met all eligibility requirements for AHCCCS Care during or after the month of application but prior to July 8, 2011, and has continuously met all eligibility requirements for AHCCCS Care since that date.
- D.** Exception for children. The Department and the Administration shall approve an individual as eligible for AHCCCS Care on or after July 8, 2011 who:
1. Was determined eligible under the Arizona State Plan for Medicaid based on being under the age of 19;
  2. Would otherwise be discontinued due to reaching the age of 19 on or after July 8, 2011, under subsection (B) of this Section; and
  3. Meets all eligibility requirements for AHCCCS Care on and after reaching age 19.

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- E.** Exception for KidsCare. The Department and the Administration shall approve an individual as eligible for AHCCCS Care on or after July 8, 2011 who:
1. Was determined eligible under 9 A.A.C. 31 based on being under the age of 19;
  2. Would otherwise be discontinued due to reaching the age of 19 on or after July 8, 2011, under subsection (B) of this Section; and
  3. Meets all eligibility requirements for AHCCCS Care on and after reaching age 19.
- F.** Exception for Young Adult Transitional Insurance (YATI). The Department and the Administration shall approve an individual as eligible for AHCCCS Care on or after July 8, 2011 who:
1. Was determined eligible for YATI under R9-22-1432;
  2. Would otherwise be discontinued due to reaching the age of 21 on or after July 8, 2011 under subsection (A) of this Section; and
  3. Meets all eligibility requirements for AHCCCS Care on and after reaching age 21.
- G.** Exception for certain SSI-MAO. The Department and the Administration shall approve as eligible for AHCCCS Care, on or after July 8, 2011, an individual who:
1. Was determined eligible for AHCCCS Care; and
  2. Whose eligibility category is changed on or after June 28, 2011, from AHCCCS Care to eligibility based on R9-22-1501(A)(1) (SSI Medical Assistance Only) because the individual, at the time of the change in eligibility category, is age 65 or over, under the age of 65 with Medicare coverage, or who has been determined by ADHS to have a Serious Mental Illness; but who
  3. Subsequent to the change in eligibility category, is determined not to meet eligibility requirements under Article 15; but only if
  4. The individual meets all eligibility requirements for AHCCCS Care on and after the date the individual is determined not to meet eligibility requirements under Article 15.
- H.** Exception for redeterminations. This Section does not prohibit the redetermination of an individual as eligible for AHCCCS Care on or after July 8, 2011, if the individual was determined eligible for AHCCCS Care prior to July 8, 2011 and has remained continuously eligible for AHCCCS Care since July 8, 2011 or the date on which the individual was determined eligible for AHCCCS Care under subsections (C), (D), and (E) of this Section.
- I.** Discontinuance for other reasons. Nothing in this Section prohibits or restricts the Department or the Administration from discontinuing AHCCCS Care for an individual who does not meet any other eligibility criteria set forth elsewhere in this Chapter including but not limited to discontinuance based on the individual's failure to verify eligibility information upon an application or redetermination.
- J.** Review of anticipated expenditures. At least monthly, the Director shall review the most recent estimate of the anticipated expenditures for the remainder of the state fiscal year as compared to funds remaining in the appropriations made to the agency for the state fiscal year as well as any other known or reasonably anticipated sources of other funding. Based on that review the Director may, subject to approval by the Center for Medicare and Medicaid Services, re-open the AHCCCS Care program to new enrollment otherwise prohibited by this Section.
- K.** At least 30 days prior to the effective date of any changes to eligibility for the AHCCCS Care program as described in this Section, public notice shall be provided via publication on the AHCCCS web site unless shorter notice is necessary to main-

tain a program that is reasonably anticipated to remain within available funding.

**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).

**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:
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).
- “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).
- C.** Confidentiality. The Administration shall maintain the confidentiality of an applicant's or member's records and limit the release of safeguarded information under R9-22-512.
- D.** Application process.
1. A person may apply for AHCCCS medical coverage by submitting a signed application to any Administration office or outstation location under R9-22-1406.
  2. The provisions in R9-22-1406(B), (C), and (E) apply to this Section.
  3. The application date is the date a signed application is received at any Administration office or outstation location approved by the Director.
  4. An applicant who files an application may withdraw the application, either orally or in writing. If an applicant withdraws an application, the Administration shall send the applicant a denial notice under subsection (G).
  5. Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 90 days for an applicant applying on the basis of disability and 45 days for all other applicants.
  6. If an applicant dies while an application is pending, the Administration shall complete an eligibility determination for the deceased applicant.
  7. The Administration shall complete an eligibility determination on an application filed on behalf of a deceased applicant, if the application is filed in the month of the applicant's death.
- E.** Redetermination of eligibility for a person terminated from the SSI cash program.
1. Continuation of AHCCCS medical coverage. The Administration shall continue AHCCCS medical coverage for a person terminated from the SSI cash program

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- until a redetermination of eligibility under subsection (E)(2) is completed.
2. Coverage group screening. The Administration shall screen a person for eligibility under any coverage group under A.R.S. §§ 36-2901(6)(a)(i), (ii), (iii), (iv), and (v) and 36-2934.
    - a. If a person files an application for Arizona Long-Term Care System (ALTCs) coverage, the Administration shall determine eligibility under 9 A.A.C. 28, Article 4.
    - b. If an applicant or member is aged, blind, or disabled, but not in need of long-term care services, the Administration shall determine eligibility under this Article.
    - c. For all other persons, the Administration shall refer the applicant's case to the Department for an eligibility decision under Article 14.
  3. Eligibility decision.
    - a. If a person is eligible under this Article or 9 A.A.C. 28, Article 4, the Administration shall send a notice as under subsection (G) informing the applicant that AHCCCS medical coverage is approved.
    - b. If a person is ineligible, the Administration shall send a notice as under subsection (G) to deny AHCCCS medical coverage.
- F.** Eligibility effective date. Eligibility is effective on the first day of the month that all eligibility requirements are met, including the period described under R9-22-303.
- G.** Notice for 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 intended action, and:
1. If approved, the notice shall contain the effective date of eligibility.
  2. If approved under FESP, the notice shall also contain:
    - a. The emergency services certification end date,
    - b. A statement detailing the reason for the denial of full services,
    - c. The legal authority supporting the decision,
    - d. Where the legal authority supporting the decision can be found,
    - e. An explanation of the right to request a hearing, and
    - f. The date by which a request for hearing shall be received by the Administration.
  3. If denied, the notice shall contain:
    - a. The effective date of the denial;
    - b. The reason for the denial, including specific financial calculations and the financial eligibility standard, if applicable;
    - c. Legal authority supporting the decision;
    - d. Where the legal authority supporting the decision can be found;
    - e. An explanation of the right to request a hearing; and
    - f. The date by which a request for hearing shall be received by the Administration.
- H.** Reporting and verifying changes.
1. An applicant or a member shall report to the Administration the following changes for the applicant or member, the applicant's or member's spouse, and the applicant or member's dependent children:
    - a. Change of address;
    - b. Change in the household's members;
    - c. Change in income;
    - d. Death;
    - e. Change in marital status;
    - f. Change in school attendance;
    - g. Change in Arizona state residency; and
    - h. Any other change that may affect the member's or applicant's eligibility.
  2. A member shall report to the Administration the following changes:
    - a. Admission to a penal institution,
    - b. Change in U.S. citizenship or immigrant status,
    - c. Receipt of a Social Security number, and
    - d. Change in first- or third-party liability that may contribute to the payment of all or a portion of the person's medical costs.
  3. A person other than a member or an applicant who reports a change to the Administration either orally or in writing shall include the:
    - a. Name of the affected applicant or member;
    - b. Description of the change;
    - c. Date the change occurred;
    - d. Name of the person reporting the change; and
    - e. Social Security or case number of the applicant or member, if known.
  4. An applicant or a member shall provide verification of changes if requested by the Administration.
  5. An applicant or a member shall report anticipated changes in eligibility to the Administration as soon as the person knows that the change will occur.
  6. An applicant or a member shall report an unanticipated change to the Administration within 10 days following the date the change occurred.
- I.** Processing of changes and redeterminations. If a member receives AHCCCS medical coverage under subsection (A), the Administration shall redetermine the member's eligibility at least once every 12 months or more frequently when changes occur that may affect eligibility.
- J.** Actions that may result from a redetermination or change. In processing a redetermination or change, the Administration shall determine whether there should be:
1. No change in eligibility,
  2. Discontinuance of eligibility if a condition of eligibility is no longer met, or
  3. A change in the program under which a person receives AHCCCS medical coverage.
- K.** Notice of discontinuance.
1. Contents of notice. The Administration shall issue a notice when it takes action to discontinue a member's eligibility. The notice shall contain the following information:
    - a. A statement of the action that is being taken;
    - b. The effective date of the action;
    - c. The reason for the discontinuance, including specific financial calculations and the financial eligibility standard if applicable;
    - d. The legal authority that supports the action proposed by the Administration;
    - e. Where the legal authority supporting the decision can be found;
    - f. An explanation of the right to request a hearing; and
    - g. The date by which a hearing request shall be received by the Administration and the right to continue medical coverage pending appeal.
  2. Advance notice of changes in eligibility. 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 (K)(3), the Administration shall issue an advance notice when an adverse action is taken to suspend, reduce or discontinue eligibility.

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3. Exceptions from advance notice. The Administration shall issue a notice to a member to discontinue eligibility no later than the effective date of the action if:
- a. The member provides to the Administration a clearly written statement, signed by that member, that:
    - i. Services are no longer wanted; or
    - ii. Gives information that requires a discontinuance or reduction of services and indicates that the member understands that this is the result of supplying the information;
  - b. The member provides information to the Administration that requires a discontinuance of eligibility and a member signs a written statement waiving advance notice;
  - c. The member cannot be located and mail sent to the member's last known address has been returned as undeliverable under 42 CFR 431.213(d) subject to reinstatement of discontinued eligibility;
  - d. The member has been admitted to a public institution where a member is ineligible for coverage;
  - e. The member has been approved for Medicaid in another state; or
  - f. The Administration receives information confirming the death of the member.
- L.** Request for hearing. An applicant or member may request a hearing under Chapter 34 for any of the following adverse actions:
1. Complete or partial denial of eligibility,
  2. Discontinuance or reduction of AHCCCS medical coverage, or
  3. Delay in the eligibility determination beyond the timeframes listed in R9-22-1501(D).
- M.** Assignment of rights. A person determined eligible assigns rights to all types of medical benefits to which the person is entitled under operation of law under A.R.S. § 36-2903.

**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).

**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, effective 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.**

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, effective 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.

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- 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;
    - 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, effective 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**

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- 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.
- 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



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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 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.

**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

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- 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.

**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 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 undeliverable 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**

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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****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**

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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.

**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

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- 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 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,

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- 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 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 that:
    - a. Provides in-house 24-hour daily dedicated trauma surgical services as defined in A.R.S. § 36-2201(26) pertaining to a trauma center, or
    - b. Is recognized as a rural regional trauma center that was providing formal organized trauma services on or before January 1, 2003.
  - 2. On or after January 1, 2005, "level I trauma center" means any acute care hospital designated by the Arizona Department of Health Services as a level I trauma center.

3. "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).

#### 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
  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 I 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

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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.

36-2904. Prepaid capitation coverage; requirements; long-term care; dispute resolution; award of contracts; notification; report

A. The administration may expend public funds appropriated for the purposes of this article and shall execute prepaid capitated health services contracts, pursuant to section 36-2906, with group disability insurers, hospital and medical service corporations, health care services organizations and any other appropriate public or private persons, including county-owned and operated facilities, for health and medical services to be provided under contract with contractors. The administration may assign liability for eligible persons and members through contractual agreements with contractors. If there is an insufficient number of qualified bids for prepaid capitated health services contracts for the provision of hospitalization and medical care within a county, the director may:

1. Execute discount advance payment contracts, pursuant to section 36-2906 and subject to section 36-2903.01, for hospital services.
2. Execute capped fee-for-service contracts for health and medical services, other than hospital services. Any capped fee-for-service contract shall provide for reimbursement at a level of not to exceed a capped fee-for-service schedule adopted by the administration.

B. During any period in which services are needed and no contract exists, the director may do either of the following:

1. Pay noncontracting providers for health and medical services, other than hospital services, on a capped fee-for-service basis for members and persons who are determined eligible. However, the state shall not pay any amount for services that exceeds a maximum amount set forth in a capped fee-for-service schedule adopted by the administration.
2. Pay a hospital subject to the reimbursement level limitation prescribed in section 36-2903.01.

If health and medical services are provided in the absence of a contract, the director shall continue to attempt to procure by the bid process as provided in section 36-2906 contracts for such services as specified in this subsection.

C. Payments to contractors 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 contractors shall be distributed to 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 health care cost containment system fund.

D. Except as prescribed in subsection E of this section, a member defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (a) may select, to the extent practicable as determined by the administration, from among the available contractors of hospitalization and medical care

and may select a primary care physician or primary care practitioner from among the primary care physicians and primary care practitioners participating in the contract in which the member is enrolled. The administration shall provide reimbursement only to entities that have a provider agreement with the administration and that have agreed to the contractual requirements of that agreement. Except as provided in sections 36-2908 and 36-2909, the system shall only provide reimbursement for any health or medical services or costs of related services provided by or under referral from the primary care physician or primary care practitioner participating in the contract in which the member is enrolled. The director shall establish requirements as to the minimum time period that a member is assigned to specific contractors in the system.

E. For a member defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (a), item (v) the director shall enroll the member with an available contractor located in the geographic area of the member's residence. The member may select a primary care physician or primary care practitioner from among the primary care physicians or primary care practitioners participating in the contract in which the member is enrolled. The system shall only provide reimbursement for health or medical services or costs of related services provided by or under referral from a primary care physician or primary care practitioner participating in the contract in which the member is enrolled. The director shall establish requirements as to the minimum time period that a member is assigned to specific contractors in the system.

F. If a person who has been determined eligible but who has not yet enrolled in the system receives emergency services, the director shall provide by rule for the enrollment of the person on a priority basis. If a person requires system covered services on or after the date the person is determined eligible for the system but before the date of enrollment, the person is entitled to receive these services in accordance with rules adopted by the director, and the administration shall pay for the services pursuant to section 36-2903.01 or, as specified in contract, with the contractor pursuant to the subcontracted rate or this section.

G. The administration shall not pay claims for system covered services that are initially submitted more than six months after the date of the service for which payment is claimed or after the date that eligibility is posted, whichever date is later, or that are submitted as clean claims more than twelve months after the date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later, except for claims submitted for reinsurance pursuant to section 36-2906, subsection C, paragraph 6. The administration shall not pay claims for system covered services that are submitted by contractors for reinsurance after the time period specified in the contract. The director may adopt rules or require contractual provisions that prescribe requirements and time limits for submittal of and payment for those claims. Notwithstanding any other provision of this article, if a claim that gives rise to a contractor's claim for reinsurance or deferred liability is the subject of an administrative grievance or appeal proceeding or other legal action, the contractor shall have at least sixty days after an ultimate decision is rendered to submit a claim for reinsurance or deferred liability. Contractors that contract with the administration pursuant to subsection A of this section shall not pay claims for system covered services that are initially submitted more than six months after the date of the service for which payment is claimed or after the date that eligibility is posted, whichever date is later, or that are submitted as clean claims more than twelve months after the

date of the service for which payment is claimed or after the date that eligibility is posted, whichever date is later. For the purposes of this subsection:

1. "Clean claims" means claims that may be processed without obtaining additional information from the subcontracted provider of care, from a noncontracting provider or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.
2. "Date of service" for a hospital inpatient means the date of discharge of the patient.
3. "Submitted" means the date the claim is received by the administration or the prepaid capitated provider, whichever is applicable, as established by the date stamp on the face of the document or other record of receipt.

H. In any county having a population of five hundred thousand or fewer persons, a hospital that executes a subcontract other than a capitation contract with a contractor for the provision of hospital and medical services pursuant to this article shall offer a subcontract to any other contractor providing services to that portion of the county and to any other person that plans to become a contractor in that portion of the county. If such a hospital executes a subcontract other than a capitation contract with a contractor for the provision of hospital and medical services pursuant to this article, the hospital shall adopt uniform criteria to govern the reimbursement levels paid by all contractors with whom the hospital executes such a subcontract. Reimbursement levels offered by hospitals to contractors pursuant to this subsection may vary among contractors only as a result of the number of bed days purchased by the contractors, the amount of financial deposit required by the hospital, if any, or the schedule of performance discounts offered by the hospital to the contractor for timely payment of claims.

I. This subsection applies to inpatient hospital admissions and to outpatient hospital services on and after March 1, 1993. The director may negotiate at any time with a hospital on behalf of a contractor for services provided pursuant to this article. If a contractor negotiates with a hospital for services provided pursuant to this article, the following procedures apply:

1. The director shall require any contractor to reimburse hospitals for services provided under this article based on reimbursement levels that do not in the aggregate exceed those established pursuant to section 36-2903.01 and under terms on which the contractor and the hospital agree. However, a hospital and a contractor may agree on a different payment methodology than the methodology prescribed by the director pursuant to section 36-2903.01. The director by rule shall prescribe:

- (a) The time limits for any negotiation between the contractor and the hospital.

- (b) The ability of the director to review and approve or disapprove the reimbursement levels and terms agreed on by the contractor and the hospital.

- (c) That if a contractor and a hospital do not agree on reimbursement levels and terms as required by this subsection, the reimbursement levels established pursuant to section 36-2903.01 apply.

(d) That, except if submitted under an electronic claims submission system, a hospital bill is considered received for purposes of subdivision (f) on initial receipt of the legible, error-free claim form by the contractor if the claim includes the following error-free documentation in legible form:

(i) An admission face sheet.

(ii) An itemized statement.

(iii) An admission history and physical.

(iv) A discharge summary or an interim summary if the claim is split.

(v) An emergency record, if admission was through the emergency room.

(vi) Operative reports, if applicable.

(vii) A labor and delivery room report, if applicable.

(e) That payment received by a hospital from a contractor is considered payment by the contractor of the 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.

(f) That a contractor shall pay for services rendered on and after October 1, 1997 under any reimbursement level according to paragraph 1 of this subsection subject to the following:

(i) If the hospital's bill is paid within thirty days of the date the bill was received, the contractor shall pay ninety-nine per cent of the rate.

(ii) If the hospital's bill is paid after thirty days but within sixty days of the date the bill was received, the contractor shall pay one hundred per cent of the rate.

(iii) If the hospital's bill is paid any time after sixty days of the date the bill was received, the contractor shall pay one hundred per cent of the rate plus a fee of one per cent per month for each month or portion of a month following the sixtieth day of receipt of the bill until the date of payment.

2. In any county having a population of five hundred thousand or fewer persons, a hospital that executes a subcontract other than a capitation contract with a provider for the provision of hospital and medical services pursuant to this article shall offer a subcontract to any other provider providing services to that portion of the county and to any other person that plans to become a provider in that portion of the county. If a hospital executes a subcontract other than a capitation contract with a provider for the provision of hospital and medical services pursuant to this article, the hospital shall adopt uniform criteria to govern the reimbursement levels paid by all providers with whom the hospital executes a subcontract.

J. If there is an insufficient number of, or an inadequate member capacity in, contracts awarded to contractors, the director, in order to deliver covered services to members enrolled or expected to be enrolled in the system within a county, may negotiate and award, without bid, a contract with a health care services organization holding a certificate of authority pursuant to title 20, chapter 4, article 9. The director shall require a health care services organization contracting under this subsection to comply with section 36-2906.01. The term of the contract shall not extend beyond the next bid and contract award process as provided in section 36-2906 and shall be no greater than capitation rates paid to contractors in the same county or counties pursuant to section 36-2906. Contracts awarded pursuant to this subsection are exempt from the requirements of title 41, chapter 23.

K. A contractor may require that a subcontracting or noncontracting provider shall be paid for covered services, other than hospital services, according to the capped fee-for-service schedule adopted by the director pursuant to subsection A, paragraph 2 of this section or subsection B, paragraph 1 of this section or at lower rates as may be negotiated by the contractor.

L. The director shall require any contractor to have a plan to notify members of reproductive age either directly or through the parent or legal guardian, whichever is most appropriate, of the specific covered family planning services available to them and a plan to deliver those services to members who request them. The director shall ensure that these plans include provisions for written notification, other than the member handbook, and verbal notification during a member's visit with the member's primary care physician or primary care practitioner.

M. The director shall adopt a plan to notify members of reproductive age who receive care from a contractor who elects not to provide family planning services of the specific covered family planning services available to them and to provide for the delivery of those services to members who request them. Notification may be directly to the member, or through the parent or legal guardian, whichever is most appropriate. The director shall ensure that the plan includes provisions for written notification, other than the member handbook, and verbal notification during a member's visit with the member's primary care physician or primary care practitioner.

N. The director shall prepare a report that represents a statistically valid sample and that indicates the number of children age two by contractor who received the immunizations recommended by the national centers for disease control and prevention while enrolled as members. The report shall indicate each type of immunization and the number and percentage of enrolled children in the sample age two who received each type of immunization. The report shall be done by contract year and shall be delivered to the governor, the president of the senate and the speaker of the house of representatives no later than April 1, 2004 and every second year thereafter.

O. If the administration implements an electronic claims submission system it may adopt procedures pursuant to subsection I, paragraph 1 of this section requiring documentation different than prescribed under subsection I, paragraph 1, subdivision (d) of this section.

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.

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (F-17-1002)**

Title 9, Chapter 22, Article 7, Standards for Payments



**GOVERNOR'S REGULATORY REVIEW COUNCIL  
ANALYSIS OF FIVE-YEAR REVIEW REPORT**

**MEETING DATE:** November 7, 2017

**AGENDA ITEM:** G-3

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

**FROM:** Council Staff

**DATE :** October 24, 2017

**SUBJECT:** **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (F-17-1002)**  
Title 9, Chapter 22, Article 7, Standards for Payments

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**COMMENTS ON THE FIVE-YEAR-REVIEW REPORT**

**Purpose of the Agency and Number of Rules in the Report**

The purpose of the Arizona Health Care Cost Containment System (AHCCCS) is "to promote a comprehensive health care system to eligible citizens of this state." Laws 2013, 1st S.S., Ch. 10, § 53. This system is managed by the Director of the AHCCCS Administration (Administration), which is established under A.R.S. § 36-2902(A). The Director has the powers and duties prescribed in A.R.S. §§ 36-2903 and 2903.01.

This five-year-review report covers 53 rules in A.A.C. Title 9, Chapter 22, Article 7. The rules in article 7 establish the standards for payments for providers who render services to persons in the AHCCCS acute care programs.

Since the previous five-year-review report, approved by the Council in July 2012, substantial changes to reimbursement have been enacted by the Legislature and the Administration has engaged in extensive rulemaking to implement the payment provisions. Specifically, the Administration has engaged in rulemaking in regards to the implementation of the Diagnosis Related Group (DRG) hospital reimbursement methodology and the updating of payment standards for outpatient hospital services. The rules were amended at various times between 2002 and 2017.

**Proposed Action**

In September 2017, the Administration filed a Notice of Proposed Rulemaking for R9-28-703 to revise supplemental payments to nursing facilities. At the same time, the Administration filed another Notice of Proposed Rulemaking for R9-22-712.05, related to

graduate medical education payment. The Administration has planned for additional rulemakings, including revisions to value based purchasing (VBP) rules and the hospital assessment rule, in 2018.

**1. Has the agency analyzed whether the rules are authorized by statute?**

Yes. The Administration cites to general and specific authority for the rules. Under A.R.S. § 36-2903.01(F), in relevant part, “[i]n addition to the rules otherwise specified in this article [Arizona Health Care Cost Containment System], the [Administration] may adopt necessary rules pursuant to [T]itle 41, [C]hapter 6 to carry out this article.”

**2. Summary of the agency’s economic impact comparison and identification of stakeholders:**

Key stakeholders that are impacted by these rules are the Administration, health care-service providers and the general public. Currently, approximately 1.7 million Arizonans are enrolled in one of several managed care entities under contract with AHCCCS.

The Administration believes that the economic impact has generally been as predicted in the prior EIS for the rules.

**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?**

Yes. The Administration indicates that the rules as written impose the least burden and cost to the regulated community.

**4. Has the agency received any written criticisms of the rules over the last five years?**

No. The Administration indicates that it has not received any written criticisms of the rules during the last five years.

**5. Has the agency analyzed the rules’ clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?**

Yes. The Administration indicates that the following amendments will make the rules more clear, concise, and understandable:

- R9-22-701: Definition of non-Indian Health Service (IHS) acute hospital should be revised to remove language “is not a freestanding hospital, such as an IMD” for clarity and greater accuracy.
- R9-22-703: Term “Tribal facility” should be amended to 638 Tribal facility. Under the 638 agreement, Indian tribes are permitted to operate health programs that furnish covered Medicaid services under a contract or compact with the IHS.

- R9-22-705: Additional language regarding recoupment of overpayments by contractors should be added, to provide more clarity.
- R9-22-712: Subsection (G) should be repealed because it is outdated.
- R9-22-712.01: The section should be repealed after the timeframe for processing and resolution of all claims subject to this rule has passed.
- R9-22-712.09: The section should be updated to specify the hospitals to which the coding hierarchy pertains.
- R9-22-712.45: Subsection (B) should be revised to refer to DRG.

The Administration also indicates that most of the rules are effective in achieving their objectives and all of the rules are consistent with their objectives.

**6. Has the agency analyzed the current enforcement status of the rules?**

Yes. The Administration indicates that the rules are enforced as written.

**7. 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 Administration indicates that the rules are not more stringent than federal law.

**8. 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?**

No. The rules do not require issuance of a permit, license, or agency authorization.

**9. Conclusion**

In addition to the Notices of Proposed Rulemaking that the Administration submitted to the Secretary of State's office last month, the Administration plans to address the issues in this report in 2018. The report meets the requirements of A.R.S. § 41-1056 and R1-6-301. Staff recommends that the report be approved.

July 25, 2017

Ms. Nicole Ong, Chair  
Governor's Regulatory Review Council  
100 N. 15<sup>th</sup> Ave, Suite 305  
Phoenix, AZ 85007

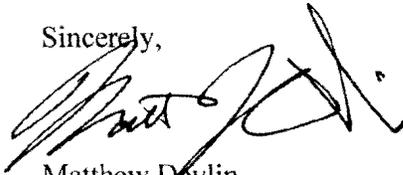
Dear Ms. Ong:

Pursuant to requirements in R1-6-301, attached is a copy of the 5-Year Review Report for Title 9, Chapter 22, Article 7. 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 Gina Relkin, Office of Administrative Legal Services at (602) 417-4575.

Sincerely,



Matthew Devlin  
Assistant Director

Attachments

**Arizona Health Care Cost Containment System  
(AHCCCS)**

**5 YEAR REVIEW REPORT**

**A.A.C. Title 9, Chapter 22, Article 7**

July 2017

## **I. General Information about 9 A.A.C. 22, Article 7**

### **Overview:**

The Arizona Health Care Cost Containment System Administration (AHCCCS) serves as the State's Medicaid Agency pursuant to Title XIX of the Social Security Act and also administers a variety of health care-related programs, including KidsCare, Arizona's version of the State Children's Health Insurance Program (SCHIP) authorized by Title XXI of the Social Security Act. Both AHCCCS Medicaid and KidsCare are cooperative joint federally and state funded programs where Arizona receives partial reimbursement of administrative and program costs from the federal government. AHCCCS must comply with federal statutes and regulations as well as state statutes and regulations to implement program requirements.

As of July 2017, AHCCCS, directly or through contracts, provides health care coverage for approximately 2 million Arizonans. Most beneficiaries receive coverage through managed care organizations (known as "health plans" and "program contractors") that contract with the AHCCCS Administration to provide covered physical and behavioral health services. In excess of 1.5 million persons are enrolled in one of several health plans under contract with the AHCCCS Administration to provide acute care services. In addition, almost 60,000 individuals are enrolled with program contractors serving as managed care organizations, coordinating delivery of both acute and long-term care services to persons whose level of care meet criteria for care in an institutional setting and who are age 65 years or older, have a physical disability, or have a developmental disability. A few hundred thousand persons eligible for AHCCCS benefits receive health services on a fee-for-service basis, including American Indians who elect not to receive services through managed care organizations, and persons who are eligible only for emergency services.

The rules in A.A.C. Title 9, Chapter 22, Article 7 delineate the standards of payments for providers who render services to persons in the AHCCCS acute care programs. Since the prior Five Year Review Report, substantial changes to reimbursement have been enacted by the Arizona Legislature and the AHCCCS Administration has engaged in extensive rulemaking to implement payment provisions. During the past few years, the Agency has engaged in extensive rulemaking activities regarding payment provisions, including the implementation of the DRG hospital

reimbursement methodology and the updating of payment standards for outpatient hospital services. In February 2017, AHCCCS promulgated new rule R9-22-712.90 “Reimbursement of Hospital-based Freestanding Emergency Departments.” In January 2017 AHCCCS amended R9-28-702 “Nursing Facility Assessment” and also amended hospital assessment rule R9-22-730 effective July 1, 2017 through exempt rulemaking. During 2016 several rules pertaining to payment were also amended including technical revisions to the DRG and VBP rules, updating R9-22-730 for the prior fiscal year, revising the Graduate Medical Education Fund Allocation described in R9-22-712.05, and the Rural Hospital Inpatient Fund Allocation described in R9-22-712.07. Additional rulemakings were completed for Article 7 in years 2013, 2014, and 2015.

## **II. Five Year Report on 9 A.A.C. 22, Article 7 rules:**

### **General and specific statutes authorizing the rule:**

A.R.S. § 36-2903.01, 36-2903, and 36-2904 provide general authority to AHCCCS to adopt rules.

A.R.S. §§ 36-2903, 36-2904, 36-2905.01, 36-2901.08, 36-2906, 36-2999.52, 36-2999.54 provide implementing authority.

### **Objective of the rule:**

R9-22-701 – The objective of this rule is to primarily provide definitions that specifically support the payment regulations outlined in Article 7.

R9-22-701.10 - The objective of this rule is to describe the limitations on the scope of the liability for the Administration and contractors.

R9-22-702 - The objective of this rule is to require health care providers to accept, as payment in full, the amount paid by the AHCCCS program plus any additional copayment or third party payments made by or on behalf of the member. It also sets forth the circumstances when a member may be billed for services.

R9-22-703 - The objective of this rule is to set forth claims submission timelines and related claims processing provisions required for reimbursement to providers for health care services.

R9-22-705 - The objective of this rule is to describe payment guidelines for contracting prepaid health plans to reimburse subcontractors and non-contracting providers for the provision of health care services rendered to an AHCCCS member.

R9-22-708 - The objective of this rule is to set forth provisions governing payment for

services rendered to eligible American Indians.

R9-22-709 – The objective of this rule is to describe provisions governing payment liability for emergency health care and subsequent care as well as facility transfer conditions.

R9-22-710 – The objective of this rule is to describe provisions relating to fee schedules maintained by the Administration to reimburse non-hospital health care services.

R9-22-711 – The objective of this rule is to describe the co-payment requirements that a member must pay when receiving medical services.

R9-22-712 – The objective of this rule is to describe the cost-based reimbursement system that uses a prospective tiered per diem reimbursement methodology for inpatient services and a cost-to-charge ratio for outpatient services. The tiered per diem methodology includes: a statewide operating component, a blended statewide/hospital specific capital component and provisions for outlier payments; and provisions for transplant services and annual update factors.

R9-22-712.01 – The objective of this rule is to describe the methodology for inpatient hospital reimbursement, explaining the tier rate data, components, assignment and exclusions. In addition, it describes when the tiers are updated and how new hospitals, outliers, transplants, ownership changes, psychiatric hospital specialty facilities and outliers for new hospitals are reimbursed.

R9-22-712.05 - The objective of this rule is to describe how the Graduate Medical Education Fund will be allocated among hospitals.

R9-22-712.07 – The objective of this rule is to describe how the Rural Hospital Inpatient Fund will be allocated among rural hospitals.

R9-22-712.09 – The objective of this rule is to list the tier hierarchy of the inpatient reimbursement system.

R9-22-712.10 – The objective of this rule is to describe general information applicable to the reimbursement of outpatient hospital services.

R9-22-712.15 – The objective of this rule is to notify that reimbursement using the capped fee for service schedule is applicable to non-IHS acute hospitals.

R9-22-712.20 – The objective of this rule is to describe the methodology for reimbursement using the capped fee for service schedule for outpatient hospital services.

R9-22-712.25 – The objective of this rule is to describe how associated service costs are accounted for within the outpatient reimbursement methodology.

R9-22-712.30 – The objective of this rule is to describe how reimbursement is made for a service not listed in the outpatient capped fee-for-service schedule.

R9-22-712.35 – The objective of this rule is to describe how the outpatient capped fee for service schedule is adjusted by type of hospital submitting claims.

R9-22-712.40 – The objective of this rule is to describe when updates are made to the outpatient fee schedule and rates used for reimbursement.

R9-22-712.45 – The objective of this rule is to describe the reimbursement restrictions for outpatient hospital services.

R9-22-712.50 – The objective of this rule is to describe the forms a hospital must use when billing for outpatient hospital services.

R9-22-712.60 - The objective of this rule is to describe how the payments are made using the Diagnosis Related Group methodology.

R9-22-712.61 - The objective of this rule explains the exceptions to the Diagnosis Related Group (DRG) methodology.

R9-22-712.62 - The objective of this rule explains the calculation of the DRG base payment.

R9-22-712.63 - The objective of this rule is to describe the calculation when the DRG base payment is not based on the statewide standardized amount.

R9-22-712.64 - The objective of this rule sets forth the methodology for DRG base payments and the Outlier CCR (Cost-To-Charge Ratio) for out-of-state hospitals.

R9-22-712.65 - The objective of this rule is to describe the DRG provider policy adjuster.

R9-22-712.66 - The objective of this rule is to describe the DRG service policy adjuster.

R9-22-712.67 - The objective of this rule explains the DRG reimbursement when there is a “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.

R9-22-712.68 - The objective of this rule is to describe the DRG reimbursement when there is an unadjusted outlier add-on payment.

R9-22-712.69 – The objective of this rule explains the DRG reimbursement when there is a covered day adjusted DRG base payment and covered day adjusted outlier add-on payment.

R9-22-712.70 – The objective of this rule explains the DRG reimbursement when there is a covered day adjusted DRG payment and covered day adjusted outlier add-on payment for FES members.

R9-22-712.71 – The objective of this rule describes the final DRG payment.

R9-22-712.72 – The objective of this rule explains DRG reimbursement when there is an enrollment change during an inpatient stay.

R9-22-712.73 - The objective of this rule explains DRG reimbursement for Inpatient stays for members eligible for Medicare.

R9-22-712.74 – The objective of this rule describes DRG reimbursement when there is third party liability.

R9-22-712.75 – The objective of this rule describes the payment for administrative days in relation to DRG reimbursement.

R9-22-712.76 – The objective of this rule explains the reimbursement of interim claims in relations to DRG reimbursement.

R9-22-712.77 – The objective of this rule describes DRG reimbursement when there are admissions and discharges on the same day.

R9-22-712.78 – The objective of this rule explains DRG reimbursement when a member is readmitted to the hospital.

R9-22-712.79 – The objective of this rule describes DRG reimbursement when there is a change in hospital's ownership.

R9-22-712.80 – The objective of this rule explains DRG reimbursement pertaining to new hospitals.

R9-22-712.81 – The objective of this rule describes how the Administration handles updates to the DRG

R9-22-712.90-The objective of this rule sets forth reimbursement requirements for hospital-based freestanding emergency departments.

R9-22-713 – The objective of this rule is to require a provider to repay overpayments to the Administration.

R9-22-714 – The objective of this rule is to describe the requirement of a provider agreement and to set forth specific requirements for the Administration and a contractor to reimburse a provider.

R9-22-715 - The objective of this rule is to describe basic contractor responsibilities relating to hospital negotiations. This subsection also enables the Administration to negotiate with hospitals on behalf of prepaid health plans for AHCCCS services.

R9-22-718 – The objective of this rule is to require contractors to enter into a contract for reimbursement of inpatient hospital services with one or more hospitals in a county of more than 500,000 individuals. This rule also delineates mandatory terms to be included in the contract.

R9-22-719 – The objective of this rule is to allow the Administration to retain a specified percentage of capitation reimbursement in order to distribute monies to contractors based on their performance outcomes.

R9-22-720 – The objective of this rule is to describe the reimbursement of reinsurance for high cost hospital services.

R9-22-730-The objective of this rule is to set forth the requirements for the hospital assessment levied against hospitals pursuant to ARS 36-2901.08

**Effectively meets its objectives, including any available data supporting conclusion:**

Chapter 22, Article 7 meets the objectives listed above. No data was attained.

**Consistent with Statutes, rules, (including Federal, State, Waiver, Policy)**

Chapter 22, Article 7 is consistent with statutes and federal regulations.

**Is enforced:**

Chapter 22, Article 7 is enforced with no issues.

**Clarity, conciseness and understandability of the rule:**

The Administration has recently completed or is currently in the process of multiple rulemakings regarding reimbursement rules in Article 7. Two rulemakings, those updating the DRG inpatient reimbursement methodology and revising the value based purchasing (VBP) rules for inpatient and outpatient hospitals have already been completed. These rulemakings pertain to DRG rules A.A.C. R9-22-712.60 through 712.80 and VBP rules A.A.C. R9-22-712.35, 712.61, and 712.71. On July 1, 2017 Hospital Assessment rule A.A.C. R9-22-730 became effective through exempt rulemaking.

As of September 2017, a Notice of Proposed Rulemaking has been filed with the Secretary of State for A.A.C. R9-28-703 to revise supplemental payments to nursing facilities. At the same time, the Administration has submitted a Notice of Proposed Rulemaking regarding the graduate medical education payment rule A.A.C. R9-22-712.05. Additional rulemakings are planned for 2018 including revisions to VBP payments rules for the following contract year and the hospital assessment rule.

Finally, the following clarifications for rules in Article 7 are recommended. Otherwise, the rules in Article 7 are clear, concise and understandable.

R9-22-701 -The Administration recommends revision of the definition of non IHS acute hospital to remove language “is not a freestanding hospital, such as an IMD” for greater clarity and accuracy.

R9-22-703: The Administration intends to clarify that American Indians who are eligible to receive services through IHS may be enrolled with a Contractor. For greater clarity, it is recommended that the term “Tribal facility” be revised to 638 Tribal facility. A 638 Tribal facility is a facility owned and operated by a federally recognized American Indian tribe or tribal organization under a 638 agreement pursuant to the 1975 Indian Self- Determination and Education Assistance Act, Public Law 93-638 which permits Indian Tribes to directly operate health programs that furnish covered Medicaid services under a contract or compact with the Indian Health Service (IHS).

R9-22-705-To provide greater clarity, the Administration recommends additional language regarding recoupment of overpayments by Contractors similar to language from R9-22-703(F).

R9-22-712: The Administration intends to repeal subsection (G) because the rule applies to outpatient reimbursement for services from March 1, 1993 through June 30, 2005.

R9-22-712.01-After the timeframe for processing and resolution of all claims subject to this rule has passed, repeal of this rule is recommended as the provisions pertain to hospital reimbursement for claims with discharge dates through September 30, 2014.

R9-22-712.09- To provide greater clarity, the Administration recommends updating the rule to specify the hospitals to which the coding hierarchy pertains.

R9-22-712.45: The Administration intends to update the language in subsection (B) to refer to DRG.

**Had written criticisms in the past five years, including written analyses submitted questioning if the rule is based on valid scientific or reliable principles or methods:**

Written criticisms or written analyses for Chapter 22, Article 7 have not been submitted in the past five years.

**Comparison of estimated economic, small business, and consumer impact.**

The economic impact estimated at the time of rule promulgation has not been significantly different than the actual economic impact.

**Was there any analysis submitted to the agency by another person regarding the rule's impact on this state's business competitiveness as compared to the competitiveness of businesses in other states:**

No.

**If applicable, has the agency completed the course of action indicated in the agency's previous five-year review:**

As explained above, AHCCCS completed rulemakings authorizing DRG reimbursement for inpatient hospital services, and multiple revisions have been made to many reimbursement provisions in Article 7. Regarding recommendations from the prior Report, AHCCCS did not strike A.A.C. R9-22-720(C), however, the requirements of the reinsurance process are specified in contract. The recommendation discussed in A.A.C. R9-22-714 is expected to be addressed in a future rulemaking which will revise the grievance and appeals system requirements to conform with federal regulations which recently became effective.

**Has there been 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 persons regulated 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.

**A determination after analysis that the rule is not more stringent than a corresponding federal law. Are the rules more stringent than a corresponding federal law? Is there a statutory authority that exceeds the requirements of that federal law?:**

The rules are not more stringent than corresponding federal law.

**Does the rule comply with section 41-1037 for issuance of permit, license or agency authorization?**

Not applicable, the Administration does not issue permits, license or agency authorization for the imposition the definitions section of Chapter 22.

**Course of action, including the month and year when the agency anticipates submitting rules to the GRRC to amend repeal or make a rule:**

As previously mentioned, AHCCCS is currently in the process of amending the DRG Rules located at R9-22-712.60 through 712.81, and the VBP rules in R9-22-712.35, 712.61, and 712.71. Proposed DRG rules have been filed and a public hearing is scheduled for August 8, 2017. The final VBP rules will be presented at the August 1, 2017 GRRC Council meeting. With respect to the courses of action described above, AHCCCS intends to complete these actions in 2018.



Within the stated calendar quarter, this Title 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.

**TITLE 9. Health Services**

**Chapter 22. Arizona Health Care Cost Containment System - Administration**

Sections, Parts, Exhibits, Tables or Appendices modified  
R9-22-730

REMOVE Supp. 16-4  
Pages: 1 - 120

REPLACE with Supp. 17-2  
Pages: 1 - 121

*The agency's contact person who can answer questions about rules in this Chapter:*

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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.*

**PUBLISHER**  
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## 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  
ADMINISTRATIVE RULES DIVISION  
June 30, 2017

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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 2017 is cited as Supp. 17-1.

### **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 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION**

*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), pursuant to 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.*

**ARTICLE 1. DEFINITIONS**

*New Article 1, consisting of Sections R9-22-101 through R9-22-103, R9-22-105, and R9-22-106 through R9-22-112 adopted effective December 8, 1997 (Supp. 97-4).*

*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.*

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*Article 22, consisting of Sections R9-22-901 through R9-22-908, adopted effective August 29, 1985.*

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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).

Article 13, consisting of Sections R9-22-1301 through R9-22-1309, adopted effective September 9, 1998 (Supp. 98-3).

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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 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

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

Definition	Section or Citation	Definition	Section or Citation
"Accommodation"	R9-22-701	"Cost-To-Charge Ratio" or "CCR"	R9-22-701 or R9-22-712
"Active treatment"	R9-22-1301	"Court-ordered evaluation"	R9-22-1201
"ADHS"	R9-22-101	"Court-ordered pre-petition screening"	R9-22-1201
"Administration"	A.R.S. § 36-2901	"Court-ordered treatment"	R9-22-1201
"Adult behavioral health therapeutic home"	9 A.A.C. 10, Article 1	"Covered charges"	R9-22-701
"Adverse action"	R9-22-101	"Covered services"	R9-22-101
"Affiliated corporate organization"	R9-22-101	"CPT"	R9-22-701
"Aged"	42 U.S.C. 1382c(a)(1)(A) and R9-22-1501	"Creditable coverage"	R9-22-2003 and 42 U.S.C. 300gg(c)
"Agency"	R9-22-1201	"Crisis services"	R9-22-1201
"Aggregate"	R9-22-701	"Critical Access Hospital"	R9-22-701
"AHCCCS"	R9-22-101	"CRS application"	R9-22-1301
"AHCCCS inpatient hospital day or days of care"	R9-22-701	"CRS condition"	R9-22-1301
"AHCCCS registered provider"	R9-22-101	"CRS provider"	R9-22-1301
"Ambulance"	A.R.S. § 36-2201	"Cryotherapy"	R9-22-2001
"Ancillary service"	R9-22-101	"Customized DME"	R9-22-212
"Anticipatory guidance"	R9-22-201	"Day"	R9-22-101 and R9-22-1101
"Annual enrollment choice"	R9-22-1701	"Date of the Notice of Adverse Action"	R9-22-1441
"APC"	R9-22-701	"DBHS"	R9-22-101
"Applicant"	R9-22-101 or R9-22-301	"DCSS"	R9-22-301
"Application"	R9-22-101	"Department"	A.R.S. § 36-2901
"Assessment"	R9-22-1101 or R9-22-1201	"Dependent child"	A.R.S. § 46-101 or R9-22-1401
"Assignment"	R9-22-101	"DES"	R9-22-101
"Attending physician"	R9-22-101 or R9-22-202	"Diagnostic services"	R9-22-101
"Authorized representative"	R9-22-101	"Direct graduate medical education costs" or "direct program costs"	R9-22-701
"Authorization"	R9-22-202	"Direct supervision"	R9-22-1201
"Auto-assignment algorithm"	R9-22-1701	"Director"	R9-22-101
"AZ-NBCCEDP"	R9-22-2001	"Disabled"	R9-22-1501
"Behavior management services"	R9-22-1201	"Discussion"	R9-22-101
"Behavioral health therapeutic home care services"	R9-22-1201	"Disenrollment"	R9-22-1701
"Behavioral health paraprofessional"	R9-22-101	"DME"	R9-22-101
"Behavioral health professional"	R9-22-101	"DRI inflation factor"	R9-22-701
"Behavioral health recipient"	R9-22-201	"E.P.S.D.T. services"	42 CFR 440.40(b)
"Behavioral health services"	R9-22-1201	"Eligibility posting"	R9-22-701
"Behavioral health technician"	R9-22-1201	"Eligible person"	A.R.S. § 36-2901
"Benefit year"	R9-22-201	"Emergency behavioral health condition for a non-FES member"	R9-22-201
"BHS" R9-22-301		"Emergency behavioral health services for a non-FES member"	R9-22-201
"Billed charges"	R9-22-701	"Emergency medical condition for a non-FES member"	R9-22-201
"Blind"	R9-22-1501	"Emergency medical services for a non-FES member"	R9-22-201
"Burial plot"	R9-22-1401	"Emergency medical services provider"	R9-22-1201
"Business agent"	R9-22-701	"Emergency medical or behavioral health condition for a FES member"	R9-22-217
"Calculated inpatient costs"	R9-22-712.07	"Emergency services costs"	A.R.S. § 36-2903.07
"Capital costs"	R9-22-701	"Emergency services for a FES member"	R9-22-217
"Capped fee-for-service"	R9-22-101	"Encounter"	R9-22-701
"Caretaker relative"	R9-22-1401	"Enrollment"	R9-22-1701
"Case management"	R9-22-1201	"Equity"	R9-22-101
"Case record"	R9-22-101	"Experimental services"	R9-22-203
"Cash assistance"	R9-22-1401	"Existing outpatient service"	R9-22-701
"Certified psychiatric nurse practitioner"	R9-22-1201	"Expansion funds"	R9-22-701
"Charge master"	R9-22-712	"FAA"	R9-22-301
"Child"	R9-22-1503	"Facility"	R9-22-101
"Children's Rehabilitative Services" or "CRS"	R9-22-101 or R9-22-301	"Factor"	R9-22-701 and 42 CFR 447.10
"Chronic"	R9-22-1301	"FBR"	R9-22-101
"Claim"	R9-22-1101	"Federal financial participation" or "FFP"	42 CFR 400.203
"Claims paid amount"	R9-22-712.07	"Federal poverty level" or "FPL"	A.R.S. § 36-2981
"Clean claim"	A.R.S. § 36-2904	"Fee-For-Service" or "FFS"	R9-22-101
"Clinical oversight"	9 A.A.C. 10	"FES member"	R9-22-101
"CMDP"	R9-22-1701	"FESP"	R9-22-101
"CMS"	R9-22-101	"First-party liability"	R9-22-1001
"Continuous stay"	R9-22-101	"File"	R9-22-1101
"Contract"	R9-22-101	"Fiscal agent"	R9-22-210
"Contract year"	R9-22-101	"Fiscal intermediary"	R9-22-701
"Contractor"	A.R.S. § 36-2901 or R9-22-210.01	"Foster care maintenance payment"	42 U.S.C. 675(4)(A)
"Copayment"	R9-22-701	"FQHC"	R9-22-101
"Cost avoid"	R9-22-1201	"Freestanding Children's Hospital"	R9-22-701
		"Functionally limiting"	R9-22-1301
		"Fund"	R9-22-712.07
		"Graduate medical education (GME) program"	R9-22-701

## Arizona Health Care Cost Containment System - Administration

“GME program approved by the Administration” or “approved GME program”	R9-22-701	“Person”	R9-22-1101
“Grievance”	A.A.C. Chapter 34	“Pharmaceutical service”	R9-22-201
“GSA”	R9-22-101	“Physical therapy”	R9-22-201
“HCAC”	R9-22-701	“Physician”	R9-22-101
“HCPCS”	R9-22-701	“Physician assistant”	R9-22-1201
“Health care institution”	A.R.S. § 36-401	“Post-stabilization services”	R9-22-201 or 42 CFR 422.113
“Health care practitioner”	R9-22-1201	“PPS bed”	R9-22-701
“Hearing aid”	R9-22-201	“Practitioner”	R9-22-101
“HIPAA”	R9-22-701	“Pre-enrollment process”	R9-22-301
“Home health services”	R9-22-201	“Prescription”	R9-22-101
“Hospital”	R9-22-101	“Primary care provider” or “PCP”	R9-22-101
“ICU”	R9-22-701	“Primary care provider services”	R9-22-201
“IHS”	R9-22-101	“Prior authorization”	R9-22-101
“IHS enrolled” or “enrolled with IHS”	R9-22-708	“Prior period coverage” or “PPC”	R9-22-101
“IMD” or “Institution for Mental Diseases”	42 CFR 435.1010 and R9-22-101	“Procedure code”	R9-22-701
“Income”	R9-22-301	“Procurement file”	R9-22-601
“Indirect program costs”	R9-22-701	“Proposal”	R9-22-101
“Individual”	R9-22-211	“Prospective rates”	R9-22-701
“In-kind income”	R9-22-1420	“Psychiatrist”	R9-22-1201
“Inmate of a public institution”	42 CFR 435.1010	“Psychologist”	R9-22-1201
“Inpatient covered charges”	R9-22-712.07	“Psychosocial rehabilitation services”	R9-22-201
“Intermediate Care Facility for the Mentally Retarded” or “ICF-MR”	42 U.S.C. 1396d(d)	“Public hospital”	R9-22-701
“Intern and Resident Information System”	R9-22-701	“Qualified alien”	A.R.S. § 36-2903.03
“LEEP”	R9-22-2001	“Qualified behavioral health service provider”	R9-22-1201
“Legal representative”	R9-22-101	“Quality management”	R9-22-501
“Level I trauma center”	R9-22-2101	“Radiology”	R9-22-101
“License” or “licensure”	R9-22-101	“RBHA” or “Regional Behavioral Health Authority”	R9-22-201
“Licensee”	R9-22-1201	“Reason to know” or “had reason to know”	R9-22-1101
“MAGI-based income”	R9-22-1401	“Rebase”	R9-22-701
“Mailing date”	R9-22-101	“Redetermination”	R9-22-1301
“Medical education costs”	R9-22-701	“Referral”	R9-22-101
“Medical expense deduction” or “MED”	R9-22-1401	“Rehabilitation services”	R9-22-101
“Medical practitioner”	R9-22-1201	“Reinsurance”	R9-22-701
“Medical record”	R9-22-101	“Remittance advice”	R9-22-701
“Medical review”	R9-22-701	“Resident”	R9-22-701
“Medical services”	A.R.S. § 36-401	“Residual functional deficit”	R9-22-201
“Medical supplies”	R9-22-101	“Resources”	R9-22-301
“Medical support”	R9-22-301	“Respiratory therapy”	R9-22-201
“Medically eligible”	R9-22-1301	“Respite”	R9-22-1201
“Medically necessary”	R9-22-101	“Responsible offeror”	R9-22-101
“Medicare claim”	R9-22-101	“Responsive offeror”	R9-22-101
“Medicare Urban or Rural Cost-to-Charge Ratio (CCR)”	R9-22-701	“Revenue Code”	R9-22-701
“Member”	A.R.S. § 36-2901 or R9-22-301	“Review”	R9-22-101
“Mental disorder”	A.R.S. § 36-501	“Review month”	R9-22-101
“Milliman study”	R9-22-712.07	“RFP”	R9-22-101
“Monthly equivalent”	R9-22-1401	“Rural Contractor”	R9-22-718
“Monthly income”	R9-22-1401	“Rural Hospital”	R9-22-712.07 and R9-22-718
“National Standard code sets”	R9-22-701	“Scope of services”	R9-22-201
“New hospital”	R9-22-701	“Section 1115 Waiver”	A.R.S. § 36-2901
“NICU”	R9-22-701	“Service location”	R9-22-101
“Noncontracted Hospital”	R9-22-718	“Service site”	R9-22-101
“Noncontracting provider”	A.R.S. § 36-2901	“SOBRA”	R9-22-101
“Non-FES member”	R9-22-101	“Specialist”	R9-22-101
“Non-IHS Acute Hospital”	R9-22-701	“Specialty facility”	R9-22-701
“Nursing facility” or “NF”	42 U.S.C. 1396r(a)	“Speech therapy”	R9-22-201
“Observation day”	R9-22-701	“Spendthrift restriction”	R9-22-1401
“Occupational therapy”	R9-22-201	“Sponsor”	R9-22-301
“Offeror”	R9-22-101	“Sponsor deemed income”	R9-22-301
“Operating costs”	R9-22-701	“Sponsoring institution”	R9-22-701
“OPPC”	R9-22-701	“Spouse”	R9-22-101
“Organized health care delivery system”	R9-22-701	“SSA”	42 CFR 1000.10
“Outlier”	R9-22-701	“SSI”	42 CFR 435.4
“Outpatient hospital service”	R9-22-701	“SSN”	R9-22-101
“Ownership change”	R9-22-701	“Stabilize”	42 U.S.C. 1395dd
“Ownership interest”	42 CFR 455.101	“Standard of care”	R9-22-101
“Partial Care”	R9-22-1201	“Sterilization”	R9-22-201
“Participating institution”	R9-22-701	“Subcontract”	R9-22-101
“Peer group”	R9-22-701	“Submitted”	A.R.S. § 36-2904
“Peer-reviewed study”	R9-22-2001	“Substance abuse”	R9-22-201
“Penalty”	R9-22-1101	“SVES”	R9-22-301
		“Tax dependent”	42 CFR 435.4
		“Taxi”	A.R.S. § 28-101(53)
		“Taxpayer”	R9-22-1401

## Arizona Health Care Cost Containment System - Administration

“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.

“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.

## Arizona Health Care Cost Containment System - Administration

“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, whichever 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.

## Arizona Health Care Cost Containment System - Administration

“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 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,

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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****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

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(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:

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.

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“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, practi-

tioner, 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.
- 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.

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- 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 10, 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.
  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.

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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.
- C.** 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 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).
- 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

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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:
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).

**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**

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- 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.
- 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).

**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:
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

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(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 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.

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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.
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.

**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), paragraph (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.
  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 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.**

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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.
- 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.
  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

**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

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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 travelling 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 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;

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- 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), para-

graph (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 (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

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- 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;
  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

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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 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. Reserved****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).

**R9-22-302. Reserved****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).

**R9-22-303. Prior Quarter Eligibility**

- A.** Prior Quarter eligibility shall be effective no earlier than January 1, 2014. An applicant may be eligible during any of the three months prior to application if the applicant:
1. 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
  2. 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.
- B.** The Prior Quarter requirements do not apply to:
1. Qualified Medicare Beneficiaries
  2. KidsCare

**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).

**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, effective 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 cooperat-

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- ing 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 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.
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

**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, effective 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:

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- 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.
      - 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 Adminis-

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tration 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), 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, effective 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 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 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, effective 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, effective 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). 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, effective 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, effective 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, effective 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, effective 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 withdrawal 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 Pro-

cedure 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, effective 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, effective 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.

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**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 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, effective 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
  - f. The victim does not currently live with the perpetrator.
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

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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 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, effective 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, effective 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

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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).

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.

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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).

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. 97-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-340. Repealed**

**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.
- 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 informa-

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tion 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 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 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;

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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**

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**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

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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.
- 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

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- 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 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 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

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(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 AHCCCS 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 AHCCCS or a contractor.

“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 by a hospital 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.

“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 provide 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 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 hospital experiences as a result of having an approved graduate medical education program and that is not accounted for by the hospital’s direct program costs.

“Intern and Resident Information System” means a software program used by teaching hospitals and the provider community for collecting and reporting information on resident training in hospital and non-hospital settings.

“Medical education costs” means direct hospital 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,

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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.

“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 UB-04 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).

**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 contractor. 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

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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 or electronic claim to be submitted on the date that it is received by the Administration. The Administration shall do one or more of the following for each claim it 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 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 IHS 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,

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- 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.
  - 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).

**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**

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- 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.
  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.

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- 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,
    - 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**

##### **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 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 publi-*

*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.*

**R9-22-710. 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 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.

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- 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 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;

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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) 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.

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- 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 provider 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 subse-*

*quently 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 or before September 30, 2014, at the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article.
  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

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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.
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

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(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 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

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- 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 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

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- 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 revenue 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.

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- 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 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.

**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 rulemaking 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:

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- i. The program name and number assigned by the accrediting organization;
- ii. The original date of accreditation;
- 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):
    - 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

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- 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 Medicaid share by dividing the AHCCCS inpatient hospital days of care by the total inpatient hospital days from the Medicare Cost Report. For this purpose, the Administration shall use the information described by subsection (B)(4)(c) for adjusting allocated residents for Arizona Medicaid utilization.
      - ii. Calculate each hospital's Medicare share by dividing the Medicare inpatient days on the Medicare Cost Report by the total inpatient hospital days on the Medicare Cost Report.
      - iii. Divide the Medicaid share by the Medicare share and multiply the resulting ratio by the indirect medical education payment calculated on the Medicare Cost Report.
      - iv. Total the results for all hospitals, divide the result by the total allocated residents determined under subsection (B)(4)(b)(ii) for these 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)(b)(ii) by 12 by the per resident per month conversion factor determined under subsection (D)(4)(b);
    2. The amount calculated for the hospital at subsection (D)(4)(b)(iii); or
    3. The median of all amounts calculated at subsection (D)(4)(b)(iii) if the hospital does not have an indirect medical education payment calculated on the Medicare Cost Report.

**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).

**R9-22-712.06. Reserved****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

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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. 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.
- B.** 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. 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. Reserved**

**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

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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**

- 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.

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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 subsection (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:
1. By 48 percent for public hospitals on July 1, 2005, and hospitals that were public anytime during the calendar year 2004;
  2. 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;
  3. 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;
  4. By 115 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been design-

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- nated as Critical Access Hospitals but meet the criteria during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
5. 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
  6. 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:
1. By 73 percent for public hospitals;
  2. 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;
  3. 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;
  4. 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;
  5. By 78 percent for a Freestanding Children's Hospital with at least 110 pediatric beds as of October 1 of that contract year; or
  6. 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, 2016 through September 30, 2017, 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, 2016. To qualify, a hospital providing outpatient hospital services must meet the following criteria:
1. By June 1, 2016, the hospital must have executed an agreement with and electronically submitted admission, discharge, and transfer information, as well as data from the hospital emergency department, to a qualifying health information exchange organization, and
  2. No sooner than January 4, 2016, and no later than February 29, 2016, CMS must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015; or, for a children's hospital that does not participate in the Medicare electronic health record incentive program, no sooner than January 4, 2016, and no later than the date established by CMS, the administration must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015.
- F.** Fee adjustments made under subsection (A), (B), (C), (D), and (E) are on file with AHCCCS and current adjustments are 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 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).

**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.
- 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.:

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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.

**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 sections 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 version 31 of the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health Information Systems. If version 31 of the APR-DRG classification system will no longer support assigning DRG codes and relative weights to claims, and 3M Health Information Systems issues a newer version of the APR-DRG classification system using updated DRG codes and/or updated relative weights, then an updated version established by 3M Health Information Systems will be used; however, if the version employs updated relative weights, those weights will be adjusted using a single adjustment factor applied to all relative weights to ensure that the statewide weighted average of the updated relative weights does not increase or decrease from the statewide weighted average of the relative weights used under version 31.
- 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.

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- 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 version 31 of 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).

**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 701 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.

**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).

**R9-22-712.62. 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 adjustors.
- 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, where the standardized amount is \$5,295.40, and the hospital's labor share and the hospital's wage index are those used in the Medicare inpatient prospective payment system for the fiscal year beginning October 1, 2013.
- 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).

**R9-22-712.63. DRG Base Payments Not Based on the Statewide Standardized Amount**

Notwithstanding section R9-22-712.62, the amount of \$3,436.08 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.

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**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**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 \$5,184.75.

**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, 2010.****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).

**R9-22-712.65.DRG Provider Policy Adjustor****A. After calculating the DRG base payment as required in sections 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 of 1.055.****B. A hospital is a high-utilization hospital if the hospital had:**

1. At least 46,112 AHCCCS-covered inpatient days using adjudicated claim and encounter data during the fiscal year beginning October 1, 2010, which is equal to at least four hundred percent of the statewide average number of AHCCCS-covered inpatient days at all hospitals of 11,528 days; and,
2. A Medicaid inpatient utilization rate greater than 30% 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 2011.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.66.DRG Service Policy Adjustor**

In addition to subsection 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 following service policy adjustors:

1. Normal newborn DRG codes: 1.55
2. Neonates DRG codes: 1.10

3. Obstetrics DRG codes: 1.55
4. Psychiatric DRG codes: 1.65
5. Rehabilitation DRG codes: 1.65
6. Claims for members under age 19 assigned DRG codes other than listed above:
  - a. 1.25 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. 1.25 for dates of discharge on or after January 1, 2016 for severity of illness levels 1 and 2,
  - c. 1.60 for dates of discharge on or after January 1, 2016 for severity of illness levels 3 and 4.

**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).

**R9-22-712.67.DRG Reimbursement: Transfers**

- 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 is \$5,000 for critical access hospitals and \$65,000 for all other hospitals.
- 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 is 90% for claims assigned DRG codes associated with the treatment of burns and 80% for all other claims.

#### Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

#### **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 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**

The final DRG payment is the sum of the final DRG base payment, the final DRG outlier add-on payment, and the Inpatient Value Based Purchasing (VBP) Differential Adjusted Payment.

1. 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.
2. 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.
3. 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 701 E. Jefferson Street, Phoenix, Arizona.
4. For inpatient services with a date of discharge from October 1, 2016 through September 30, 2017, the Inpatient VBP 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, 2016. To qualify for the Inpatient VBP

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Differential Adjusted Payment, a hospital providing inpatient hospital services must meet the following criteria:

- a. By June 1, 2016, the hospital must have executed an agreement with and electronically submitted admission, discharge, and transfer information, as well as data from the hospital emergency department, to a qualifying health information exchange organization, and
- b. No sooner than January 4, 2016, and no later than February 29, 2016, CMS must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015; or, for a children's hospital that does not participate in the Medicare electronic health record incentive program, no sooner than January 4, 2016, and no later than the date established by CMS, the administration must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 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 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4).

**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. The claim may include all surgical procedures performed during the entire inpatient stay, but the hospital shall only include revenue codes, service units, and charges for services performed on or after the date of enrollment.
- 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).

**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. 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.
  1. 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.
  2. 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.
  3. 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.
- B. 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.
- 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.
- E. Administrative days 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 (e.g., as nursing facility days).

**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).

**R9-22-712.76.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

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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 section R9-22-712.62(B) because the hospital was not in operation, the DRG base rate described in section R9-22-712.62(B) shall be calculated as the statewide standardized amount of \$5,295.40 after adjusting that amount for the labor-related share and the wage index published by CMS as described in section R9-22-712.62(B) that is appropriate to the location of the hospital published by CMS as described in section 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 section 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 section 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).

**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 adjust the statewide standardized amount in section R9-22-712.62, the base payments in sections R9-22-712.63 and R9-22-712.64, the provider policy adjustor in section R9-22-712.65, service policy adjustors section R9-22-712.66, and the fixed loss amounts and marginal cost percentages used to calculate the outlier threshold in section 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 to the general population in the geographic area.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.90. Reimbursement of Hospital-based Free-standing 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 sections R9-22-712.20 through R9-22-712.30. All other covered codes shall be reimbursed in accordance with sections R9-22-712.20 through R9-22-712.30 without a percentage reduction.
1. 60% for a level 1 emergency department visit as indicated by CPT 99281.
  2. 80% for a level 2 emergency department visit as indicated by CPT 99282.
  3. 90% for a level 3 emergency department visit as indicated by CPT 99283.
  4. 100% 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

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city or town operating an emergency department closed on or after January 1, 2015, shall be reimbursed under sections 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;
    - 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,

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- 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.*

**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 adopted 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 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.*

**R9-22-718. Urban Hospital Inpatient Reimbursement Program**

- A. Definitions. The following definitions apply to this Section:
  1. "Noncontracted Hospital" means an urban hospital which does not have a contract under this Section with an urban contractor in the same county.
  2. "Rural Contractor" means a contractor or program contractor as defined in A.R.S. Title 36, Chapter 29 that does not provide services to members residing in either Maricopa or Pima County.
  3. "Urban Contractor" means a contractor or program contractor as defined in A.R.S. Title 36, Chapter 29, that provides services to members residing in Maricopa or Pima County and may also provide services to members who reside in other counties. An urban contractor does not include ADHS/BHS, or a TRBHA.
  4. "Rural Hospital" means a hospital, as defined in R9-22-712.07, that is physically located in Arizona but in a county other than Maricopa and Pima County.
  5. "Urban Hospital" means a hospital that is not a rural hospital and 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. An urban 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 urban contractor.
  5. A noncontracted urban hospital shall be reimbursed for inpatient services by an urban contractor at 95% of the

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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 urban 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).

**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 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. Reserved**
- 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).*

## Arizona Health Care Cost Containment System - Administration

*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**

- A.** For purposes of this Section, the following terms are defined as provided below unless the context specifically requires another meaning:
1. "2011 Medicare Cost Report" means:
    - a. The Medicare Cost Report for the hospital fiscal year ending in calendar year 2011 as reported in the CMS Healthcare Provider Cost Reporting Information System (HCRIS) release dated December 31, 2012; or
    - b. For hospitals not included in that CMS HCRIS report, the "as filed" Medicare Cost Report for the hospital fiscal year ending in calendar year 2011 submitted by the hospital to the Administration.
  2. "2011 Uniform Accounting Report" means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of December 19, 2012.
  3. "2012 Uniform Accounting Report" means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of August 2, 2013.
  4. "Quarter" means the three month period beginning January 1, April 1, July 1, and October 1 of each year.
- B.** Beginning January 1, 2014, 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 July 1, 2017, the assessment shall be calculated by multiplying the number of discharges reported on the hospital's 2011 Medicare Cost Report, excluding discharges reported on the Medicare Cost Report as "Other Long Term Care Discharges" by the following rates based on the hospital's peer group:
1. \$483.00 per discharge for hospitals located in a county with a population less than 500,000 that are designated as type: hospital, subtype: short-term.
  2. \$483.00 per discharge for hospitals designated as type: hospital, subtype: critical access hospital.
  3. \$120.75 per discharge for hospitals designated as type: hospital, subtype: long term.
  4. \$120.75 per discharge for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the 2011 Medicare Cost Report.
  5. \$386.50 per discharge 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 2012 Uniform Accounting Report.
  6. \$434.75 per discharge 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 2012 Uniform Accounting Report.
  7. \$483.00 per discharge for hospitals designated as type: hospital, subtype: short-term not included in another peer group.
- C.** Peer groups for the four quarters beginning July 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 April 1, 2017.
- D.** Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's 2011 Medicare Cost Report, are assessed a rate of \$120.75 for each discharge from the psychiatric sub-provider as reported in the 2011 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 2011 Medicare Cost Report, are assessed a rate of \$0 for each discharge from the rehabilitative sub-provider as reported in the 2011 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 28,200 discharges on the hospital's 2011 Medicare Cost Report, discharges in excess of 28,200 are assessed a rate of \$48.25 for each discharge in excess of 28,200. The initial 28,200 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 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:
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 2011 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 April 1, 2017:
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 2011 Medicare Cost Report.
  4. Hospitals designated as type: hospital, subtype; rehabilitation.
  5. Hospitals designated as type: hospital, subtype: children's.
  6. Hospitals designated as type: med-hospital, subtype: special hospitals.
  7. 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 2011 Medicare Cost Report are reimbursed by Medicare.
- J.** New hospitals. For hospitals that did not file a 2011 Medicare Cost Report because of the date the hospital began operations:

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1. If the hospital was open on the April 1 preceding the July assessment start date, the hospital assessment will begin on July 1 following the date the hospital began operating.
  2. If the hospital began operating between April 2 and June 30, the assessment will begin on July 1 of the following calendar year.
  3. A hospital is not considered a new hospital based on a change in ownership.
  4. Until the first full year of data is available, the assessment will be based on the annualized number of discharges from the date hospital operations began through April 30 preceding the July assessment start date. The hospital shall submit the discharge data and all other data requested by the Administration necessary to determine the appropriate assessment to the Administration no later than May 15 preceding the assessment start date for the new hospitals. Thereafter, 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; however, when 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. No later than August 15, 2017, new hospitals shall also submit to the Administration discharge data and all other data requested by the Administration necessary to determine the appropriate assessment beginning July 1, 2018.
  5. For hospitals providing self-reported data:
    - 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 any hospital that has not filed a 2011 Medicare Cost report, or if the 2011 Medicare Cost report does not include the reliable information sufficient for the Administration to calculate the assessment, the Administration shall use data reported on the 2011 Uniform Accounting Report filed by the hospital in place of the 2011 Medicare Cost report to calculate the assessment. If the 2011 Uniform Accounting Report filed by the hospital does not include reliable information sufficient for the Administration to calculate the assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2011 Medicare Cost report to calculate the assessment.
- N.** 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.
- O.** 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).

**ARTICLE 8. REPEALED**

*Article 8, consisting of Sections 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 subsections (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 (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).

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 rulemaking 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

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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.
- 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) 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**

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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,
  - 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.

#### 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
  - 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).

#### 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.
  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.

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“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.

“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 AHCCCS 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;

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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 behavioral 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

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- 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.
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;

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- ix. A medical practitioner; and
  - 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;
  8. 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**

**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 enrolled with the CRS contractor. An American Indian member shall obtain CRS services through the CRS contractor. A member enrolled in CMDP shall also obtain CRS services through the CRS contractor. Initial enrollment with the CRS contractor is limited to individuals under the age of 21. The CRS contractor shall provide covered services necessary to treat the CRS condition(s) and other services described within the CRS contract. The effective date of enrollment in CRS 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).

**R9-22-1303. Medical Eligibility**

The following lists identify those medical condition(s) that do qualify for the CRS program as well as those that do not qualify for the CRS program. The list of condition(s) that qualify for CRS medical eligibility is all inclusive. The list of condition(s) that do not qualify for CRS medical eligibility 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,
    - v. Hyperparathyroidism,
    - vi. Hyperthyroidism,

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- 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. Arthrogyposis (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,
    - v. Deformity and dysfunction secondary to trauma or injury,
    - vi. Ehlers Danlos,
    - vii. Flat foot,
    - viii. Fracture,
    - ix. Ganglion cyst,
    - x. Ingrown toenail,

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- 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, dermamyositis, 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.
  - 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:
- i. Amino acid or organic acidopathy,

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- ii. Biotinidase deficiency,
  - iii. Homocystinuria,
  - iv. Inborn error of metabolism,
  - v. Maple syrup urine disease,
  - vi. Phenylketonuria, and
  - vii. 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).

**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 the CRS program shall be redetermined by verifying active treatment status of the CRS qualifying medical condition(s) as follows:
- 1. The CRS Contractor is responsible for notifying the AHCCCS Administration of the date when a CRS member is no longer in active treatment for the CRS qualifying condition(s).
  - 2. The Administration may request, at any time, that the CRS contractor submit the medical documentation requested in the CRS medical redetermination form within the specified time-frames in contract.
  - 3. The Administration shall notify the CRS member or authorized representative of the redetermination process.
- B. If the Administration determines that a CRS member is no longer medically eligible for CRS, the Administration shall provide the CRS member or authorized representative a written notice that informs the CRS member that the Administration is transitioning the CRS member's enrollment according to R9-22-1306. The member may appeal the redetermination under Chapter 34.
- C. Upon reaching his or her 21st birthday, the CRS member will be enrolled with a non-CRS contractor unless the member requests to continue enrollment with the CRS contractor.

**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).

**R9-22-1306. Transition or Termination**

- A. The Administration shall transition a CRS member from the CRS contractor when the Administration determines the CRS member does not meet the medical eligibility requirements under this Article.
- B. The Administration shall terminate a CRS member from the CRS contractor and the AHCCCS program when the Administration determines the CRS member does not meet the AHCCCS eligibility requirements. The member may appeal the termination under Chapter 34.
- C. If the Administration transitions a CRS member from the CRS contractor, the Administration shall provide the CRS member, or authorized representative a written notice of transition. The member may appeal the transition under Chapter 34.

**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).

**R9-22-1307. Covered Services**

The Administration will cover medically necessary services as described within Article 2 unless otherwise specified in contract.

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**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). 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).

**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

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tive December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, effective 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, effective 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, effective 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, effective 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, effective January 7, 2014 (Supp. 14-1).

**R9-22-1407. Deceased Applicants**

- A. If an applicant dies while an application is pending, the Administration or Administration's designee shall complete an eligibility determination for all applicants listed on the application, including the deceased applicant.
- B. The Administration or Administration's designee shall complete an eligibility determination on an application filed on behalf of a deceased applicant.

**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, effective January 7, 2014 (Supp. 14-1). Amended by final rulemaking at 19 A.A.R. 3309, November 30, 2013 (Supp. 13-4).

**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, effective 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, effective 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. 192, effective 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, effective 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

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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, effective 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, effective 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, effective 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, effective 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, effective 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, effective 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, effective 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, effective 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

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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.
  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, effective 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

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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, effective 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.
  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, effective 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, effective 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 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, effective 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, effective January 7, 2014 (Supp. 14-1).

**R9-22-1426. 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). 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, effective 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;
  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, effective 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, effective 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, effective 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, effective 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, effective 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, effective 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, effective 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 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:

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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 presumed 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

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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 time-frames 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 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. Closing New Eligibility for Persons Not Covered under the State Plan**

- A.** Definition. For purposes of this Section, "AHCCCS Care" refers to the eligibility category that includes individuals encompassed within the expanded definition of "eligible person" under A.R.S. § 36-2901.01 and R9-22-1428(4), but who do not meet eligibility criteria for an optional or mandatory Title XIX coverage group described in the Arizona State Plan for Medicaid.
- B.** General Rule. Except as provided by this Section, neither the Department nor the Administration shall approve an individual for AHCCCS Care with an effective date of eligibility on or after July 8, 2011.
- C.** Exception for pending applications. With respect to any applications that are pending as of July 8, 2011, the Department and the Administration shall approve any individual as eligible for AHCCCS Care who has met all eligibility requirements for AHCCCS Care during or after the month of application but prior to July 8, 2011, and has continuously met all eligibility requirements for AHCCCS Care since that date.
- D.** Exception for children. The Department and the Administration shall approve an individual as eligible for AHCCCS Care on or after July 8, 2011 who:
1. Was determined eligible under the Arizona State Plan for Medicaid based on being under the age of 19;
  2. Would otherwise be discontinued due to reaching the age of 19 on or after July 8, 2011, under subsection (B) of this Section; and
  3. Meets all eligibility requirements for AHCCCS Care on and after reaching age 19.

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- E.** Exception for KidsCare. The Department and the Administration shall approve an individual as eligible for AHCCCS Care on or after July 8, 2011 who:
1. Was determined eligible under 9 A.A.C. 31 based on being under the age of 19;
  2. Would otherwise be discontinued due to reaching the age of 19 on or after July 8, 2011, under subsection (B) of this Section; and
  3. Meets all eligibility requirements for AHCCCS Care on and after reaching age 19.
- F.** Exception for Young Adult Transitional Insurance (YATI). The Department and the Administration shall approve an individual as eligible for AHCCCS Care on or after July 8, 2011 who:
1. Was determined eligible for YATI under R9-22-1432;
  2. Would otherwise be discontinued due to reaching the age of 21 on or after July 8, 2011 under subsection (A) of this Section; and
  3. Meets all eligibility requirements for AHCCCS Care on and after reaching age 21.
- G.** Exception for certain SSI-MAO. The Department and the Administration shall approve as eligible for AHCCCS Care, on or after July 8, 2011, an individual who:
1. Was determined eligible for AHCCCS Care; and
  2. Whose eligibility category is changed on or after June 28, 2011, from AHCCCS Care to eligibility based on R9-22-1501(A)(1) (SSI Medical Assistance Only) because the individual, at the time of the change in eligibility category, is age 65 or over, under the age of 65 with Medicare coverage, or who has been determined by ADHS to have a Serious Mental Illness; but who
  3. Subsequent to the change in eligibility category, is determined not to meet eligibility requirements under Article 15; but only if
  4. The individual meets all eligibility requirements for AHCCCS Care on and after the date the individual is determined not to meet eligibility requirements under Article 15.
- H.** Exception for redeterminations. This Section does not prohibit the redetermination of an individual as eligible for AHCCCS Care on or after July 8, 2011, if the individual was determined eligible for AHCCCS Care prior to July 8, 2011 and has remained continuously eligible for AHCCCS Care since July 8, 2011 or the date on which the individual was determined eligible for AHCCCS Care under subsections (C), (D), and (E) of this Section.
- I.** Discontinuance for other reasons. Nothing in this Section prohibits or restricts the Department or the Administration from discontinuing AHCCCS Care for an individual who does not meet any other eligibility criteria set forth elsewhere in this Chapter including but not limited to discontinuance based on the individual's failure to verify eligibility information upon an application or redetermination.
- J.** Review of anticipated expenditures. At least monthly, the Director shall review the most recent estimate of the anticipated expenditures for the remainder of the state fiscal year as compared to funds remaining in the appropriations made to the agency for the state fiscal year as well as any other known or reasonably anticipated sources of other funding. Based on that review the Director may, subject to approval by the Center for Medicare and Medicaid Services, re-open the AHCCCS Care program to new enrollment otherwise prohibited by this Section.
- K.** At least 30 days prior to the effective date of any changes to eligibility for the AHCCCS Care program as described in this Section, public notice shall be provided via publication on the AHCCCS web site unless shorter notice is necessary to main-

tain a program that is reasonably anticipated to remain within available funding.

**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).

**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:
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).
- “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).
- C.** Confidentiality. The Administration shall maintain the confidentiality of an applicant's or member's records and limit the release of safeguarded information under R9-22-512.
- D.** Application process.
1. A person may apply for AHCCCS medical coverage by submitting a signed application to any Administration office or outstation location under R9-22-1406.
  2. The provisions in R9-22-1406(B), (C), and (E) apply to this Section.
  3. The application date is the date a signed application is received at any Administration office or outstation location approved by the Director.
  4. An applicant who files an application may withdraw the application, either orally or in writing. If an applicant withdraws an application, the Administration shall send the applicant a denial notice under subsection (G).
  5. Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 90 days for an applicant applying on the basis of disability and 45 days for all other applicants.
  6. If an applicant dies while an application is pending, the Administration shall complete an eligibility determination for the deceased applicant.
  7. The Administration shall complete an eligibility determination on an application filed on behalf of a deceased applicant, if the application is filed in the month of the applicant's death.
- E.** Redetermination of eligibility for a person terminated from the SSI cash program.
1. Continuation of AHCCCS medical coverage. The Administration shall continue AHCCCS medical coverage for a person terminated from the SSI cash program

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- until a redetermination of eligibility under subsection (E)(2) is completed.
2. Coverage group screening. The Administration shall screen a person for eligibility under any coverage group under A.R.S. §§ 36-2901(6)(a)(i), (ii), (iii), (iv), and (v) and 36-2934.
    - a. If a person files an application for Arizona Long-Term Care System (ALTCs) coverage, the Administration shall determine eligibility under 9 A.A.C. 28, Article 4.
    - b. If an applicant or member is aged, blind, or disabled, but not in need of long-term care services, the Administration shall determine eligibility under this Article.
    - c. For all other persons, the Administration shall refer the applicant's case to the Department for an eligibility decision under Article 14.
  3. Eligibility decision.
    - a. If a person is eligible under this Article or 9 A.A.C. 28, Article 4, the Administration shall send a notice as under subsection (G) informing the applicant that AHCCCS medical coverage is approved.
    - b. If a person is ineligible, the Administration shall send a notice as under subsection (G) to deny AHCCCS medical coverage.
- F.** Eligibility effective date. Eligibility is effective on the first day of the month that all eligibility requirements are met, including the period described under R9-22-303.
- G.** Notice for 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 intended action, and:
1. If approved, the notice shall contain the effective date of eligibility.
  2. If approved under FESP, the notice shall also contain:
    - a. The emergency services certification end date,
    - b. A statement detailing the reason for the denial of full services,
    - c. The legal authority supporting the decision,
    - d. Where the legal authority supporting the decision can be found,
    - e. An explanation of the right to request a hearing, and
    - f. The date by which a request for hearing shall be received by the Administration.
  3. If denied, the notice shall contain:
    - a. The effective date of the denial;
    - b. The reason for the denial, including specific financial calculations and the financial eligibility standard, if applicable;
    - c. Legal authority supporting the decision;
    - d. Where the legal authority supporting the decision can be found;
    - e. An explanation of the right to request a hearing; and
    - f. The date by which a request for hearing shall be received by the Administration.
- H.** Reporting and verifying changes.
1. An applicant or a member shall report to the Administration the following changes for the applicant or member, the applicant's or member's spouse, and the applicant or member's dependent children:
    - a. Change of address;
    - b. Change in the household's members;
    - c. Change in income;
    - d. Death;
    - e. Change in marital status;
    - f. Change in school attendance;
    - g. Change in Arizona state residency; and
    - h. Any other change that may affect the member's or applicant's eligibility.
  2. A member shall report to the Administration the following changes:
    - a. Admission to a penal institution,
    - b. Change in U.S. citizenship or immigrant status,
    - c. Receipt of a Social Security number, and
    - d. Change in first- or third-party liability that may contribute to the payment of all or a portion of the person's medical costs.
  3. A person other than a member or an applicant who reports a change to the Administration either orally or in writing shall include the:
    - a. Name of the affected applicant or member;
    - b. Description of the change;
    - c. Date the change occurred;
    - d. Name of the person reporting the change; and
    - e. Social Security or case number of the applicant or member, if known.
  4. An applicant or a member shall provide verification of changes if requested by the Administration.
  5. An applicant or a member shall report anticipated changes in eligibility to the Administration as soon as the person knows that the change will occur.
  6. An applicant or a member shall report an unanticipated change to the Administration within 10 days following the date the change occurred.
- I.** Processing of changes and redeterminations. If a member receives AHCCCS medical coverage under subsection (A), the Administration shall redetermine the member's eligibility at least once every 12 months or more frequently when changes occur that may affect eligibility.
- J.** Actions that may result from a redetermination or change. In processing a redetermination or change, the Administration shall determine whether there should be:
1. No change in eligibility,
  2. Discontinuance of eligibility if a condition of eligibility is no longer met, or
  3. A change in the program under which a person receives AHCCCS medical coverage.
- K.** Notice of discontinuance.
1. Contents of notice. The Administration shall issue a notice when it takes action to discontinue a member's eligibility. The notice shall contain the following information:
    - a. A statement of the action that is being taken;
    - b. The effective date of the action;
    - c. The reason for the discontinuance, including specific financial calculations and the financial eligibility standard if applicable;
    - d. The legal authority that supports the action proposed by the Administration;
    - e. Where the legal authority supporting the decision can be found;
    - f. An explanation of the right to request a hearing; and
    - g. The date by which a hearing request shall be received by the Administration and the right to continue medical coverage pending appeal.
  2. Advance notice of changes in eligibility. 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 (K)(3), the Administration shall issue an advance notice when an adverse action is taken to suspend, reduce or discontinue eligibility.

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3. Exceptions from advance notice. The Administration shall issue a notice to a member to discontinue eligibility no later than the effective date of the action if:
- The member provides to the Administration a clearly written statement, signed by that member, that:
    - Services are no longer wanted; or
    - Gives information that requires a discontinuance or reduction of services and indicates that the member understands that this is the result of supplying the information;
  - The member provides information to the Administration that requires a discontinuance of eligibility and a member signs a written statement waiving advance notice;
  - The member cannot be located and mail sent to the member's last known address has been returned as undeliverable under 42 CFR 431.213(d) subject to reinstatement of discontinued eligibility;
  - The member has been admitted to a public institution where a member is ineligible for coverage;
  - The member has been approved for Medicaid in another state; or
  - The Administration receives information confirming the death of the member.
- L.** Request for hearing. An applicant or member may request a hearing under Chapter 34 for any of the following adverse actions:
- Complete or partial denial of eligibility,
  - Discontinuance or reduction of AHCCCS medical coverage, or
  - Delay in the eligibility determination beyond the timeframes listed in R9-22-1501(D).
- M.** Assignment of rights. A person determined eligible assigns rights to all types of medical benefits to which the person is entitled under operation of law under A.R.S. § 36-2903.

**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).

**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, effective 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.**

- In-kind support and maintenance under 42 U.S.C. 1382a(a)(2)(A) is excluded.
- 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.
- 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.
- 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.
- 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, effective 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:
- Meet one of the income tests described in subsection (B) or (C), or
  - 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.

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- 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;
    - 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, effective 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**

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- 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.
- 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



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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 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**

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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). 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.

**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

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- 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.

**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 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 undeliverable 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**

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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****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**

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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.

**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

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- 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 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,

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- 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 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 that:
    - a. Provides in-house 24-hour daily dedicated trauma surgical services as defined in A.R.S. § 36-2201(26) pertaining to a trauma center, or
    - b. Is recognized as a rural regional trauma center that was providing formal organized trauma services on or before January 1, 2003.
  - 2. On or after January 1, 2005, "level I trauma center" means any acute care hospital designated by the Arizona Department of Health Services as a level I trauma center.

3. "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).

#### 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
  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 I 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

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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. 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.

36-2904. Prepaid capitation coverage; requirements; long-term care; dispute resolution; award of contracts; notification; report

A. The administration may expend public funds appropriated for the purposes of this article and shall execute prepaid capitated health services contracts, pursuant to section 36-2906, with group disability insurers, hospital and medical service corporations, health care services organizations and any other appropriate public or private persons, including county-owned and operated facilities, for health and medical services to be provided under contract with contractors. The administration may assign liability for eligible persons and members through contractual agreements with contractors. If there is an insufficient number of qualified bids for prepaid capitated health services contracts for the provision of hospitalization and medical care within a county, the director may:

1. Execute discount advance payment contracts, pursuant to section 36-2906 and subject to section 36-2903.01, for hospital services.
2. Execute capped fee-for-service contracts for health and medical services, other than hospital services. Any capped fee-for-service contract shall provide for reimbursement at a level of not to exceed a capped fee-for-service schedule adopted by the administration.

B. During any period in which services are needed and no contract exists, the director may do either of the following:

1. Pay noncontracting providers for health and medical services, other than hospital services, on a capped fee-for-service basis for members and persons who are determined eligible. However, the state shall not pay any amount for services that exceeds a maximum amount set forth in a capped fee-for-service schedule adopted by the administration.
2. Pay a hospital subject to the reimbursement level limitation prescribed in section 36-2903.01.

If health and medical services are provided in the absence of a contract, the director shall continue to attempt to procure by the bid process as provided in section 36-2906 contracts for such services as specified in this subsection.

C. Payments to contractors 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 contractors shall be distributed to 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 health care cost containment system fund.

D. Except as prescribed in subsection E of this section, a member defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (a) may select, to the extent practicable as determined by the administration, from among the available contractors of hospitalization and medical care

and may select a primary care physician or primary care practitioner from among the primary care physicians and primary care practitioners participating in the contract in which the member is enrolled. The administration shall provide reimbursement only to entities that have a provider agreement with the administration and that have agreed to the contractual requirements of that agreement. Except as provided in sections 36-2908 and 36-2909, the system shall only provide reimbursement for any health or medical services or costs of related services provided by or under referral from the primary care physician or primary care practitioner participating in the contract in which the member is enrolled. The director shall establish requirements as to the minimum time period that a member is assigned to specific contractors in the system.

E. For a member defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (a), item (v) the director shall enroll the member with an available contractor located in the geographic area of the member's residence. The member may select a primary care physician or primary care practitioner from among the primary care physicians or primary care practitioners participating in the contract in which the member is enrolled. The system shall only provide reimbursement for health or medical services or costs of related services provided by or under referral from a primary care physician or primary care practitioner participating in the contract in which the member is enrolled. The director shall establish requirements as to the minimum time period that a member is assigned to specific contractors in the system.

F. If a person who has been determined eligible but who has not yet enrolled in the system receives emergency services, the director shall provide by rule for the enrollment of the person on a priority basis. If a person requires system covered services on or after the date the person is determined eligible for the system but before the date of enrollment, the person is entitled to receive these services in accordance with rules adopted by the director, and the administration shall pay for the services pursuant to section 36-2903.01 or, as specified in contract, with the contractor pursuant to the subcontracted rate or this section.

G. The administration shall not pay claims for system covered services that are initially submitted more than six months after the date of the service for which payment is claimed or after the date that eligibility is posted, whichever date is later, or that are submitted as clean claims more than twelve months after the date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later, except for claims submitted for reinsurance pursuant to section 36-2906, subsection C, paragraph 6. The administration shall not pay claims for system covered services that are submitted by contractors for reinsurance after the time period specified in the contract. The director may adopt rules or require contractual provisions that prescribe requirements and time limits for submittal of and payment for those claims. Notwithstanding any other provision of this article, if a claim that gives rise to a contractor's claim for reinsurance or deferred liability is the subject of an administrative grievance or appeal proceeding or other legal action, the contractor shall have at least sixty days after an ultimate decision is rendered to submit a claim for reinsurance or deferred liability. Contractors that contract with the administration pursuant to subsection A of this section shall not pay claims for system covered services that are initially submitted more than six months after the date of the service for which payment is claimed or after the date that eligibility is posted, whichever date is later, or that are submitted as clean claims more than twelve months after the

date of the service for which payment is claimed or after the date that eligibility is posted, whichever date is later. For the purposes of this subsection:

1. "Clean claims" means claims that may be processed without obtaining additional information from the subcontracted provider of care, from a noncontracting provider or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

2. "Date of service" for a hospital inpatient means the date of discharge of the patient.

3. "Submitted" means the date the claim is received by the administration or the prepaid capitated provider, whichever is applicable, as established by the date stamp on the face of the document or other record of receipt.

H. In any county having a population of five hundred thousand or fewer persons, a hospital that executes a subcontract other than a capitation contract with a contractor for the provision of hospital and medical services pursuant to this article shall offer a subcontract to any other contractor providing services to that portion of the county and to any other person that plans to become a contractor in that portion of the county. If such a hospital executes a subcontract other than a capitation contract with a contractor for the provision of hospital and medical services pursuant to this article, the hospital shall adopt uniform criteria to govern the reimbursement levels paid by all contractors with whom the hospital executes such a subcontract.

Reimbursement levels offered by hospitals to contractors pursuant to this subsection may vary among contractors only as a result of the number of bed days purchased by the contractors, the amount of financial deposit required by the hospital, if any, or the schedule of performance discounts offered by the hospital to the contractor for timely payment of claims.

I. This subsection applies to inpatient hospital admissions and to outpatient hospital services on and after March 1, 1993. The director may negotiate at any time with a hospital on behalf of a contractor for services provided pursuant to this article. If a contractor negotiates with a hospital for services provided pursuant to this article, the following procedures apply:

1. The director shall require any contractor to reimburse hospitals for services provided under this article based on reimbursement levels that do not in the aggregate exceed those established pursuant to section 36-2903.01 and under terms on which the contractor and the hospital agree. However, a hospital and a contractor may agree on a different payment methodology than the methodology prescribed by the director pursuant to section 36-2903.01. The director by rule shall prescribe:

(a) The time limits for any negotiation between the contractor and the hospital.

(b) The ability of the director to review and approve or disapprove the reimbursement levels and terms agreed on by the contractor and the hospital.

(c) That if a contractor and a hospital do not agree on reimbursement levels and terms as required by this subsection, the reimbursement levels established pursuant to section 36-2903.01 apply.

(d) That, except if submitted under an electronic claims submission system, a hospital bill is considered received for purposes of subdivision (f) on initial receipt of the legible, error-free claim form by the contractor if the claim includes the following error-free documentation in legible form:

(i) An admission face sheet.

(ii) An itemized statement.

(iii) An admission history and physical.

(iv) A discharge summary or an interim summary if the claim is split.

(v) An emergency record, if admission was through the emergency room.

(vi) Operative reports, if applicable.

(vii) A labor and delivery room report, if applicable.

(e) That payment received by a hospital from a contractor is considered payment by the contractor of the 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.

(f) That a contractor shall pay for services rendered on and after October 1, 1997 under any reimbursement level according to paragraph 1 of this subsection subject to the following:

(i) If the hospital's bill is paid within thirty days of the date the bill was received, the contractor shall pay ninety-nine per cent of the rate.

(ii) If the hospital's bill is paid after thirty days but within sixty days of the date the bill was received, the contractor shall pay one hundred per cent of the rate.

(iii) If the hospital's bill is paid any time after sixty days of the date the bill was received, the contractor shall pay one hundred per cent of the rate plus a fee of one per cent per month for each month or portion of a month following the sixtieth day of receipt of the bill until the date of payment.

2. In any county having a population of five hundred thousand or fewer persons, a hospital that executes a subcontract other than a capitation contract with a provider for the provision of hospital and medical services pursuant to this article shall offer a subcontract to any other provider providing services to that portion of the county and to any other person that plans to become a provider in that portion of the county. If a hospital executes a subcontract other than a capitation contract with a provider for the provision of hospital and medical services pursuant to this article, the hospital shall adopt uniform criteria to govern the reimbursement levels paid by all providers with whom the hospital executes a subcontract.

J. If there is an insufficient number of, or an inadequate member capacity in, contracts awarded to contractors, the director, in order to deliver covered services to members enrolled or expected to be enrolled in the system within a county, may negotiate and award, without bid, a contract with a health care services organization holding a certificate of authority pursuant to title 20, chapter 4, article 9. The director shall require a health care services organization contracting under this subsection to comply with section 36-2906.01. The term of the contract shall not extend beyond the next bid and contract award process as provided in section 36-2906 and shall be no greater than capitation rates paid to contractors in the same county or counties pursuant to section 36-2906. Contracts awarded pursuant to this subsection are exempt from the requirements of title 41, chapter 23.

K. A contractor may require that a subcontracting or noncontracting provider shall be paid for covered services, other than hospital services, according to the capped fee-for-service schedule adopted by the director pursuant to subsection A, paragraph 2 of this section or subsection B, paragraph 1 of this section or at lower rates as may be negotiated by the contractor.

L. The director shall require any contractor to have a plan to notify members of reproductive age either directly or through the parent or legal guardian, whichever is most appropriate, of the specific covered family planning services available to them and a plan to deliver those services to members who request them. The director shall ensure that these plans include provisions for written notification, other than the member handbook, and verbal notification during a member's visit with the member's primary care physician or primary care practitioner.

M. The director shall adopt a plan to notify members of reproductive age who receive care from a contractor who elects not to provide family planning services of the specific covered family planning services available to them and to provide for the delivery of those services to members who request them. Notification may be directly to the member, or through the parent or legal guardian, whichever is most appropriate. The director shall ensure that the plan includes provisions for written notification, other than the member handbook, and verbal notification during a member's visit with the member's primary care physician or primary care practitioner.

N. The director shall prepare a report that represents a statistically valid sample and that indicates the number of children age two by contractor who received the immunizations recommended by the national centers for disease control and prevention while enrolled as members. The report shall indicate each type of immunization and the number and percentage of enrolled children in the sample age two who received each type of immunization. The report shall be done by contract year and shall be delivered to the governor, the president of the senate and the speaker of the house of representatives no later than April 1, 2004 and every second year thereafter.

O. If the administration implements an electronic claims submission system it may adopt procedures pursuant to subsection I, paragraph 1 of this section requiring documentation different than prescribed under subsection I, paragraph 1, subdivision (d) of this section.

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.

36-2903. 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.

36-2904. Prepaid capitation coverage; requirements; long-term care; dispute resolution; award of contracts; notification; report

A. The administration may expend public funds appropriated for the purposes of this article and shall execute prepaid capitated health services contracts, pursuant to section 36-2906, with group disability insurers, hospital and medical service corporations, health care services organizations and any other appropriate public or private persons, including county-owned and operated facilities, for health and medical services to be provided under contract with contractors. The administration may assign liability for eligible persons and members through contractual agreements with contractors. If there is an insufficient number of qualified bids for prepaid capitated health services contracts for the provision of hospitalization and medical care within a county, the director may:

1. Execute discount advance payment contracts, pursuant to section 36-2906 and subject to section 36-2903.01, for hospital services.
2. Execute capped fee-for-service contracts for health and medical services, other than hospital services. Any capped fee-for-service contract shall provide for reimbursement at a level of not to exceed a capped fee-for-service schedule adopted by the administration.

B. During any period in which services are needed and no contract exists, the director may do either of the following:

1. Pay noncontracting providers for health and medical services, other than hospital services, on a capped fee-for-service basis for members and persons who are determined eligible. However, the state shall not pay any amount for services that exceeds a maximum amount set forth in a capped fee-for-service schedule adopted by the administration.
2. Pay a hospital subject to the reimbursement level limitation prescribed in section 36-2903.01.

If health and medical services are provided in the absence of a contract, the director shall continue to attempt to procure by the bid process as provided in section 36-2906 contracts for such services as specified in this subsection.

C. Payments to contractors 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 contractors shall be distributed to 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 health care cost containment system fund.

D. Except as prescribed in subsection E of this section, a member defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (a) may select, to the extent practicable as determined by the administration, from among the available contractors of hospitalization and medical care

and may select a primary care physician or primary care practitioner from among the primary care physicians and primary care practitioners participating in the contract in which the member is enrolled. The administration shall provide reimbursement only to entities that have a provider agreement with the administration and that have agreed to the contractual requirements of that agreement. Except as provided in sections 36-2908 and 36-2909, the system shall only provide reimbursement for any health or medical services or costs of related services provided by or under referral from the primary care physician or primary care practitioner participating in the contract in which the member is enrolled. The director shall establish requirements as to the minimum time period that a member is assigned to specific contractors in the system.

E. For a member defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (a), item (v) the director shall enroll the member with an available contractor located in the geographic area of the member's residence. The member may select a primary care physician or primary care practitioner from among the primary care physicians or primary care practitioners participating in the contract in which the member is enrolled. The system shall only provide reimbursement for health or medical services or costs of related services provided by or under referral from a primary care physician or primary care practitioner participating in the contract in which the member is enrolled. The director shall establish requirements as to the minimum time period that a member is assigned to specific contractors in the system.

F. If a person who has been determined eligible but who has not yet enrolled in the system receives emergency services, the director shall provide by rule for the enrollment of the person on a priority basis. If a person requires system covered services on or after the date the person is determined eligible for the system but before the date of enrollment, the person is entitled to receive these services in accordance with rules adopted by the director, and the administration shall pay for the services pursuant to section 36-2903.01 or, as specified in contract, with the contractor pursuant to the subcontracted rate or this section.

G. The administration shall not pay claims for system covered services that are initially submitted more than six months after the date of the service for which payment is claimed or after the date that eligibility is posted, whichever date is later, or that are submitted as clean claims more than twelve months after the date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later, except for claims submitted for reinsurance pursuant to section 36-2906, subsection C, paragraph 6. The administration shall not pay claims for system covered services that are submitted by contractors for reinsurance after the time period specified in the contract. The director may adopt rules or require contractual provisions that prescribe requirements and time limits for submittal of and payment for those claims. Notwithstanding any other provision of this article, if a claim that gives rise to a contractor's claim for reinsurance or deferred liability is the subject of an administrative grievance or appeal proceeding or other legal action, the contractor shall have at least sixty days after an ultimate decision is rendered to submit a claim for reinsurance or deferred liability. Contractors that contract with the administration pursuant to subsection A of this section shall not pay claims for system covered services that are initially submitted more than six months after the date of the service for which payment is claimed or after the date that eligibility is posted, whichever date is later, or that are submitted as clean claims more than twelve months after the

date of the service for which payment is claimed or after the date that eligibility is posted, whichever date is later. For the purposes of this subsection:

1. "Clean claims" means claims that may be processed without obtaining additional information from the subcontracted provider of care, from a noncontracting provider or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

2. "Date of service" for a hospital inpatient means the date of discharge of the patient.

3. "Submitted" means the date the claim is received by the administration or the prepaid capitated provider, whichever is applicable, as established by the date stamp on the face of the document or other record of receipt.

H. In any county having a population of five hundred thousand or fewer persons, a hospital that executes a subcontract other than a capitation contract with a contractor for the provision of hospital and medical services pursuant to this article shall offer a subcontract to any other contractor providing services to that portion of the county and to any other person that plans to become a contractor in that portion of the county. If such a hospital executes a subcontract other than a capitation contract with a contractor for the provision of hospital and medical services pursuant to this article, the hospital shall adopt uniform criteria to govern the reimbursement levels paid by all contractors with whom the hospital executes such a subcontract. Reimbursement levels offered by hospitals to contractors pursuant to this subsection may vary among contractors only as a result of the number of bed days purchased by the contractors, the amount of financial deposit required by the hospital, if any, or the schedule of performance discounts offered by the hospital to the contractor for timely payment of claims.

I. This subsection applies to inpatient hospital admissions and to outpatient hospital services on and after March 1, 1993. The director may negotiate at any time with a hospital on behalf of a contractor for services provided pursuant to this article. If a contractor negotiates with a hospital for services provided pursuant to this article, the following procedures apply:

1. The director shall require any contractor to reimburse hospitals for services provided under this article based on reimbursement levels that do not in the aggregate exceed those established pursuant to section 36-2903.01 and under terms on which the contractor and the hospital agree. However, a hospital and a contractor may agree on a different payment methodology than the methodology prescribed by the director pursuant to section 36-2903.01. The director by rule shall prescribe:

(a) The time limits for any negotiation between the contractor and the hospital.

(b) The ability of the director to review and approve or disapprove the reimbursement levels and terms agreed on by the contractor and the hospital.

(c) That if a contractor and a hospital do not agree on reimbursement levels and terms as required by this subsection, the reimbursement levels established pursuant to section 36-2903.01 apply.

(d) That, except if submitted under an electronic claims submission system, a hospital bill is considered received for purposes of subdivision (f) on initial receipt of the legible, error-free claim form by the contractor if the claim includes the following error-free documentation in legible form:

(i) An admission face sheet.

(ii) An itemized statement.

(iii) An admission history and physical.

(iv) A discharge summary or an interim summary if the claim is split.

(v) An emergency record, if admission was through the emergency room.

(vi) Operative reports, if applicable.

(vii) A labor and delivery room report, if applicable.

(e) That payment received by a hospital from a contractor is considered payment by the contractor of the 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.

(f) That a contractor shall pay for services rendered on and after October 1, 1997 under any reimbursement level according to paragraph 1 of this subsection subject to the following:

(i) If the hospital's bill is paid within thirty days of the date the bill was received, the contractor shall pay ninety-nine per cent of the rate.

(ii) If the hospital's bill is paid after thirty days but within sixty days of the date the bill was received, the contractor shall pay one hundred per cent of the rate.

(iii) If the hospital's bill is paid any time after sixty days of the date the bill was received, the contractor shall pay one hundred per cent of the rate plus a fee of one per cent per month for each month or portion of a month following the sixtieth day of receipt of the bill until the date of payment.

2. In any county having a population of five hundred thousand or fewer persons, a hospital that executes a subcontract other than a capitation contract with a provider for the provision of hospital and medical services pursuant to this article shall offer a subcontract to any other provider providing services to that portion of the county and to any other person that plans to become a provider in that portion of the county. If a hospital executes a subcontract other than a capitation contract with a provider for the provision of hospital and medical services pursuant to this article, the hospital shall adopt uniform criteria to govern the reimbursement levels paid by all providers with whom the hospital executes a subcontract.

J. If there is an insufficient number of, or an inadequate member capacity in, contracts awarded to contractors, the director, in order to deliver covered services to members enrolled or expected to be enrolled in the system within a county, may negotiate and award, without bid, a contract with a health care services organization holding a certificate of authority pursuant to title 20, chapter 4, article 9. The director shall require a health care services organization contracting under this subsection to comply with section 36-2906.01. The term of the contract shall not extend beyond the next bid and contract award process as provided in section 36-2906 and shall be no greater than capitation rates paid to contractors in the same county or counties pursuant to section 36-2906. Contracts awarded pursuant to this subsection are exempt from the requirements of title 41, chapter 23.

K. A contractor may require that a subcontracting or noncontracting provider shall be paid for covered services, other than hospital services, according to the capped fee-for-service schedule adopted by the director pursuant to subsection A, paragraph 2 of this section or subsection B, paragraph 1 of this section or at lower rates as may be negotiated by the contractor.

L. The director shall require any contractor to have a plan to notify members of reproductive age either directly or through the parent or legal guardian, whichever is most appropriate, of the specific covered family planning services available to them and a plan to deliver those services to members who request them. The director shall ensure that these plans include provisions for written notification, other than the member handbook, and verbal notification during a member's visit with the member's primary care physician or primary care practitioner.

M. The director shall adopt a plan to notify members of reproductive age who receive care from a contractor who elects not to provide family planning services of the specific covered family planning services available to them and to provide for the delivery of those services to members who request them. Notification may be directly to the member, or through the parent or legal guardian, whichever is most appropriate. The director shall ensure that the plan includes provisions for written notification, other than the member handbook, and verbal notification during a member's visit with the member's primary care physician or primary care practitioner.

N. The director shall prepare a report that represents a statistically valid sample and that indicates the number of children age two by contractor who received the immunizations recommended by the national centers for disease control and prevention while enrolled as members. The report shall indicate each type of immunization and the number and percentage of enrolled children in the sample age two who received each type of immunization. The report shall be done by contract year and shall be delivered to the governor, the president of the senate and the speaker of the house of representatives no later than April 1, 2004 and every second year thereafter.

O. If the administration implements an electronic claims submission system it may adopt procedures pursuant to subsection I, paragraph 1 of this section requiring documentation different than prescribed under subsection I, paragraph 1, subdivision (d) of this section.

36-2901.08. Hospital assessment

(Conditionally Rpld.)

A. The director shall establish, administer and collect an assessment on hospital revenues, discharges or bed days for the purpose of funding the nonfederal share of the costs, except for costs of the services described in section 36-2907, subsection F, that are incurred beginning January 1, 2014 and that are not covered by the proposition 204 protection account established by section 36-778 and the Arizona tobacco litigation settlement fund established by section 36-2901.02 or any other monies appropriated to cover these costs, for all of the following individuals:

1. Persons who are defined as eligible pursuant to section 36-2901.07.
2. Persons who do not meet the eligibility standards described in the state plan or the section 1115 waiver that were in effect immediately before November 27, 2000, but who meet the eligibility standards described in the state plan as effective October 1, 2001.
3. Persons who are defined as eligible pursuant to section 36-2901.01 but who do not meet the eligibility standards in either section 36-2934 or the state plan in effect as of January 1, 2013.

B. The director shall adopt rules regarding the method for determining the assessment, the amount or rate of the assessment, and modifications or exemptions from the assessment. The assessment is subject to approval by the federal government to ensure that the assessment is not established or administered in a manner that causes a reduction in federal financial participation.

C. The director may establish modifications or exemptions to the assessment. In determining the modifications or exemptions, the director may consider factors including the size of the hospital, the specialty services available to patients and the geographic location of the hospital.

D. Before implementing the assessment, and thereafter if the methodology is modified, the director shall present the methodology to the joint legislative budget committee for review.

E. The administration shall not collect an assessment for costs associated with service after the effective date of any reduction of the federal medical assistance percentage established by 42 United States Code section 1396d(y) or 1396d(z) that is applicable to this state to less than eighty per cent.

F. The administration shall deposit the revenues collected pursuant to this section in the hospital assessment fund established by section 36-2901.09.

G. A hospital shall not pass the cost of the assessment on to patients or third-party payors that are liable to pay for care on a patient's behalf. As part of its financial statement submissions pursuant to section 36-125.04, a hospital shall submit to the department of health services an attestation that it has not passed on the cost of the assessment to patients or third-party payors.

H. If a hospital does not comply with this section as prescribed by the director, the director may suspend or revoke the hospital's Arizona health care cost containment system provider agreement registration. If the hospital does not comply within one hundred eighty days after the director suspends or revokes the hospital's provider agreement, the director shall notify the director of the department of health services, who shall suspend or revoke the hospital's license pursuant to section 36-427.

36-2905.01. Inpatient hospital reimbursement program; large counties

A. Notwithstanding any other law, beginning on October 1, 2003, pursuant to this chapter the administration shall establish and operate a program for inpatient hospital reimbursement in each county with a population of more than five hundred thousand persons.

B. Beginning on October 1, 2003, the director shall require contractors to enter into contracts with one or more hospitals in these counties and to reimburse those hospitals for services provided pursuant to this chapter based on the reimbursement levels negotiated with each hospital and specified in the contract and under the terms on which the contractor and the hospital agree and under all of the following conditions:

1. The director may review and approve or disapprove the reimbursement levels and the terms agreed on by the contractor and the hospital.
2. If the contractor implements an electronic claims submission system it may adopt procedures requiring documentation of the system.
3. Payment received by a hospital from a contractor is considered payment in full by the contractor. 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.

C. If a contractor and a hospital do not enter into a contract pursuant to subsection B of this section, the reimbursement level for inpatient services provided on dates of admission on or after October 1, 2003 for that hospital is the reimbursement level prescribed in section 36-2903.01 multiplied by ninety-five per cent.

D. For outpatient hospital services provided under the program prescribed in this section, a contractor may reimburse a hospital either pursuant to rates and terms negotiated in a contract between the contractor and the hospital or pursuant to section 36-2903.01, subsection G, paragraph 3.

E. Contracts established pursuant to this section shall specify that arbitration may be used in lieu of the grievance and appeal procedure prescribed in section 36-2903.01, subsection B, paragraph 4 to resolve any disputes arising under the contract.

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.

36-2999.52. Nursing facility quality assessments; calculation; limitation; exceptions

(Rpld. 10/1/23)

A. Beginning October 1, 2012, the administration shall charge a quality assessment on health care items and services provided by nursing facilities in order to obtain federal financial participation in the services provided pursuant to this chapter. The administration shall use these monies for supplemental payments to nursing facilities for covered medicaid expenditures, not to exceed the medicare upper payment limit program requirements.

B. Each nursing facility shall pay the assessment prescribed pursuant to this section to the department of revenue for deposit on a quarterly basis in the nursing facility assessment fund established by section 36-2999.53.

C. Unless otherwise required by law, title 42, chapter 5, article 1 governs the administration of the assessment prescribed pursuant to this section except that:

1. A separate license is not required for the assessment.
2. If a nursing facility does not have a transaction privilege tax license, it shall obtain one pursuant to section 42-5005.
3. Each facility shall report and pay the assessment on forms prescribed by the department of revenue.
4. A separate bond is not required of employees of the department of revenue who administer the assessment.
5. The assessment may be included without segregation in any notice and lien filed for unpaid transaction privilege taxes.

D. The administration shall calculate the quality assessment on the net patient service revenue of all nursing facilities that are subject to the quality assessment. The quality assessment may not exceed three and one-half per cent of net patient service revenue and shall be calculated and paid on a per resident day basis exclusive of medicare resident days. Except as prescribed in this section, the per resident day assessment is the same amount for each affected facility.

E. Pursuant to 42 Code of Federal Regulations section 433.68(e)(1) and (2), the administration shall request a waiver of the broad-based and uniform provider assessment requirements of federal law to exclude certain nursing facilities from the quality assessment and to permit certain high volume medicaid nursing facilities or facilities with a high number of total annual patient days to pay the quality assessment at a lesser amount per nonmedicare resident day.

F. Subject to federal approval pursuant to 42 Code of Federal Regulations section 433.68(c)(2), the following nursing facility providers are exempt from the quality assessment:

1. Continuing care retirement communities.
2. Nursing facilities with fifty-eight or fewer beds.

G. The administration shall lower the quality assessment for either certain high volume medicaid nursing facilities or certain facilities with high patient volumes to meet the redistributive test of 42 Code of Federal Regulations section 433.68(e)(2).

36-2999.54. Assessments; failure to pay; suspension or revocation

(Rpld. 10/1/23)

A. Each nursing facility shall pay a quality assessment as prescribed pursuant to this article. The administration shall determine the assessment rate prospectively for the applicable fiscal year on a per resident day basis, exclusive of medicare resident days. The administration shall adopt rules for facility reporting of nonmedicare resident days and for payment of the assessment.

B. A nursing facility may increase its charges to other payors to incorporate the assessment but may not establish a separate line-item charge on the bill reflecting the assessment.

C. If an entity conducts, operates or maintains more than one nursing facility, the entity must pay a quality assessment for each nursing facility separately.

D. If a nursing facility does not pay the full amount of the assessment when due, the director of the Arizona health care cost containment system administration may suspend or revoke the nursing facility's Arizona health care cost containment system provider agreement registration. If the nursing facility does not comply within one hundred eighty days after the director of the Arizona health care cost containment system administration suspends or revokes the nursing facility's provider agreement, the director of the Arizona health care cost containment system administration shall notify the director of the department of health services, who shall suspend or revoke the nursing facility's license pursuant to section 36-427.

**DEPARTMENT OF HEALTH SERVICES (F-17-1005)**

Title 9, Chapter 8, Article 8, Public and Semipublic Swimming Pools and Bathing Places



**GOVERNOR'S REGULATORY REVIEW COUNCIL  
ANALYSIS OF FIVE-YEAR REVIEW REPORT**

**MEETING DATE:** November 7, 2017

**AGENDA ITEM:** G-4

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**TO:** Members of the Governor's Regulatory Review Council (Council)  
**FROM:** Council Staff  
**DATE :** October 24, 2017  
**SUBJECT: DEPARTMENT OF HEALTH SERVICES (F-17-1005)**  
Title 9, Chapter 8, Article 8, Public and Semipublic Swimming Pools and Bathing Places

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**COMMENTS ON THE FIVE-YEAR-REVIEW REPORT**

**Purpose of the Agency and Number of Rules in the Report**

This five-year review report from the Arizona Department of Health Services (Department or DHS) covers 13 rules in A.A.C. Title 9, Chapter 8, Article 8 that relate to public and semipublic swimming pools and bathing places in the context of food, recreational, and institutional sanitation. The rules became effective on August 9, 2002 and have not been amended since. The Department indicates that the rules are intended to ensure that public<sup>1</sup> and semipublic<sup>2</sup> swimming pools and bathing places are operated and maintained in a sanitary manner. A.R.S. § 36-136(H)(10) requires the Department to develop its rules in cooperation with the Department of Environmental Quality's (DEQ) rules.

In 2012, the Department indicated that it did not plan to amend the rules. No actions have been taken on the rules in the past five years.

**Proposed Action**

To address issues anticipated because of a planned DEQ rulemaking on A.A.C. Title 18, Chapter 5, Article 2 to reference the Centers for Disease Control's 2016 Model Aquatic Health Code, the Department indicates an intent to amend the rules by June 2019.

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<sup>1</sup> According to the Department, a swimming pool or bathing place is "public" if it is open to members of the general public, regardless of whether a fee is charged for admission.

<sup>2</sup> According to the Department, a swimming pool or bathing place is "semipublic" if it is operated in conjunction with lodging such as hotel, motel, resort, apartment, or community pool facilities operated by, and exclusively for, a residential development.

**1. Has the agency analyzed whether the rules are authorized by statute?**

Yes. The Department cites to both general and specific authority for the rules. Of particular significance is A.R.S. § 36-136(I)(10), which, in relevant part, requires the Department to “[p]rescribe 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.”

**2. Summary of the agency’s economic impact comparison and identification of stakeholders:**

Stakeholders are the Department, counties, public users, businesses that own or operate public and semipublic swimming pools and bathing places, and manufacturers and distributors of disinfection products and equipment for public and semipublic swimming pools and bathing places.

In FY 2016, there were 12,817 public and semipublic swimming pools and spas in Arizona. State and county health departments conducted 25,594 swimming pool and spa inspections, and initiated 1,850 enforcement actions in FY 2016. Because the Department delegates authority to supervise, inspect and enforce the rules concerning public and semipublic pools and bathing places to the counties the Department does not incur costs for inspection and enforcement.

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

The Department incurs minimal to moderate cost for staff time to write, review and process the rules. Counties incur minimal to moderate costs for staff time to amend ordinances, train staff on new rules, and perform inspections. Counties have the authority to recapture costs for abatement and to charge a civil penalty for each nuisance and are able to offset costs incurred due to the rules.

The users of public and semipublic swimming pools and bathing places realize the greatest benefits from the due to better sanitary conditions and decreased exposure to waterborne illnesses. Since most owners and operators have already adopted national standards incorporated by the rules, their estimated additional costs from the rules have been determined to be minimal. Manufacturers and distributors of equipment and supplies for public and semipublic pools and bathing places have been determined to have minimal to moderate benefits due to increased sales of disinfection products and equipment.

**4. Has the agency received any written criticisms of the rules over the last five years?**

No. The Department indicates that it has not received any written criticisms of the rules during the last five years.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?**

Yes. The Department indicates that the rules are clear, concise, and understandable. The Department states that the finalization of DEQ's planned rule changes could create two health-related standards, thereby creating confusion among the regulated community.<sup>3</sup>

The Department indicates that the rules are consistent with state and federal statutes and rules and are generally effective.

**6. Has the agency analyzed the current enforcement status of the rules?**

Yes. The Department indicates that it has delegated its inspection and abatement authority to counties, and the rules are enforced without difficulty.

**7. 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 Department indicates that the rules are not more stringent than federal law.

**8. 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, as the rules were adopted prior to July 29, 2010.

**9. Conclusion**

As noted above, the Department intends to amend the rules by June 2019. The report meets the requirements of A.R.S. § 41-1056 and R1-6-301, and this analyst recommends that the report be approved.

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<sup>3</sup> Council Staff asked DHS if it has shared this concern with DEQ and to what extent, if any, DHS has been consulted with DEQ's process? In response, DHS stated that DEQ has not consulted DHS but is aware of DHS' interest in its rulemaking.



## ARIZONA DEPARTMENT OF HEALTH SERVICES

July 26, 2017

Nicole O. Colyer, Chairperson  
Governor's Regulatory Review Council  
Arizona Department of Administration  
100 N. 15th Avenue, Suite 402  
Phoenix, AZ 85007

RE: Report for A.A.C. Title 9, Chapter 8, Article 8, Public and Semipublic Swimming Pools and Bathing Places

Dear Ms. Colyer:

According to the five-year-review report schedule of the Governor's Regulatory Review Council (Council), a report for A.A.C. Title 9, Chapter 8, Article 8 is due to the Council no later than July 31, 2017. The Arizona Department of Health Services (Department) has reviewed A.A.C. Title 9, Chapter 8, Article 8, and is enclosing a report to the Council for these rules.

The Department believes that this report complies with the requirements of A.R.S. § 41-1056. A five-year-review summary, information that is identical for all the rules, information for individual rules, the rules reviewed, and the general and specific authority are included in the package. As described in the report, the Department anticipates submitting a Notice of Final Rulemaking to Council by June, 2019.

The Department certifies that it is in compliance with A.R.S. § 41-1091.

If you need any further information, please contact me at (602) 542-1020.

Sincerely,

A handwritten signature in blue ink, appearing to read "Robert Lane".

Robert Lane  
Director's Designee

Enclosures

Douglas A. Ducey | Governor    Cara M. Christ, MD, MS | Director



# ARIZONA DEPARTMENT OF HEALTH SERVICES

**FIVE-YEAR-REVIEW REPORT**

**TITLE 9. HEALTH SERVICES**

**CHAPTER 8. DEPARTMENT OF HEALTH SERVICES**

**FOOD, RECREATIONAL, AND INSTITUTIONAL SANITATION**

**ARTICLE 8. PUBLIC AND SEMIPUBLIC SWIMMING POOLS AND BATHING  
PLACES**

**July 2017**

**FIVE-YEAR-REVIEW REPORT**  
**TITLE 9. HEALTH SERVICES**  
**CHAPTER 8. DEPARTMENT OF HEALTH SERVICES**  
**FOOD, RECREATIONAL, AND INSTITUTIONAL SANITATION**  
**ARTICLE 8. PUBLIC AND SEMIPUBLIC SWIMMING POOLS AND BATHING**  
**PLACES**  
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## **FIVE-YEAR-REVIEW SUMMARY**

Arizona Revised Statutes (A.R.S.) § 36-132(A)(12) requires the Department of Health Services (Department) to “[s]upervise, inspect and enforce the rules concerning the operation of public bathing places and public and semipublic swimming pools” that are adopted pursuant to A.R.S. § 36-136(H)(10)<sup>1</sup>. A.R.S. § 36-136(H)(10) requires the Department to adopt rules “[p]rescrib[ing] 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.” A.R.S. § 36-136(H)(10) also requires the Department to prescribe by rule minimum standards for sanitary conditions at any public or semipublic swimming pool or bathing place, including providing for inspection of the premises and abatement as public nuisances any premises and facilities that do not comply with the rules.

The Department is required according to A.R.S. § 36-136(H)(10) to develop its rules in cooperation with, and consistent with, the Arizona Department of Environmental Quality (ADEQ) and its rules.

The Department has implemented these statutes in Arizona Administrative Code (A.C.C.) Title 9, Chapter 8, Article 8. The 13 rules in 9 A.A.C. 8, Article 8 were promulgated in 2002 to ensure that public and semipublic swimming pools and bathing places are operated and maintained in a sanitary manner. According to the Department’s Office of Environmental Health’s Food Safety and Environmental Services Annual Report, a swimming pool or bathing place is “public” if it is open to members of the general public, regardless of whether a fee is charged for admission. A swimming pool or bathing place is “semi-public” if it is operated in conjunction with lodging such as hotel, motel, resort, apartment, or community pool facilities operated by, and exclusively for, a residential development. The rules discuss:

- Water quality, disinfection, and circulation standards;
- Standards for facility sanitation, including condition of bathing towels;
- Approved methods for disposal of sewage, filter backwash, and wasted swimming pool or spa water;
- Methods to eliminate fecal contamination; and
- Cease and desist abatement authority.

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<sup>1</sup> Effective August 9, 2017, Laws 2017, Ch. 288 amended citations in this five-year-review report. Laws 2017, Ch. 288 added new A.R.S. § 36-136(C) and renumbered A.R.S. § 36-136 (D), (F), and (H) to A.R.S. §§ 36-136(E), (G), and (I), respectively.

After an analysis of the rules in 9 A.A.C. 8, Articles 8, the Department has determined all of the rules are effective or mostly effective; all of the rules are consistent with statutes and rules; all of the rules are enforced as written; and all of the rules are clear, concise, and understandable or mostly clear, concise, and understandable. There was no written criticism of the rules that has been received by the Department.

For reasons discussed in this Five-Year-Review Report, the Department anticipates submitting a Notice of Final Rulemaking to the Governor's Regulatory Review Council by June, 2019.

## **INFORMATION THAT IS IDENTICAL FOR ALL THE RULES**

**1. Authorization of the rule by existing statutes**

The general authority for the rules are A.R.S. §§ 36-132(A)(1), 36-136(A)(4)-(7), 36-136(F), and 36-601.

The specific authority for the rules are A.R.S. §§ 36-132(A)(12) and 36-136(H)(10).

**2. The purpose of the rules**

The purpose of the rules in 9 A.A.C. 8, Article 8 is to protect the public health by regulating water quality and sanitation in public or semipublic swimming pools and bathing places.

**3. Analysis of effectiveness in achieving the objectives**

The rules are currently effective in achieving their respective objectives. ADEQ, however, has begun the process of amending its rules in 18 A.A.C. 5, Article 2 to reference the Centers for Disease Control (CDC) 2016 Model Aquatic Health Code, 2<sup>nd</sup> Edition, published July 2016 (2016 CDC Model Aquatic Code) for many of the standards currently referenced in 9 A.A.C. 8, Article 8. Additional specific comments regarding anticipated future effectiveness appear in the information for individual rules.

**4. Analysis of consistency with state and federal statutes and rules**

The rules in 9 A.A.C. 8, Article 8 liberally reference ADEQ's rules in 18 A.A.C. 5, Article 2, relating to public and semipublic swimming pools and bathing places. ADEQ has begun the process of amending its rules in 18 A.A.C. 5, Article 2 and plans to reference 2016 CDC Model Aquatic Code for many of the standards currently referenced in the Department's rules. To the extent that the amendments have not yet taken effect, the rules in 9 A.A.C. 8, Article 8 are consistent with state and federal statutes and rules. Additional specific comments regarding anticipated future consistency with state and federal statutes and rules relating to the ADEQ amendments appear in the information for individual rules.

**5. Status of enforcement of the rules**

The Department has delegated its inspection and abatement authority to the counties having jurisdiction over the respective public or semipublic swimming pools and bathing places. See A.R.S. § 36-136(D). The rules are enforced without difficulty.

**6. Analysis of clarity, conciseness, and understandability**

The rules are clear, concise, and understandable. At the point that the ADEQ amendments in 18 A.A.C. 5, Article 2 are finalized, there may exist two health-related standards, which would cause confusion among the regulated community.

7. **Summary of the written criticisms of the rule received within the last five years**

The Department has not received any written criticism of the rules in the last five years.

8. **Economic, small business, and consumer impact comparison**

The economic impact statement (EIS) created as part of the 2002 rulemaking (2002 EIS) identified the following stakeholders: the Department, counties, public users, business that own and operate public and semipublic swimming pools and bathing places, and manufacturers and distributors of disinfection products and equipment for public and semipublic swimming pools and bathing places. Costs and benefits are designated as minimal when less than \$1,000, moderate when between \$1,000 and \$10,000, and substantial when greater than \$10,000.

The 2002 EIS reported that Maricopa County had 65 public swimming pools and that the total number of public swimming pools in the state was approximately 96. Since the rules in 9 A.A.C. 8, Article 8 were enacted, the number of annual inspections has increased due to an increase in the number of public and semipublic swimming pools and bathing places. In FY2016, there were 12,817 public and semi-public swimming pools and spas in Arizona. State and county health departments conducted 25,594 swimming pool and spa inspections, and initiated 1,850 enforcement actions in FY2016.

The 2002 EIS estimated that the Department would incur a minimal-to-moderate cost for staff time needed to write, review, and process the rules, as well as some administrative costs as a regulatory authority because the Department is responsible to supervise, inspect, and enforce the rules concerning public and semipublic swimming pools and bathing places. Because the Department delegates authority to the county health departments, the Department does not incur costs for inspections and enforcement.

The 2002 EIS estimated that the counties to whom the Department has delegated authority to inspect public and semipublic swimming pools and bathing places would incur minimal-to-moderate costs for staff to amend ordinances, train staff on new rules, and perform inspections. A.R.S. § 36-602 provides counties statutory authority to recapture costs for abatement and to charge a civil penalty for each nuisance. Thus, the counties are able to offset the costs incurred due to the rules. Because of this, the

Department believes that the counties continue to incur minimal-to-moderate costs as originally predicted by the 2002 EIS.

The 2002 EIS estimated that the users of public and semipublic swimming pools and bathing places will realize the greatest benefits due to better sanitary conditions and decreased exposure to waterborne illness.

The Department's Office of Infectious Disease Services collects data regarding waterborne illness. However, owners and operators of public and semipublic swimming pools and bathing places are not statutorily required to report. The CDC reports<sup>2</sup> that with correct pH and disinfectant levels, chlorine kills germs causing recreational water illness. The CDC also reports that it is "important for swimmers to help keep germs out of the water in the first place." Because the rules in 9 A.A.C. 8, Article 8 address both matters identified by the CDC, the Department believes the 2002 EIS estimate that public users realize a significant benefit is still an accurate prediction; although, the degree to which the benefit is meaningful and important is not readily quantifiable.

The 2002 EIS stated that the rules in 9 A.A.C. 8, Article 8 incorporate current national sanitation standards that had already been adopted by most owners and operators of public or semipublic swimming pools or bathing places and concluded that any additional cost caused by the rules to owners and operators would be minimal. In addition, the 2002 EIS stated the rules give owners and operators more choices in the products that they use to maintain their public and semipublic swimming pools and spas. The Department does not collect data about owners' and operators' compliance with the national sanitation standards or owners' and operators' choice of products used to maintain their public and semipublic swimming pools and bathing places. Additionally, the Department has not received feedback from stakeholders regarding these matters. Therefore, the Department believes that the economic impact is as originally stated in the 2002 EIS.

The 2002 EIS estimated that manufacturers and distributors of equipment and supplies for public and semipublic swimming pools and bathing places would incur a minimal-to-moderate benefit due to increased sales of disinfection products and equipment to owners and operators of public and semipublic swimming pools and bathing places. The Department does not collect data about disinfection products and equipment used to operate public and semipublic swimming pools and bathing places;

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<sup>2</sup> <http://www.cdc.gov/healthywater/swimming/rwi/rwi-why.html>

nor has the Department received feedback from stakeholders regarding this matter. The Department believes that it is reasonable to assume that manufactures and distributors would have experienced increased benefit consistent with owners and operators who had already adopted the national sanitation standards prior to the rules promulgation as previously mentioned. For this reason, the Department believes that the economic impact is as originally stated in the 2002 EIS.

**9. Summary of business competitiveness analyses of the rules**

The Department did not receive a business competitiveness analysis of the rules in the last five years.

**10. Status of the completion of action indicated in the previous five-year-review report**

In the 2012 Five-Year-Review Report, the Department noted that it did not plan to amend the rules in 9 A.A.C. 8, Article 8 until a substantive issue affecting public health and safety arose. Since no substantive issues arose during that time, and the Department, therefore, did not amend the rules, the Department complied with the act in the previous 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 persons regulated by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective**

The Department and local health departments continue to use the rules without increased cost or burden. For this reason, the Department has determined that the rules currently provide the least burden and cost to the Department and persons regulated by the rules, and achieve the regulatory objective consistent with statutory requirements.

**12. Analysis of stringency compared to federal laws**

The rules are not more stringent than federal laws.

**13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rule complies with section 41-1037**

The rules were adopted before July 29, 2010.

**14. Proposed course of action**

To address issues caused by the ADEQ rulemaking, Department anticipates submitting a Notice of Final Rulemaking to the Governor's Regulatory Review Council by June, 2019. This course of action is subject to change based on the Governor's rulemaking moratorium and the Department's priorities.

## INFORMATION FOR INDIVIDUAL RULES

### **R9-8-801. Definitions**

#### **2. Objective**

The objective of the rule is to define terms and phrases to enable the reader to have a better understanding of the requirements contained in the Article.

#### **4. Analysis of consistency with state and federal statutes and rules**

Although the rule is currently consistent with state and federal statutes and rules, the rule incorporates certain ADEQ definitions found in 18 A.A.C. 5, Article 2. ADEQ is currently revising its rules to incorporate some definitions found in the 2016 CDC Model Aquatic Code. When those amendments are adopted, some references to ADEQ rules would be obsolete.

### **R9-8-802. Applicability**

#### **2. Objective**

The objective of the rule is to clarify the scope of Article 8 by enumerating four specific examples to which Article 8 does not apply.

### **R9-8-803. Public and Semipublic Swimming Pool and Spa Water Quality and Disinfection Standards**

#### **2. Objective**

The objective of the rule is to protect public health by setting forth the water quality and disinfection standards for public and semipublic swimming pools and spas, including specific water quality and disinfection standards, prohibited methods for disinfection, and quality standards relative to the surface water and bottom and sides of the swimming pool or spa.

### **R9-8-804. Public and Semipublic Swimming Pool and Spa Circulation Requirements**

#### **2. Objective**

The objective of the rule is to protect public health by setting forth the water circulation requirements for public and semipublic swimming pools and spas, including reference to ADEQ rules that provide for the specific equipment necessary to ensure that circulation requirements are satisfied.

**4. Analysis of consistency with state and federal statutes and rules**

Although the rule is currently consistent with state and federal statutes and rules, the rule incorporates certain ADEQ requirements found in 18 A.A.C. 5, Article 2. ADEQ is currently revising its rules to incorporate some requirements found in the 2016 CDC Model Aquatic Code. When those amendments are adopted, some references to ADEQ rules would be obsolete.

**R9-8-805. Public and Semipublic Swimming Pool and Spa Maximum Bathing Loads**

**2. Objective**

The objective of the rule is to require that the maximum bathing load of a public and semipublic swimming pool or spa does not exceed calculated design capacity according to the Department of Environmental Quality rules, 18 A.A.C. 5, Article 2.

**4. Analysis of consistency with state and federal statutes and rules**

Although the rule is currently consistent with state and federal statutes and rules, the rule incorporates certain ADEQ requirements found in 18 A.A.C. 5, Article 2. ADEQ is currently revising its rules to incorporate some requirements found in the 2016 CDC Model Aquatic Code. When those amendments are adopted, some references to ADEQ rules would be obsolete.

**R9-8-806. Posting Requirements**

**2. Objective**

The objective of the rule is to protect public health by requiring operators to post a sign notifying users of a public or semipublic swimming pool or spa to follow specific instructions before entering the water and to observe safety regulations.

**R9-8-807. Public and Semipublic Pool and Spa and Bathing Place Facility Sanitation**

**2. Objective**

The objective of the rule is to protect public health by setting forth the sanitary facility requirements for a public or semipublic pool or spa, including the requirement that an operator of a public or semipublic swimming pool or spa to maintain a sanitary facility in a clean condition equipped with a soap dispenser and soap.

**R9-8-808. Bathing Place Towels**

**2. Objective**

The objective of the rule is to protect public health by setting forth the hygienic standard requirements for a public or semipublic pool or spa providing for bathing towels.

**R9-8-809. Disposal of Sewage, Filter Backwash, and Wasted Swimming Pool or Spa Water**

**2. Objective**

The objective of the rule is to protect public health by requiring an operator to dispose of sewage, filter backwash, or swimming pool or spa water at a public or semipublic pool or spa in accordance with ADEQ rules.

**4. Analysis of consistency with state and federal statutes and rules**

Although the rule is currently consistent with state and federal statutes and rules, the rule incorporates certain ADEQ requirements found in 18 A.A.C. 5, Article 2. ADEQ is currently revising its rules to incorporate some requirements found in the 2016 CDC Model Aquatic Code. When those amendments are adopted, some references to ADEQ rules would be obsolete.

**R9-8-810. Fecal Contamination in Public and Semipublic Swimming Pools and Spas**

**2. Objective**

The objective of the rule is to protect public health by setting forth requirements regarding the cleanup of fecal matter in a public or semipublic pool or spa.

**R9-8-811. Natural and Semi-Artificial Bathing Place and Artificial Lake Water Quality Standards**

**2. Objective**

The objective of the rule is to protect public health by requiring the operator of a public or semipublic natural bathing place, a semi-artificial bathing place, or an artificial lake to meet ADEQ's water quality standards when open for water contact recreation.

**4. Analysis of consistency with state and federal statutes and rules**

Although the rule is currently consistent with state and federal statutes and rules, the rule incorporates certain ADEQ definitions found in 18 A.A.C. 5, Article 2. ADEQ is currently revising its rules to incorporate some definitions found in the 2016 CDC Model

Aquatic Code. When those amendments are adopted, some references to ADEQ rules would be obsolete.

**R9-8-812. Inspections**

**2. Objective**

The objective of the rule is to protect public health by permitting inspections by a regulatory authority to ensure compliance with this Article.

**R9-8-813 Cease and Desist Abatement**

**2. Objective**

The objective of the rule is to implement enforcement of this Article by providing a process by which enforcement is carried out that allows a regulatory authority to serve a written cease and desist and abatement order requiring an operator to discontinue any activity that the regulatory authority has reasonable belief is in violation of this Article.

# ATTACHMENT A

## TITLE 9. HEALTH SERVICES

CHAPTER 8. DEPARTMENT OF HEALTH SERVICES  
FOOD, RECREATIONAL, AND INSTITUTIONAL SANITATION

## ARTICLE 8. PUBLIC AND SEMIPUBLIC SWIMMING POOLS AND BATHING PLACES

Section	
R9-8-801.	Definitions
R9-8-802.	Applicability
R9-8-803.	Public and Semipublic Swimming Pool and Spa Water Quality and Disinfection Standards
R9-8-804.	Public and Semipublic Swimming Pool and Spa Water Circulation Requirements
R9-8-805.	Public and Semipublic Swimming Pool and Spa Maximum Bathing Loads
R9-8-806.	Posting Requirements
R9-8-807.	Public and Semipublic Swimming Pool and Spa and Bathing Place Facility Sanitation
R9-8-808.	Bathing Place Towels
R9-8-809.	Disposal of Sewage, Filter Backwash, and Wasted Swimming Pool or Spa Water
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R9-8-811.	Natural and Semi-artificial Bathing Place and Artificial Lake Water Quality Standards
R9-8-812.	Inspections
R9-8-813.	Cease and Desist and Abatement
R9-8-814.	Repealed
R9-8-815.	Repealed
R9-8-816.	Repealed
R9-8-817.	Repealed
R9-8-818.	Reserved
R9-8-819.	Reserved
R9-8-820.	Reserved
R9-8-821.	Repealed
R9-8-822.	Repealed
R9-8-823.	Repealed
R9-8-824.	Repealed
R9-8-825.	Reserved
R9-8-826.	Reserved
R9-8-827.	Reserved
R9-8-828.	Reserved
R9-8-829.	Reserved
R9-8-830.	Reserved
R9-8-831.	Repealed
R9-8-832.	Repealed
R9-8-833.	Repealed
R9-8-834.	Repealed
R9-8-835.	Repealed
R9-8-836.	Repealed
R9-8-837.	Repealed
R9-8-838.	Repealed
R9-8-839.	Repealed
R9-8-840.	Reserved
R9-8-841.	Repealed
Exhibit A.	Repealed
R9-8-842.	Repealed
R9-8-843.	Repealed
R9-8-844.	Repealed
R9-8-845.	Repealed
R9-8-846.	Repealed
R9-8-847.	Repealed
R9-8-848.	Reserved
R9-8-849.	Reserved
R9-8-850.	Reserved
R9-8-851.	Repealed
R9-8-852.	Repealed

**ARTICLE 8. PUBLIC AND SEMIPUBLIC SWIMMING POOLS AND BATHING PLACES**

**R9-8-801. Definitions**

In this Article, unless otherwise specified:

1. "Artificial lake" has the same meaning as in A.A.C. R18-5-201.
2. "Backwash" has the same meaning as in A.A.C. R18-5-201.
3. "Bathing place" means a volume of water that is used for water contact recreation.
4. "Clean" means free from slime, scum, dirt, or other debris.
5. "Deck" has the same meaning as in A.A.C. R18-5-201.
6. "Department" means the Arizona Department of Health Services.
7. "Incontinent" means unable to restrain a bowel movement.
8. "Local health department" has the same meaning as in R9-18-101.
9. "Maximum bathing load" has the same meaning as in A.A.C. R18-5-201.
10. "Natural bathing place" has the same meaning as in A.A.C. R18-5-201.
11. "Operate" has the same meaning as in A.A.C. R18-5-201.
12. "Operator" means an individual who owns, runs, maintains, or otherwise controls or directs the functioning of a bathing place.
13. "Oxidation-reduction potential" means the measurement in millivolts of the potential for transfer of electrons from one atom or molecule to another in water.
14. "Potable water" has the same meaning as in A.A.C. R18-5-201.
15. "Ppm" means parts per million.
16. "Private residential spa" has the same meaning as in A.A.C. R18-5-201.
17. "Private residential swimming pool" has the same meaning as in A.A.C. R18-5-201.
18. "Public health services district" has the same meaning as "district" in A.R.S. § 48-5801.
19. "Public spa" has the same meaning as in A.A.C. R18-5-201.
20. "Public swimming pool" has the same meaning as in A.A.C. R18-5-201.
21. "Regulatory authority" means the Department or a local health department or public health services district operating under a delegation of authority from the Department.
22. "Sanitary facility" means a designated area that includes a toilet, urinal, sink, or shower.
23. "Scum" means a film that forms on the surface of water.
24. "Semi-artificial bathing place" means a lake, pond, river, stream, swimming hole, or hot spring that is modified to be used for water contact recreation.
25. "Semipublic spa" has the same meaning as in A.A.C. R18-5-201.
26. "Semipublic swimming pool" has the same meaning as in A.A.C. R18-5-201.
27. "Shallow area" has the same meaning as in A.A.C. R18-5-201.
28. "Shock treatment" means adding chlorine to water to elevate the free chlorine residual to 20 ppm and destroy ammonia and nitrogenous and organic contaminants in the water.
29. "Slime" means a glutinous or viscous liquid matter.
30. "Spa" has the same meaning as in A.A.C. R18-5-201.
31. "Surface water" has the same meaning as in A.A.C. R18-11-101.
32. "Swimming pool" has the same meaning as in A.A.C. R18-5-201.
33. "Turnover rate" has the same meaning as in A.A.C. R18-5-201.
34. "Wading pool" has the same meaning as in A.A.C. R18-5-201.
35. "Water circulation system" has the same meaning as in A.A.C. R18-5-201.
36. "Water circulation system components" has the same meaning as in A.A.C. R18-5-201.
37. "Water fountain" means a bathing place that functions by using mechanical means to propel a stream of water out of an opening or structure.
38. "Water contact recreation" means an activity for enjoyment in which an individual wets all or part of the individual's body with water.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-802. Applicability**

This Article does not apply to:

1. A private residential swimming pool,
2. A private residential spa,
3. A bathing place used for medical treatment or physical therapy supervised by licensed medical personnel, or
4. A body of water that is not used as a bathing place.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

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**R9-8-803. Public and Semipublic Swimming Pool and Spa Water Quality and Disinfection Standards**

- A. An operator of a public or semipublic swimming pool or spa shall ensure that:
1. The swimming pool or spa is filled only with potable water;
  2. The water in the swimming pool or spa:
    - a. Complies with the water quality standards in this Section when the swimming pool or spa is open for water contact recreation;
    - b. Maintains a pH of between 7.2 and 7.8;
    - c. Maintains a total alkalinity of between 60 and 100 ppm; and
    - d. Is sufficiently clear so that the main drain in the swimming pool or spa is visible from the deck of the swimming pool or spa;
  3. The surface of the water in the swimming pool or spa is free from scum and floating debris;
  4. The bottom and sides of the swimming pool or spa are free from sediment, dirt, slime, and algae;
  5. The chemical disinfection level, pH, total alkalinity, and temperature of the water is tested at least once daily; and
  6. A daily operating log that includes the results of the tests in subsection (A)(5) is maintained for 12 months from the date of the test and is available to a regulatory authority or a member of the public upon request.
- B. An operator of a public or semipublic swimming pool or spa:
1. Shall not use chloramine as a primary disinfectant in the swimming pool or spa;
  2. Shall not add gaseous disinfectant directly into the swimming pool;
  3. Shall not add dry or liquid disinfectant directly into the swimming pool or spa for routine disinfection; and
  4. May add dry or liquid disinfectant directly into the swimming pool or spa for shock treatment.
- C. An operator of a public or semipublic swimming pool or spa using chlorinated isocyanurates or cyanuric acid stabilizer for disinfection and stabilization in the swimming pool or spa shall ensure that the water in the swimming pool or spa maintains an oxidation-reduction potential equal to or greater than 650 millivolts and that cyanuric acid levels, whether from chlorinated isocyanurates or from the separate addition of cyanuric acid stabilizer, do not exceed 150 ppm.
- D. An operator of a public or semipublic swimming pool shall ensure that the water in the swimming pool meets one of the following chemical disinfection standards:
1. A free chlorine residual between 1.0 and 3.0 ppm as measured by the N, N-Diethyl-p-phenylenediamine test,
  2. A free bromine residual between 2.0 and 4.0 ppm as measured by the N, N-Diethyl-p-phenylenediamine test, or
  3. An oxidation-reduction potential equal to or greater than 650 millivolts.
- E. An operator of a public or semipublic spa shall ensure that:
1. A chlorine gas disinfection system is not used in the spa;
  2. The water temperature in the spa does not exceed 40EC; and
  3. The water in the spa meets one of the following chemical disinfection standards:
    - a. A free chlorine residual between 3.0 and 5.0 ppm as measured by the N, N-Diethyl-p-phenylenediamine test,
    - b. A free bromine residual between 3.0 and 5.0 ppm as measured by the N, N-Diethyl-p-phenylenediamine test, or
    - c. An oxidation-reduction potential equal to or greater than 650 millivolts.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-804. Public and Semipublic Swimming Pool and Spa Water Circulation Requirements**

- A. An operator of a public or semipublic swimming pool or spa shall ensure that:
1. The swimming pool or spa water circulation system complies with the water circulation requirements in 18 A.A.C. 5, Article 2; and
  2. The swimming pool or spa is equipped with:
    - a. A flow meter as specified in 18 A.A.C. 5, Article 2; and
    - b. A vacuum cleaning system as specified in 18 A.A.C. 5, Article 2.
- B. An operator may draw water from a swimming pool for a water slide or a water fountain without filtering or disinfecting the water.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-805. Public and Semipublic Swimming Pool and Spa Maximum Bathing Loads**

An operator of a public or semipublic swimming pool or spa shall ensure that the maximum bathing load, as specified in 18 A.A.C. 5, Article 2, is not exceeded.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-806. Posting Requirements**

An operator of a public or semipublic swimming pool or spa shall ensure that a sign is posted within 50 feet of the swimming pool or spa, that includes the following instructions:

1. Use the toilet before entering the pool or spa;
2. Take a shower before entering the pool or spa;
3. Do not enter the pool with a cold, skin or other body infection, open wound, diarrhea, or any other contagious condition;
4. If incontinent, wear tight fitting rubber or plastic pants or a swim diaper; and
5. Observe all safety regulations.

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**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-807. Public and Semipublic Swimming Pool and Spa and Bathing Place Facility Sanitation**

- A. An operator of a public or semipublic swimming pool or spa shall ensure that a sanitary facility at the public or semipublic swimming pool is maintained in a clean condition.
- B. An operator of a public or semipublic swimming pool or bathing place shall provide a soap dispenser with liquid or powdered soap at each sink in a sanitary facility.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-808. Bathing Place Towels**

If a towel is provided by a bathing place to an individual using the bathing place, an operator of the bathing place shall ensure that the towel is washed with soap or detergent and hot water and thoroughly dried after each individual use.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-809. Disposal of Sewage, Filter Backwash, and Wasted Swimming Pool or Spa Water**

An operator of a public or semipublic swimming pool or spa shall ensure that sewage, filter backwash, and swimming pool or spa water are disposed of according to A.A.C. R18-5-236.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-810. Fecal Contamination in Public and Semipublic Swimming Pools and Spas**

- A. If solid feces are found in a public or semipublic swimming pool or spa, an operator of the swimming pool or spa shall ensure that:
  - 1. Each individual in the swimming pool or spa exits the swimming pool or spa and the swimming pool or spa is closed,
  - 2. The feces in the swimming pool or spa are removed and disposed of in a toilet,
  - 3. The chemical disinfection level of the water in the swimming pool or spa is tested to determine whether the water complies with the water quality and disinfection standards in R9-8-803, and
  - 4. The swimming pool or spa is not reopened until a test conducted under subsection (A)(3) indicates that the water complies with the water quality and disinfection standards in R9-8-803.
- B. If liquid feces are found in a public or semipublic swimming pool or spa, an operator of the swimming pool or spa shall ensure that:
  - 1. Each individual in the swimming pool or spa exits the swimming pool or spa and the swimming pool or spa is closed;
  - 2. The swimming pool or spa is closed for at least 24 hours;
  - 3. As much of the liquid feces as possible in the swimming pool or spa is removed and disposed of in a toilet;
  - 4. The swimming pool or spa is chemically treated with a shock treatment;
  - 5. The water in the swimming pool or spa is tested 24 hours after applying the shock treatment to determine whether the water complies with the water quality and disinfection standards in R9-8-803; and
  - 6. The swimming pool or spa is not reopened until a test conducted under subsection (B)(5) indicates that the water complies with the water quality and disinfection standards in R9-8-803.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-811. Natural and Semi-artificial Bathing Place and Artificial Lake Water Quality Standards**

An operator of a public or semipublic natural bathing place, a semi-artificial bathing place, or an artificial lake shall ensure that the public or semipublic natural bathing place, semi-artificial bathing place, or artificial lake meets the narrative and numeric water quality standards in 18 A.A.C. 11, Article 1 when the public or semipublic natural bathing place, semi-artificial bathing place, or artificial lake is open for water contact recreation.

**Historical Note**

Section repealed; new Section made by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-812. Inspections**

- A. A regulatory authority shall inspect a bathing place to determine whether the bathing place complies with this Article.
- B. A regulatory authority shall inspect a public swimming pool at least once each month that the swimming pool is open for water contact recreation.

**Historical Note**

Section repealed; new Section made by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-813. Cease and Desist and Abatement**

- A. Engaging in any practice in violation of this Article is a public nuisance.
- B. If a regulatory authority has reasonable cause to believe that an operator of a public or semipublic swimming pool or bathing place is creating or maintaining a public nuisance at the public or semipublic swimming pool or bathing place, the regulatory authority shall order the operator to discontinue the activity and to abate the public nuisance as follows:

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1. The regulatory authority shall serve on the operator a written cease and desist and abatement order requiring the operator to discontinue the activity and to remove the public nuisance at the operator's expense within 24 hours after service of the order. The order shall contain:
  - a. A reference to the statute or rule that is alleged to have been violated or on which the order is based,
  - b. A description of the operator's right to request a hearing, and
  - c. A description of the operator's right to request an informal settlement conference.
2. The regulatory authority shall serve the order and any subsequent notices by personal delivery or certified mail, return receipt requested, to the operator or other party's last address of record with the regulatory authority or by any other method reasonably calculated to effect actual notice to the operator or other party.
3. The operator or another party whose rights are determined by the order may obtain a hearing to appeal the order by filing a written notice of appeal with the regulatory authority within 30 days after service of the order. The operator or other party appealing the order shall serve the notice of appeal upon the regulatory authority by personal delivery or certified mail, return receipt requested, to the office of the regulatory authority or by any other method reasonably calculated to effect actual notice on the regulatory authority. Appealing an order does not release the operator from the obligation to comply with the order.
4. If a notice of appeal is timely filed, the regulatory authority shall do one of the following:
  - a. If the regulatory authority is the Department or a local health department or public health services district to which the duty to comply with A.R.S. Title 41, Chapter 6, Article 10 is delegated, the notification and hearing shall comply with A.R.S. Title 41, Chapter 6, Article 10 and any rules promulgated by the Office of Administrative Hearings.
  - b. For all other regulatory authorities, the notification and hearing shall comply with the procedures adopted by a county board of supervisors as required by A.R.S. § 36-183.04(E).
5. If a written notice of appeal is not timely filed, the order becomes final.
6. A regulatory authority shall inspect the public or semipublic swimming pool or bathing place 24 hours after service of the order to determine whether the operator has complied with the order. If the regulatory authority determines upon inspection that the operator has not ceased the activity and abated the public nuisance, the regulatory authority shall cause the public nuisance to be removed.

**Historical Note**

Section repealed; new Section made by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-814. Repealed**

**Historical Note**

Section repealed by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-815. Repealed**

**Historical Note**

Section repealed by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-816. Repealed**

**Historical Note**

Section repealed by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-817. Repealed**

**Historical Note**

Section repealed by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-818. Reserved**

**R9-8-819. Reserved**

**R9-8-820. Reserved**

**R9-8-821. Repealed**

**Historical note**

R9-8-821 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

**R9-8-822. Repealed**

**Historical note**

R9-8-822 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

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**R9-8-823. Repealed**

**Historical Note**

Section repealed by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-824. Repealed**

**Historical Note**

Section repealed by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-825. Reserved**

**R9-8-826. Reserved**

**R9-8-827. Reserved**

**R9-8-828. Reserved**

**R9-8-829. Reserved**

**R9-8-830. Reserved**

**R9-8-831. Repealed**

**Historical Note**

R9-8-831 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

**R9-8-832. Repealed**

**Historical Note**

R9-8-832 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

**R9-8-833. Repealed**

**Historical Note**

R9-8-833 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

**R9-8-834. Repealed**

**Historical Note**

R9-8-834 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

**R9-8-835. Repealed**

**Historical Note**

R9-8-835 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

**R9-8-836. Repealed**

**Historical Note**

R9-8-836 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

**R9-8-837. Repealed**

**Historical Note**

R9-8-837 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

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R9-8-838. Repealed

**Historical Note**

Section repealed by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

R9-8-839. Repealed

**Historical Note**

R9-8-839 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-840. Reserved

R9-8-841. Repealed

**Historical Note**

R9-8-841 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

Exhibit A. Repealed

**Historical Note**

Exhibit A repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-842. Repealed

**Historical Note**

R9-8-842 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-843. Repealed

**Historical Note**

R9-8-843 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-844. Repealed

**Historical Note**

R9-8-844 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-845. Repealed

**Historical Note**

R9-8-845 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-846. Repealed

**Historical Note**

R9-8-846 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-847. Repealed

**Historical Note**

Section repealed by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

R9-8-848. Reserved

R9-8-849. Reserved

R9-8-850. Reserved

R9-8-851. Repealed

**Title 9, Ch. 8** *Arizona*  
*Code*

Department of Health Services – Food, Recreational, and Institutional Sanitation

**Historical Note**

Editorial correction, spelling of “political” (Supp. 89-2). Section repealed by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

**R9-8-852. Repealed**

**Historical Note**

Section repealed by final rulemaking at 8 A.A.R. 3645, effective August 9, 2002 (Supp. 02-3).

# **ATTACHMENT B**

**36-132. Department of health services; functions; contracts**

A. The department shall, in addition to other powers and duties vested in it by law:

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 the state and the prevention of diseases as may be useful in the discharge of functions of the department not in conflict with the provisions of 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 school children, 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 the 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 H, 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 of 1938 (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 the developmentally disabled. 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**

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 the state.
6. Exercise general supervision over all matters relating to sanitation and health throughout the state. When in the opinion of the director it is necessary or advisable, a sanitary survey of the whole or of any part of the 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 the 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 the state, the director may inspect any person or property in transportation through the 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 may depute, 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.

D. 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.

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 assure the accomplishment of recognized local public health activities and delegated functions, powers and duties in accordance with applicable standards of performance. Whenever 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.

E. The compensation of all personnel shall be as determined pursuant to section 38-611.

F. The director may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.

G. Notwithstanding subsection H, 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 no longer than eighteen months.

H. 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, 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 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 assure 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 that takes place at a workplace, 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 fund-raising 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 and that is displayed in an area of less than ten linear feet.
- (g) Baked and confectionary goods that are not potentially hazardous and that are prepared in a kitchen of a private home for commercial purposes if packaged with a label that clearly states the address of the maker, includes contact information for the maker, lists all the ingredients in the product and discloses that the product was prepared in a home. The label must be given to the final consumer of the product. If the product was made in a facility for developmentally disabled individuals, the label must also disclose that fact. The person preparing the food or supervising the food preparation must obtain a food handler's card or certificate if one is issued by the local county and must register with an online registry established by the department pursuant to paragraph 13 of this subsection. For the purposes of this subdivision, "potentially hazardous" means baked and confectionary goods 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.

5. Prescribe reasonably necessary measures to assure 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 assure 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 assure that all ice sold or distributed for human consumption or for the preservation or storage of 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 preparation of 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.

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 food for commercial purposes pursuant to paragraph 4 of this subsection.

I. 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.

J. 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.

K. 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.

L. 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.

M. Until the department adopts exemptions by rule as required by subsection H, paragraph 4, subdivision (b) of this section, a kitchen in a private home that is used as a cooking school and that prepares and offers food to students is exempt from the rules prescribed in subsection H of this section if all of the following are true:

1. Only one cooking school meal per day is prepared and served.
2. The meal is served to not more than fifteen cooking school students.
3. The students are informed by a statement contained in a published advertisement, mailed brochure and placard posted at the cooking school's registration that the food is prepared in a kitchen that is not regulated and inspected by the department or by a local health authority.

### **36-601. Public nuisances dangerous to public health**

A. The following conditions are specifically declared public nuisances dangerous to the public health:

1. Any condition or place in populous areas that constitutes a breeding place for flies, rodents, mosquitoes and other insects that are capable of carrying and transmitting disease-causing organisms to any person or persons or any condition or place that constitutes a feral colony of honeybees that is not currently maintained by a beekeeper and that poses a health or safety hazard to the public.
2. Any spoiled or contaminated food or drink intended for human consumption.
3. Any restaurant, food market, bakery or other place of business or any vehicle where food is prepared, packed, processed, stored, transported, sold or served to the public that is not constantly maintained in a sanitary condition.
4. Any place, condition or building that is controlled or operated by any governmental agency and that is not maintained in a sanitary condition.
5. All sewage, human excreta, wastewater, garbage or other organic wastes deposited, stored, discharged or exposed so as to be a potential instrument or medium in the transmission of disease to or between any person or persons.
6. Any vehicle or container that is used in the transportation of garbage, human excreta or other organic material and that is defective and allows leakage or spillage of contents.
7. The presence of ectoparasites such as bedbugs, lice, mites and others in any place where sleeping accommodations are offered to the public.
8. The maintenance of any overflowing septic tank or cesspool, the contents of which may be accessible to flies.
9. The pollution or contamination of any domestic waters.
10. The use of the so-called common drinking cup used for drinking purposes by more than one person. This paragraph does not apply to receptacles properly washed and sanitized after each service.
11. The presence of common towels for use of the public in any public or semipublic place unless properly washed and sanitized following each use.
12. Buildings or any parts of buildings that are in a filthy condition and that may endanger the health of persons living in the vicinity.
13. Spitting or urinating on sidewalks, or floors or walls of a public building or buildings used for public assemblage, or a building used for manufacturing or industrial purposes, or on the floors or platforms or any part of a railroad or other public conveyance.
14. The use of the contents of privies, cesspools or septic tanks or the use of sewage or sewage plant effluents for fertilizing or irrigation purposes for crops or gardens except by specific approval of the department of health services or the department of environmental quality.

15. The maintenance of public assemblage or places of assemblage without providing adequate sanitary facilities. Open surface privies are adequate sanitary facilities if they are outside populous areas and meet reasonable health requirements.

16. Hotels, tourist courts and other lodging establishments that are not kept in a clean and sanitary condition or for which suitable and adequate toilet facilities are not provided.

17. The storage, collection, transportation, disposal and reclamation of garbage, trash, rubbish, manure and other objectionable wastes other than as provided and authorized by law.

18. Water, other than that used by irrigation, industrial or similar systems for nonpotable purposes, that is sold to the public, distributed to the public or used in production, processing, storing, handling, servicing or transportation of food and drink and that is unwholesome, poisonous or contains deleterious or foreign substances or filth or disease causing substances or organisms.

19. The emission of mercaptan in a concentration level that causes endangerment to the health or safety of any considerable number of persons of a neighborhood or community.

20. The operation of an environmental laboratory in violation of chapter 4.3, article 1 of this title.

B. If the director has reasonable cause to believe from information furnished to the director or from investigation made by the director that any person is maintaining a nuisance or engaging in any practice contrary to the health laws of this state, the director shall promptly serve on that person by certified mail a cease and desist order requiring the person, on receipt of the order, promptly to cease and desist from that act. Within fifteen days after receipt of the order, the person to whom it is directed may request the director to hold a hearing. The director, as soon as practicable, shall hold a hearing, and if the director determines the order is reasonable and just and that the practice engaged in is contrary to the health laws of this state, the director shall order the person to comply with the cease and desist order.

C. If a person fails or refuses to comply with the order of the director, or if a person to whom the order is directed does not request a hearing and fails or refuses to comply with the cease and desist order served by mail under subsection B, the director may file an action in the superior court in the county in which a violation occurred, restraining and enjoining the person from engaging in further acts. The court shall proceed as in other actions for injunctions.

D. Notwithstanding subsection A, paragraph 19, the emission of mercaptan as a by-product of a pesticide is not a nuisance if applied according to state and federal restrictions.

E. Notwithstanding subsection A, paragraph 3, a restaurant that uses sawdust on the floors of its dining areas is not in violation of this section or local health department sanitary rules if the restaurant replaces the sawdust each day with clean sawdust and complies with applicable standards for fire safety.

**DEPARTMENT OF HEALTH SERVICES (F-17-1007)**  
Title 9, Chapter 13, Article 1, Hearing Screening



**GOVERNOR'S REGULATORY REVIEW COUNCIL  
ANALYSIS OF FIVE-YEAR REVIEW REPORT**

**MEETING DATE:** November 7, 2017

**AGENDA ITEM:** G-5

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

**FROM:** Council Staff

**DATE :** October 24, 2017

**SUBJECT: DEPARTMENT OF HEALTH SERVICES (F-17-1007)**  
Title 9, Chapter 13, Article 1, Hearing Screening

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**COMMENTS ON THE FIVE-YEAR-REVIEW REPORT**

**Purpose of the Agency and Number of Rules in the Report**

This five-year review report from the Arizona Department of Health Services (Department) covers eight rules in A.A.C. Title 9, Chapter 13, Article 1 that relate to hearing screening. A.R.S. § 36-899.01 requires the Department to establish a program of hearing evaluation services to be administered to children attending school.

The rules were last amended on July 16, 2002. In its 2012 five-year review report, the Department indicated that it planned to amend the rules no later than June 30, 2016. Due to other priorities, no actions have been taken on the rules in the past five years.

**Proposed Action**

On July 18, 2017, the Governor's Office approved the Department's request for an exception from Executive Order 2017-02 to amend the rules. To address issues identified in the report, the Department indicates that it plans to amend the rules by March 2019.

**1. Has the agency analyzed whether the rules are authorized by statute?**

Yes. The Department cites to both general and specific authority for the rules. Of particular significance is A.R.S. § 36-899.03, which requires the Department to “develop rules and regulations governing standards, procedures, techniques and criteria for conducting and administering hearing evaluation services.”

**2. Summary of the agency’s economic impact comparison and identification of stakeholders:**

Stakeholders are schools, school age children (students) and their families, the Department, and charter and private schools that are small businesses. Currently the program affects 2,852 Arizona public, accommodation, charter, and private schools of which 799 are charter schools and 469 are private schools. As of 2016-17, the Arizona Department of Education reported that Arizona has approximately 1.7 million enrolled students. During 2016-17, 568,888 students received hearing screenings and 972 students were identified as having a hearing loss. As of June 2016, there are 110 trainers in Arizona providing hearing, screening training, and there are 1,490 certified hearing screeners providing hearing screenings to Arizona students. The Department believes that enactment of the rules did not significantly change the way schools conduct hearing screenings.

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

The Department believes that the rules have improved the efficiency and effectiveness of the hearing screening process and that the benefits of having the rules are greater than the costs. The Department believes the rules do provide the least burden and costs to affected persons.

**4. Has the agency received any written criticisms of the rules over the last five years?**

Yes. The Department indicates that it has received written criticisms on Sections 102, 103, 104, 105, 107, and 109 during the last five years. The Department indicates that it plans to consider all of the comments and criticisms in the process of amending the rules. The Department has provided a summary of these comments as an attachment to the report, and the Department’s responses can be found in the “Information for Individual Rules” section of the report.

**5. Has the agency analyzed the rules’ clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?**

Yes. The clarity, conciseness, and understandability of the rules could be improved as follows:

- Section 101 – *Definitions*: The rule should state that the definitions in A.R.S. § 36-899 apply to this Article. In addition, antiquated definitions should be amended or deleted.
- Section 102 – *Hearing Screening Population*: Subsection (C)(4) should contain separate subsections for the terms “hearing aid,” “assistive listening device,” and “cochlear implant.” In subsection (D), “A.A.C.” should be included in the citation to R7-2-401.
- Section 103 – *Hearing Screening Requirements*: The term “drainage” in subsection (A) should be defined. The words “inspects a student's outer ears and” in subsection (B) should be deleted.

- Section 104 – *Criteria for Passing a Hearing Screening; Requirements for Performing a Second Hearing Screening*: The requirements in subsection (B) should be simplified, and the terms “calendar day” and “working day” should be added.
- Section 105 – *Referral; Notification; Follow-up*: Timeframes for when to notify a parent that their student does not require a hearing screening, did not have a hearing screening, and did not pass a second hearing screening, including related referrals, should be clarified. In subsection (B)(2), a screener should be required to perform a hearing screening per Section 103. In subsection (F), the citation to R9-2-401 should include “A.A.C.” Additionally, the understandability of the rule would be improved by deleting excess language.
- Section 107 – *Screener Qualifications*: The rule would be clearer if it identified current processes for becoming a certified screener and renewing screener certification.
- Section 108 – *Equipment Standards*: The reference to R9-16-209(B)(1) in subsection (A)(1) should be changed to R9-16-212(B)(1). The incorporation by reference in subsections (A)(1) and (B)(1) should not state that the documents are on file with the Secretary of State.
- Section 109 – *Recordkeeping, Reporting Requirements*: The rule would be more clear and concise with the removal of outdated language.

The Department indicates that the rules are consistent with state and federal statutes and rules. In addition, the Department states that the rules are effective, but will be more effective once issues with clarity, conciseness, and understandability are addressed.

**6. Has the agency analyzed the current enforcement status of the rules?**

Yes. The Department indicates that the rules are enforced as written.

**7. 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 Department indicates that no federal laws relate to the rules.

**8. 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, as the rules were adopted prior to July 29, 2010.

**9. Conclusion**

As noted above, the Department intends to amend the rules by March 2019. The report meets the requirements of A.R.S. § 41-1056 and R1-6-301, and this analyst recommends that the report be approved.



# ARIZONA DEPARTMENT OF HEALTH SERVICES

July 26, 2017

Nicole O. Colyer, Esq., Chair  
Governor's Regulatory Review Council  
Arizona Department of Administration  
100 N. 15th Avenue, Suite 402  
Phoenix, AZ 85007

RE: Report for A.A.C. Title 9, Chapter 13, Article 1, Hearing Screening

Dear Ms. Colyer:

According to the five-year-review report schedule of the Governor's Regulatory Review Council (Council), a report for A.A.C. Title 9, Chapter 13, Article 1 is due to the Council no later than July 31, 2017. The Arizona Department of Health Services (Department) reviewed A.A.C. Title 9, Chapter 13, Article 1, and is enclosing a report to the Council for these rules.

The Department believes that this report complies with the requirements of A.R.S. § 41-1056. The report contains a five-year-review summary, information identical for all rules, and information for individual rules. In addition to the report, the packet includes the rules reviewed; general and specific authorities; 2002 economic, small business and consumer impact statement; and written criticisms. As described in the report, the Department plans to amend the rules in 9 A.A.C. 13, Article 1 through regular rulemaking.

The Department certifies that it is in compliance with A.R.S. § 41-1091.

If you need any further information, please contact me at (602) 542-1020.

Sincerely,

A handwritten signature in blue ink, appearing to read "Robert Lane".

Robert Lane  
Director's Designee

RL:tk

Enclosures

Douglas A. Ducey | Governor    Cara M. Christ, MD, MS | Director



# ARIZONA DEPARTMENT OF HEALTH SERVICES

**FIVE-YEAR-REVIEW REPORT**  
**TITLE 9. HEALTH SERVICES**  
**CHAPTER 13. DEPARTMENT OF HEALTH SERVICES**  
**HEALTH PROGRAMS SERVICES**  
**ARTICLE 1. HEARING SCREENING**

**July 2017**

**FIVE-YEAR-REVIEW REPORT**  
**TITLE 9. HEALTH SERVICES**  
**CHAPTER 13. DEPARTMENT OF HEALTH SERVICES**  
**HEALTH PROGRAMS SERVICES**  
**ARTICLE 1. HEARING SCREENING**

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2.	INFORMATION THAT IS IDENTICAL FOR ALL RULES	Page 4
3.	INFORMATION FOR INDIVIDUAL RULES	Page 9
4.	CURRENT RULES	Attachment A
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6.	2002 ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT	Attachment C
7.	WRITTEN CRITICISMS	Attachment D

## **FIVE-YEAR-REVIEW SUMMARY**

Arizona Revised Statutes (A.R.S.) § 36-899.01 requires a program of hearing evaluation services to be established by the Arizona Department of Health Services (Department) and hearing evaluation services administered to children attending school. A.R.S. § 36-899.03 requires the Department to “develop rules and regulations governing standards, procedures, techniques and criteria for conducting and administering hearing evaluation services.”

The Department adopted hearing screening rules in Arizona Administrative Code (A.A.C.) Title 9, Chapter 13, Article 1 in 1986 to implement A.R.S. Title 36, Chapter 7.2, Article 1. The rules establish the students required to receive hearing screening; hearing screening methods, criteria for passing a hearing screening, hearing screener qualifications, referral and notification requirements, hearing screening equipment standards; and school records and reporting requirements. The rules were last amended July 2002.

Since the 2012 Five-year Review Report, the Department has received written criticisms about the rules. After review of the rules, the written criticisms, and previous five-year-review report, the rules are determined to be mostly effective, clear, and understandable; and generally, enforced as written. In this five-year-review report, the Department identifies changes that will improve the rules. The Department plans to amend all 9 A.A.C. 13, Article 1 rules to include changes that will address the written criticisms, previous five-year review reports, and this five-year review report.

The Department submitted a letter to the Governor requesting an exception to the rulemaking moratorium, established by Executive Order 2017-02. On July 18, 2017, the Governor's Office approved the Department's rulemaking request related to hearing screening. The Department plans to amend 9 A.A.C. 13, Article 1, Hearing Screening rules through regular rulemaking and anticipates submitting a Notice of Final Rulemaking to the Governor's Regulatory Review Council by March, 2019.

## INFORMATION THAT IS IDENTICAL FOR ALL THE RULES

1. **Statutory authority for the rules**

The general statutory authority for the rules are in A.R.S. §§ 36-132(A) and 36-136(F). The specific statutory authority for the rules are in A.R.S. §§ 36-899.02 and 36-899.03.

2. **The purpose of the rules**

The purpose of the rules is to establish a program of hearing evaluation services for children attending school.

4. **Analysis of consistency with state and federal statutes and rules**

The rules are consistent with state and federal statutes and rules.

5. **Status of enforcement of the rule**

The rules are enforced as written.

6. **Analysis of clarity, conciseness, and understandability**

In addition to the information identified in the Information for Individual Rules sections, the rules would be improved by making technical changes to ensure consistency with current rulemaking format and style requirements. Also, previous five-year review reports identified a need to make distinction between 9 A.A.C. 13, Article 1, hearing screening for children attending school from the hearing screening of newborns and infants under A.R.S. § 36-694 and R9-13-207 through the Department's Newborn Screening Program. For clarity, the Department plans to change the heading of 9 A.A.C. 13, Article 1, "Hearing Screening" to an appropriate heading that will better distinguish the Department's Hearing Screening Program from the Newborn Screening Program.

7. **Summary of the written criticisms of the rule received within the last five years**

The Department has received several comments regarding the rules. The summaries and Department responses for the comments received are included in the Information for Individual Rules section.

8. **Economic, small business, and consumer impact comparison**

The Department in its 2002 economic, small business, and consumer impact statement (EIS) reported that the rulemaking for the Hearing Evaluation Services Program would affect 1,975 Arizona public, charter, accommodation, and private schools and more than 900,000 enrolled students and their families<sup>1</sup>. The rulemaking for 9 A.A.C. 13, Article 1 made significant changes

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<sup>1</sup> Number of schools and currents based on the Arizona Department of Education 2000/2001 data.

to clarify the student population to be screened, including hearing screening for students attending preschool; hearing screening equipment standards; and information schools are required to maintain and report to the Department. Further, based on current national standards and practices, the rulemaking made changes to update hearing screening requirements and acceptable hearing screening methods, screener training requirements, and identify standards for passing a hearing screening and student referrals. Annual costs and revenues are designated as minimal when more than \$0 and less than \$1,000, moderate when between \$1,000 and \$10,000, and substantial when \$10,000 or greater. The EIS stated that the rulemaking would directly affect schools, school age children and their families, the Department, and small businesses. In summary of the overall costs and benefits, the EIS reported an overall economic impact of the rulemaking to be minimal, with the benefits outweighing the costs.

Currently, the Hearing Screening Program affects 2,852 Arizona public, accommodation, charter, and private schools of which 799 are charter schools and 469 are private schools. As of 2016-17, the Arizona Department of Education reported that Arizona has over 1,726,497 enrolled students. During 2016-2017, 568,888 students received hearing screenings and 972 students identified as having hearing loss. As of June 2016, there are 110 trainers in Arizona providing hearing screening training, and there are 1,490 certified hearing screeners providing hearing screenings to Arizona students. The Department agrees with the EIS that the cost bears and beneficiaries affected by the rules continue to be schools, school age children (students) and their families, the Department, and charter and private schools that are small businesses.

For schools, the EIS reported that the Department anticipated the rules would not significantly change the way schools conduct students' hearing screenings. Further, the Department expected that schools would continue to be responsible for administration of the hearing screening program, including ensuring students receiving hearing evaluation referrals are evaluated and students enrolled in special education services or under evaluation for special education have hearing evaluations. The costs associated with administering hearing screenings was not expected to change and the expected cost for hearing screening per student, depending on who performed the hearing screening, was expected to be approximately \$1.50 to \$3.00. The EIS also stated that schools might incur a minimal increase in costs due to new requirement that children enrolled in preschool have hearing screenings. A minimal increase was anticipated since a number of children enrolled in preschool programs are children with disabilities and already required to receive hearing screenings. The Arizona Department of Education showed that for school year

2001/2002 there were 5,827 children enrolled in public schools, accommodation schools, and charter schools preschool programs for children with disabilities. For the same school year, Department statistics showed that there were 11,843 preschool children screened for hearing in Arizona preschool programs. In addition, the EIS stated that a school might incur slightly higher costs to purchase and maintain hearing testing equipment, if a school chooses to use otoacoustic emission testing. The benefits for schools were expected to come from new requirements designed to improve efficiency and effectiveness of the hearing screening process and new technology and testing methodologies allowing for more accurate screening. The overall economic impact on schools was expected to be minimal, with the benefit of the rulemaking outweighing the cost.

The Department believes that the schools continue to be responsible for administration of the hearing screening program as expected in the EIS. The Arizona Department of Education reported for school year 2016-17 there were 15,555 children enrolled in public schools, accommodation schools, and charter schools preschool programs for children with disabilities. For the same school year, Department reported there were 21,444 preschool children screened for hearing in Arizona preschool programs. However, the Department has determined, based on current wages paid to individuals who perform hearing screening, that costs for hearing screening per student has increased; the current expected costs to perform a hearing screening is approximately \$1.70 to \$8.00. Additionally, the Department has received comments that appear to indicate schools are experiencing increased costs associated with administering hearing screening. The comments received do not provide enough information for the Department to assess, with any accuracy, the amount of increase in costs schools may be incurring. It could be that the increase in costs, as indicated in the comments received, may be related to the new requirement adding preschool students to the hearing screening population or perhaps schools who may have chosen to use otoacoustic emission testing as reported in the EIS. The Department believes that early detection of hearing loss allows for early intervention and facilitates proper development. The Department considers this benefit as significant; it is meaningful and important. Hence, the Department believes that the impact reported in the EIS is as expected regarding its reported costs and benefits analysis for schools.

The EIS stated that for students and their families the cost of paying for medical or audiological follow-up of identified hearing loss would continue. Additionally, the EIS stated that Arizona students and their families would benefit from the revised rules as recipients of quality hearing

screening services, early identification of significant hearing loss, and appropriate referral for treatment. The EIS further expected that the addition of new technologies and testing methods would allow for more accuracy in screening; resulting in more reliable results and appropriate referrals. The Department believes the impact is as expected.

The EIS reported that for the Department administrative costs would be incurred for tracking of information related to data collection and screener qualifications. The Department continues to incur moderate costs to operate the Hearing Screening Program including costs for salaries and benefits equivalent to two full-time employees, as well as costs for printed materials and hearing screening equipment. The EIS also stated the Department would benefit from rules that better protect the public, reflect industry standards and practices, and reflect current Department policy. The Department believes the expectations identified in the EIS are as anticipated. Lastly, small businesses, identified as charter and private schools, were expected to incur administrative costs in carrying out the requirements in the rules, just as the public and accommodation schools. The Department, based on data received from charter and private schools, believes that the administrative costs incurred are minimal to moderate and consistent as expected.

The Department believes that the EIS accurately indicated that the rulemaking would improve the efficiency and effectiveness of the hearing screening process and that the benefits of having the rules are greater than the costs. The rules do provide the least burden to affected persons.

**9. Summary of business competitiveness analysis of the rules**

The Department has not received any business competitiveness analysis for the rules in the last five years.

**10. Status of the completion of action indicated in the previous five-year-review**

The Department in its 2012 five-year-review report stated that the Department, in its 2007 five-year-review report and its 2012 five-year-review report, identified changes that will improve the rules and planned to conduct a regular or expedited rulemaking. The Department also planned to submit a Notice of Final Rulemaking to GRRC no later than June 30, 2016. Due to the Department priorities, the Hearing Screening rulemaking was delayed and the Department did not submit a Notice of Final Rulemaking to GRRC no later than June 30, 2016.

**11. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rules, 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**

On December 31, 2015, the Department's Cooperative Agreement (Agreement) with the University of Arizona (UOA) terminated. Through the Agreement, the UOA provided hearing screening training to individuals interested in becoming a trainer or master trainer. Additionally, the UOA agreed to provide renewal hearing screening courses. With the termination of the Agreement, the Department has begun providing hearing screening training and renewal hearing screening courses. As such, the Department anticipates that individuals interested in becoming a trainer or master trainer and schools may experience a decrease in costs since the Department in providing hearing screening training does not require interested individuals or schools to pay a fee for hearing screening training. Because of this change, the Department believes that rules remain to impose the least necessary cost and burden to fulfill the Department's statutory requirement to provide hearing screening services to children attending school.

**12. Analysis of stringency compared to federal laws**

The rules are not related to 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 complies with section 41-1037**

The rules were adopted before July 29, 2010.

**14. Proposed course of action**

The Department plans to amend all the rules in 9 A.A.C. 13, Article 1. On July 18, 2017, the Governor's Office approved the Department's rulemaking request related to hearing screening. The Department has begun a regular rulemaking and anticipates submitting a Notice of Final Rulemaking to the Governor's Regulatory Review Council by March, 2019.

## INFORMATION FOR INDIVIDUAL RULES

### **R9-13-101. Definitions**

#### **2. Objective of the rule**

The objective of the rule is to define terms used in 9 A.A.C. 13, Article 1 so that a reader can consistently interpret requirements in the Article.

#### **3. Analysis of effectiveness of the rule**

The rule is effective in meeting its objective. The rule would be more effective if amended to include matters stated in paragraph 6.

#### **6. Analysis of clarity, conciseness, and understandability**

The rule is mostly clear, concise, and understandable, but would be improved if it stated that the definitions in A.R.S. § 36-899 apply to this Article. The rule would further be improved if antiquated definitions were amended or deleted. For example, the term "hearing aid" is used twice; both times with the term, "assistive listening device." The term "assistive listening device" in its definition includes "hearing aids." The term "hearing aid" could be deleted. The rules would also be clearer if the definition of "hearing screening" were amended to refer to "a screener" rather than to "an individual." The term "noise floor" is no longer used in the current American Association of Audiologist Children Hearing Guidelines and the term "otitis media" is not used in the rules. Both the terms could be deleted. Additionally, improving the definitions of terms such as "reproducibility," "documentation," "tympanometer," and "tympanometry" would allow for better understanding of their meaning.

#### **7. Summary of the written criticisms of the rule received within the last five years**

The Department has not received any comments regarding rule R9-13-101.

### **R9-13-102. Hearing Screening Population**

#### **2. Objective of the rule**

The objective of the rule is to identify which students should receive hearing screening and which students are not required to have hearing screening.

#### **3. Analysis of effectiveness of the rule**

The rule is effective in meeting its objective. The rule would be more effective if amended to include matters stated in paragraph 6.

#### **6. Analysis of clarity, conciseness, and understandability**

The rule is mostly clear, concise, and understandable. The rule would be clearer if subsection (C)(4) contained separate subsections for "hearing aid," "assistive listening device," and "cochlear implant;" and if in subsection (D), "A.A.C." were included in R7-2-401 citation.

7. **Summary of written criticism of the rule received within the last five years**

Criticism: Comments were made stating that the rule is not clear as to when and which students should receive hearing screening each school year and the word "fail" should not be used, stating that students do not "fail" a hearing screening.

Response: The Department believes the rule is clear in (1) identifying which students should receive hearing screening each school year and (2) identifying which students should not receive hearing screening if written documentation demonstrating that a student had a hearing screening in or after certain grades. Students are required to receive hearing screening in preschool, kindergarten, and in first, second, sixth, and ninth grade. However, should a student not receive a hearing screening during one of those school years, the student will have an opportunity to receive a hearing screening during one of the other school years. The word "failed" is used only in this rule. The Department believes changing the word "failed" to "did not pass" would make the rule consist with the other rules. As stated in paragraph 14, the Department plans to amend the rules and will consider these comments again during that time.

**R9-13-103. Hearing Screening Requirements**

2. **Objective of the rule**

The objective of the rule is to identify the condition of an outer ear that prevents a student from receiving hearing screening and establish criteria for each method of hearing screening.

3. **Analysis of effectiveness of the rule**

The rule is mostly effective in meeting its objective. The rule would be improved if the hearing screening methods in subsection (C) were update to include new American Academy of Audiology Childhood Hearing Screening Guidelines and if amended to include matters stated in paragraph 6.

6. **Analysis of clarity, conciseness, and understandability**

The rule is mostly clear, concise, and understandable. The rule would be better understandable and more concise if the term "drainage" in subsection (A) were defined and if the words "inspects a student's outer ears and" in subsection (B) were deleted.

7. **Summary of the written criticisms of the rule received within the last five years**

Criticism: A comment was made communicating that the rule should reflect recommendations from new national standards and should clarify when to use hearing screening methods such as otoacoustic emissions hearing screening and play audiometry.

Response: The Department believes that amending the rule to reflect current national standards would improve the effectiveness of the rules. As stated in paragraph 14, the Department plans to amend the rules and will address this comment again during that time.

**R9-13-104. Criteria for Passing a Hearing Screening; Requirements for Performing a Second Hearing Screening**

**2. Objective of the rule**

The objective of the rule is to establish a criterion that shows when a student passes a hearing screening and a requirement for a second hearing screening for a student does not pass a hearing screening.

**3. Analysis of effectiveness of the rule**

The rule is effective in meeting its objective. The rule would be more effective if amended to include matters stated in paragraph 6.

**6. Analysis of clarity, conciseness, and understandability**

The rule is mostly clear, concise, and understandable. The rule would be clearer if the requirements in subsection (B) were simplified such that a screener shall (1) during first hearing screening, verify the do not pass result by performing once more; (2) perform a second hearing screening; (2)(a) perform the second hearing screening 30 to 45 days after the first hearing screening; and (2)(b) use the same method as the first hearing screening. The rule would also be clearer if the terms "calendar day" and "working day" were added.

**7. Summary of the written criticisms of the rule received within the last five years**

Criticism: A comment was made expressing a concern that the rule puts students expected to be in need of special education services at risk. To eliminate the risk, the rule should allow for students, expected to be in need of special education services, given an immediate referral to an audiologist for a hearing evaluation, rather than to a screener for a second hearing screening to occur some 30-45 days from the date of first hearing screening. Further, if an audiologist determines that a student did not pass the hearing screening while performing the first hearing screening and the audiologist performs a hearing evaluation; the rule should allow the audiologist hearing evaluation instead of requiring a hearing screener to perform a second hearing screening.

Response: The Department believes that if a hearing evaluation is performed by an audiologist after determining that a student did not pass the first hearing screening provided and the hearing

evaluation is provided to the student's school should be accepted in place of a second hearing screening. As stated in paragraph 14, the Department plans to amend the rules and will consider this comment again during that time.

**R9-13-105. Referral; Notification; Follow-up**

**2. Objective of the rule**

The objective of the rule is to require a school administrator to provide a parent notification when a parent's student requires hearing evaluation, did not complete hearing screening, or did not pass a hearing screening. The notification processes includes exception for school-provided audiologist and notification to teachers and other person, as applicable, when a student is diagnosed as deaf or hard of hearing.

**3. Analysis of effectiveness of the rule**

The rule is mostly effective in meeting its objective. The rule would be more effective if the rule were amended to include matters in paragraph 6.

**6. Analysis of clarity, conciseness, and understandability**

The rule is mostly clear, concise, and understandable. The rule would be clearer if the rule in subsection (A) through (G) were amended to add clarification of the timeframes for when to notify a parent that their student does not require a hearing screening, did not have a hearing screening, and did not pass a second hearing screening, including related referrals. The rule would be clearer and more concise if in subsection (B)(2) a screener is required to perform a hearing screening according to R9-13-103 and if in subsection (F), the citation of R9-2-401 included "A.A.C." Additionally, the understandability of the rule would be improved by deleting excess language, such as in subsection (C) "within the time period required."

**7. Summary of the written criticisms of the rule received within the last five years**

Criticism: A comment was made expressing concern that doctors' offices are not following screening regulations, have people screening who have no training, and are not using equipment properly or are using the wrong equipment. The commenter expressed that these doctors' offices are putting [school] districts in a bad position and are preventing children who are in need of services from receiving the services or are receiving the inappropriate services.

Response: Because the Department has no first-hand knowledge regarding the matter identified in the comment, the Department plans to inquire of the matter. As stated in paragraph 14, the Department plans to amend the rules and should the Department determine that the comments are factual, the Department will make rules to ensure all hearing screenings comply with this Article.

**R9-13-107. Screener Qualifications**

**2. Objective of the rule**

The objective of the rule is to identify the requirements for individuals who: may become a certified screener; may teach hearing screening courses; and may perform limited hearing screening under the supervision of a certified screener.

**3. Analysis of effectiveness of the rule**

The rule is somewhat effective in meeting its objective. The rule would be more effective if amended to include matters stated in paragraph 6.

**6. Analysis of clarity, conciseness, and understandability**

The rule is mostly clear, concise, and understandable. However since University of Arizona and the Department no longer have a Cooperative Agreement for Train-the-trainer and renewal hearing screening courses, the rule would be clearer if amended to identify current processes for becoming a certified screener and renewing screener certification. The rule would be more concise and understandable if (B)(8) and (9) were moved to make a new subsection (D).

**7. Written criticism of the rule received within the last five years**

Criticism: Comments were made stating that current training is not consistent with best practice and asks that hearing screening training requirements be simplified, using an approved curriculum; having more focus specific to hearing course and demonstration of technical competencies using pure tone, tympanometry, otoacoustic emissions, and hearing screening equipment. Additional comments expressed hardship due to the amount of time required for hearing screening trainings. For [school] districts, the hardship is paying employees to attend training and hiring substitutes to cover during employees' absence or paying employees to train on weekends or during school breaks in order to avoid hiring substitutes. Commenters suggest reducing the amount of time it takes to certify screeners and to allow online hearing screening courses. Other comments suggest that renewal requirements should allow a certified screener who provides hearing screening to many students annually be allowed to complete fewer renewal hearing screening course hours in subsection (C), while a certified screener who provides hearing screening only to a few students or no students annually be required to complete all hearing screening courses in subsection (B). The last few comments for this rule expressed that audiologists should not have to attend a 3-day training in order to be trainers and that T3 training should include training on the report form.

Response: With the University of Arizona and the Department no longer having a Cooperative Agreement for Train-the-trainer and renewal hearing screening courses, the Department plans to amend the rule to address current hearing screening training processes and curriculum for

becoming a certified screener and renewing screener certification. The Department will consider national standards and best practices when amending curriculum, including the amount of time to complete hearing screening courses, and adding online hearing screening courses, if appropriate. The Department believes that these types of changes to the rule will affect school districts' hardship. The current rule requires a certified screener to take 5.5 hours of hearing screener courses to renew their certification. The Department does not believe 5.5 hearing screening course hours every five-year is excessive, and in fact, note that other professional are required to complete twice as many or more continuing education hours and are required to renew each year. The Department believes that the rule in subsection (A) clearly states that an audiologist may perform a hearing screening, without requiring 3-day training, and in subsection (B), the rule clearly states that an individual who is not an audiologist may perform hearing screening only if the individual passes hearing screening courses as identified in (B)(1) through (7). Lastly, the current rule requires a school administrator, in R9-13-109(B), to complete the report form. The Department plans to inquire in to the matter of who is completing the report form to determine what changes are needed, if any. As stated in paragraph 14, the Department plans to amend the rules and will consider these comments again during that time.

**R9-13-108. Equipment Standards**

**2. Objective of the rule**

The objective of the rule is to establish standards for calibration and inspection for audiometers, tympanometers, and otoacoustic emissions equipment used for hearing screening.

**3. Analysis of effectiveness of the rule**

The rule is mostly effective in meeting its objective. The rule would be more effective for the reasons if:

- The American National Standard Specification for Audiometers citation S3.6-1996, in subsection (A)(1), were updated to S3.6-2010; and
- The American National Standard Specifications for Instruments to Measure Aural Acoustic Impedance and Admittance citation S3.39-1987, in subsection (B)(1), were updated to S3.39-1987 (R2012).

**6. Analysis of clarity, conciseness, and understandability**

The rule is mostly clear, concise, and understandable. The rule would be clearer if the reference to R9-16-209(B)(1) in subsection (A)(1) were changed to R9-16-212(B)(1) since 9 A.A.C. 16 Article 2 was last amended effective July 2014. The rule would also be clearer if the

incorporation by reference in subsection (A)(1) and (B)(1) did not state that the documents are on file with the Secretary of State.

7. **Summary of the written criticisms of the rule received within the last five years**

The Department has not received any comments regarding rule R9-13-108.

**R9-13-109. Recordkeeping, Reporting Requirements**

2. **Objective of the rule**

The objective of the rule is to establish requirements for hearing screening records and for reporting hearing screening information using a Department-provided reporting form.

3. **Analysis of effectiveness of the rule**

The rule is mostly effective in meeting its objective. The rule would be more effective if amended to include all hearing screening information required on the Department-provided report form. The rule would also be more effective if amended to include matters stated in paragraph 6.

6. **Analysis of clarity, conciseness, and understandability**

The rule is mostly clear, concise, and understandable. The rule would be more clear and concise if outdated language were amended. For example, subsection (B)(2)(b) if simplified to read, "A copy of the certified screener's certificate of completion;" and in subsection (A), the rule would be clearer if the term "written record" were not used, and rather, define "record" to include types of records, such as written and electronic.

7. **Summary of the written criticisms of the rule received within the last five years**

Criticism: A comment was made stating the rule may need to be rewritten because the form, in subsection (B), has been revised to require additional information and the information is now required to be entered electronically by accessing the form at the Department's website.

Response: The current rule requires specific hearing screening information be provided to the Department by June 30th each year on a form available from the Department. The Department believes that the rule should be amended to add additional hearing screening information required. While the Department believes the rule is clear in stating that the form is available from the Department, the Department sees that the rule would be more clear and concise if the rule included electronic reporting process. As stated in paragraph 14, the Department plans to amend the rules and will consider these comments again during that time.

## ATTACHMENT D

### Hearing Screening Rules Written Criticisms

(Program received comments May-June 2017)

#### 1. Lylis Olsen, EHDl Coordinator from Arizona

Before the moratorium in 2009 we had met several times and drafted some changes that were not finalized at the time.

- Since then new national standards have been introduced. The American Academy of Audiology guidelines published in 2011 have specific recommendations that should be followed for school hearing screening.

[https://www.cdc.gov/ncbddd/hearingloss/documents/AAA\\_Childhood%20Hearing%20Guidelines\\_2011.pdf](https://www.cdc.gov/ncbddd/hearingloss/documents/AAA_Childhood%20Hearing%20Guidelines_2011.pdf)

American Academy of Audiology Hearing Screening Guidelines, [www.cdc.gov](http://www.cdc.gov)

Summary of Hearing Screening Recommendations\* \* Refer to the full Guidelines document for more detail on these recommendations

- inclusion of tympanometric width in pass criteria options
- possible removal of 500 Hz puretone
- criteria for OAEs
- Additional recommendations are to simplify the requirements for training in screening. The amount of time and the topics covered are not consistent with best practice. Would prefer to see training using an approved curriculum, demonstrated competency using the puretone, tympanometry and/or OAE.
- OAEs should only be done with those students who are unable to do puretones and require practice during the training, ideally with real children, to be successful.
- In addition it is critical that the statute which requires screening as soon as a child enters school but also mentions kindergarten is clarified so that if a child enters school at preschool age they are screened as this population is most likely special needs and the statute requirement to screen as soon as possible should be clarified as preschool. Clarification should be made that this relates to schools not child care preschool programs.

#### 2. Rebecca Gregory, Tempe USD

- Focus more on actual hearing screening and condense or delete the sections on speech development, auditory development, and early identification of hearing loss.
- Delete the redundancy.
- Training completed in four hours.
- Audiologists should not have to attend a 3-day training in order to be trainers.
- Screening process needs to be streamlined. People recognize the importance of it and want to do a good job, but the reality is, health offices are extremely busy. Staff are dealing with so many more

## Hearing Screening Rules Written Criticisms

(Program received comments May-June 2017)

pressing issues on a daily basis, that screening is not a high priority. My district does not allow us to use volunteers for privacy reasons. Nor would I want us to, because I don't believe the majority of those individuals would have the experience needed to do good screenings.

- Training - The reality is, it is a hardship for us to have staff out for an entire day for this training, because we have to find subs to cover for them. I have scheduled and arranged for trainings on numerous occasions where I had to either cancel it entirely, or do more than one (not a good use of time and resources) because we got additional absences and didn't have enough coverage for all of our health offices. It is a hardship to ask districts to pay employees to attend trainings on weekends or school breaks in order to avoid this problem. I would like to be able to do both hearing and vision in one day, each for 4 hours. This makes for 1/2 day if employees only need one training, or 1 full day instead of 2 if they need both, which eases the burden on scheduling.
- Renewal could be divided into 2 groups. Those who screen regularly could do a 2-hour renewal. Those who have not or do not screen regularly within the previous year could do the full training again. Some of my staff have been screening for 20 or more years and don't need to have all the information repeated multiple times.
- Hearing re-screening should not be required if an audiologist does a hearing evaluation following an initial failed screening within the same school year. There are some occasions where this happens-- normally because a special education team needs to evaluate a child for services. They cannot proceed until they have clearance on hearing. They cannot wait 30-45 days for a rescreen to be done, (and cross their fingers the child passes), because this puts them out of compliance with special education timelines. If they wait and the child does not pass the rescreen and then an audiologist is needed, then they are even further behind. This is not in the best interest of the child.
- Physicians' Offices Screening -- Something needs to be done with doctor's offices and how they do hearing screenings. They are not following screening regulations, and have people screening who have no training, using who knows what equipment. This puts districts in a bad position, as was previously stated, hearing loss must first be ruled-out before special education testing can occur. If hearing impairment is getting missed because they are using inappropriate methods and/or random pass criteria (both of which I've seen happen), then the child's eligibilities and services are not appropriate.
- Play Audiometry--As an audiologist, I do not believe that anyone other than an audiologist should do play audiometry. Period. It takes a long time to master this skill, especially with young or difficult to test children. This leaves the door too open for hearing impairment to get missed.

### 3. Pamela Wood

- R9-13-102: A:1: Should use the word and between mandatory grades to be screened. The current use of the word "OR" implies that there is a choice of what grades you screen.

So A:1 under R9-13-102 should read; A student enrolled in preschool, kindergarten, grades 1,2, 6 and 9.

## Hearing Screening Rules Written Criticisms

(Program received comments May-June 2017)

- R9-13-102: A:5 A student receiving special education— we need a reference or rule for trainees who challenge this—I had someone who was head of special ed challenge me on this rule that a screening is required every year & none of us (trainers) have been able to find the rule that justifies this!
- R9-13-102 C:1 Student is 16 years or over—again should we reference the AZ statute that says a student age 16 can be legally emancipated ....

When I train I inform my trainees not to let 16 year old know they have a choice; best practice is always to err on the side of the student & screen! **[Department would like more information]**

- Can we change the use of the word “FAIL” throughout the rules to “DID NOT PASS” or even “REFER” —students don’t FAIL if they make an attempt to do the screening.
- R9-13-104 B: .... a screener shall perform a second hearing screening on the student no earlier than 30 DAYS and no later than 45 DAYS.....

Need to define “DAYS”: calendar days or school days—

- Same wording in R9-13-105 B2: ... no earlier than 30 DAYS and no later than 45 DAYS.... define DAYS
- R9-13-107B: (Units 1-4) Screener Qualifications:

We (ADHS & hearing screening trainers many of whom are audiologists) are presently working on revamping the teaching curriculum for this program, still abiding by the rules, but rewriting, reorganizing, focusing more on hearing loss & its associated sequel rather than teaching so much speech & language information (for example). Some information from existing Unit 2 is now in Unit 1 where it belongs....so my concern is that the rules list everything that is to be taught per unit & new rules should reflect the newer curriculum. Frankly after all the years of training with the current curriculum, an overhaul is past due & the new stuff is terrific. Thus far Units 1 & 3 has been rewritten.

- R9-13-107 B5 & B6: amount of time allowed for teaching Tympanometry (#5) and OAE(#6) is not currently a sufficient amount of time. Those units have already been rewritten to provide more information and knowledge to the trainees & 60 minutes is not enough time to train the unit & have screeners practice the technique so they will feel comfortable screening students.
- R9-13-107B9: Certificate of completion—Katharine Levandowsky @ADHS has changed the way certificates will be awarded to those screeners who pass the training. The plan is for screeners to go to the ADHS website, complete their course evaluation on line & once received they will be sent an electronic certificate. I believe that Kathryn wants to have this in place by the start of the new 2017-2018 school year.
- R9-13-107 C: Every 5 years after completing hearing screener course....No one that I know of is training the RENEWAL CURRICULUM as stated in the rules in this section. It is too time consuming for a trainer because it doesn’t take as long as the full course but still takes a day out of a trainer’s schedule—All of the trainers that I know send their screeners through the all-day initial curriculum

## Hearing Screening Rules Written Criticisms

(Program received comments May-June 2017)

when it is time to “RENEW” their certification. I have had many screeners who have done this & none have objected to taking the entire class again. IT IS STILL IMPORTANT THAT A SCREENER RENEW THEIR CERTIFICATION EVERY 5 YEARS!

- R9-13-109 B: By June 30th off each school year, a school administrator shall.... Again Katharine Levandowsky has changed the form to be more informative & comprehensive and now is going to be required to be entered on the ADHS website electronically; so this section may need to be rewritten in the rules.

As for the **Newborn rules** since I do not perform the screenings i will defer to those that do. I am a Birth-3 OAE trainer for the EAR Foundation & will soon be attending their curriculum update training as soon as Melissa, director of The EAR Foundation schedules it.

I hope this is helpful. i also seem to remember discussing whether or not parents/guardians had to be notified before the initial hearing screening—as it stands now they do not; I thought in the past (2007 when we started rules revision & then a moratorium was placed on rules writing) we discussed this changing to requiring parent/guardian permission prior—my personal opinion is that making a school have written permission in advance of screening is not necessary—places undue time & burden on schools & we may only get one chance with some students to screen hearing—I’ve never understood a parent/ guardian who objects to what is being done to help children who do have problems that can interfere with learning

#### 4. Ear Foundation

- Guidelines put together 20 years ago.
- Wrote curriculum for T3 it used to be both now it’s just hearing T3 training doesn’t match schools
- Percent of schools who report hearing
- Make assumption that hearing and vision are both mandated
- T3 training does not train on report form, curriculum needs to be updated
- Training needs to be interactive focused on key points, condensed, shorter.
- The focus of the training is on learning equipment.
- Training needs to be online.
- **Birth to 3 needs to have different training. [Newborn Screening Program]**
- National standards don’t match state standards.
- The costs for parents and schools overruled.
- Loaner Equipment Program -- include better maintenance of audiology equipment, clean, make sure all equipment is there and correct, check when they come in, probe tips are correct.

## ATTACHMENT A

### ARTICLE 1. HEARING SCREENING

#### R9-13-101. Definitions

In this Article, unless the context otherwise requires:

1. “Assistive listening device” has the meaning in A.R.S. § 36-1901.
2. “Audiologist” means an individual licensed under A.R.S. Title 36, Chapter 17.
3. “Audiometer” means an electronic device that generates signals used to measure hearing.
4. “Calibration” means a determination of the accuracy of an instrument by measurement of a variation from a standard.
5. “Cochlear implant” means a surgically inserted device that electrically stimulates the hearing nerve in the inner ear.
6. “dB” means decibel.
7. “dB HL” means decibel hearing level.
8. “Deaf” has the meaning in A.R.S. § 36-1941.
9. “Department” means the Arizona Department of Health Services.
10. “Documentation” means signed and dated information in written, photographic, electronic, or other permanent form.
11. “Effusion” means the escape of fluid from a blood or lymphatic vessel into tissue or a cavity.
12. “Frequency” means the number of cycles per second of a sound wave.
13. “Hard of hearing” has the meaning in A.R.S. § 36-1941.
14. “Hearing aid” has the meaning in A.R.S. § 36-1901.
15. “Hearing screening” means a test of a student’s ability to hear certain frequencies at a consistent loudness performed in a school by an individual who meets the requirements in R9-13-107.
16. “Hz” means Hertz, a unit of frequency equal to one cycle per second.
17. “Immittance” means the ease of transmission of sound through the middle ear.
18. “Inner ear” means the semicircular canals, auditory nerve, and cochlea.
19. “Intensity” means the strength of a sound wave striking the eardrum resulting in the perception of loudness as expressed in decibels or decibels hearing level.
20. “Kindergarten” means the grade level immediately preceding first grade.
21. “Middle ear” means the eardrum, malleus, incus, stapes, and eustachian tube.
22. “mm H<sub>2</sub>O” means millimeters of water.

23. “Noise floor” means sounds present in the auditory canal from either the environment or bodily functions such as breathing and blood flow.
24. “Otitis media” means inflammation of the middle ear.
25. “Otoacoustic emissions” means the sounds generated from the inner ear.
26. “Outer ear” means the pinna, lobe, and auditory canal.
27. “Parent” has the meaning in A.R.S. § 15-101.
28. “Physician” means an individual licensed under A.R.S. Title 32, Chapter 13 or 17.
29. “Preschool” means the instruction preceding kindergarten provided to individuals three to five years old through a:
  - a. School as defined in A.R.S. § 15-101,
  - b. Accommodation school as defined in A.R.S. § 15-101,
  - c. Charter school as defined in A.R.S. § 15-101, or
  - d. Private school as defined in A.R.S. § 15-101.
30. “Primary care practitioner” means an individual licensed as a registered nurse practitioner under A.R.S. Title 32, Chapter 15 or a physician assistant under A.R.S. 32, Chapter 25.
31. “Pure tone” means a single frequency sound.
32. “Reproducibility” means the correlation of two responses measured simultaneously and reported by percentage.
33. “School” means:
  - a. School as defined in A.R.S. § 15-101;
  - b. Preschool,
  - c. Kindergarten,
  - d. Accommodation school as defined in A.R.S. § 15-101,
  - e. Charter school as defined in A.R.S. § 15-101, or
  - f. Private school as defined in A.R.S. § 15-101
34. “School administrator” means an individual or the individual’s designee assigned to act on behalf of a school by the body organized for the government and the management of the school.
35. “School year” means the period between July 1 and the following June 30.
36. “Screener” means an individual qualified to perform a hearing screening in a school according to R9-13-107.
37. “Special education” has the meaning in A.R.S. § 15-761.
38. “Speech-language pathologist” means an individual licensed under A.R.S. Title 36, Chapter 17.

39. “Student” means an individual enrolled in a school.
40. “Supervision” has the meaning in A.R.S. § 36-401.
41. “Tympanogram” means a chart of the indirect measurements of the ease of movement of the parts of the middle ear as air pressure in the auditory canal changes.
42. “Tympanometer” means a device that indirectly measures the ease of movement of the parts of the middle ear as air pressure in the auditory canal changes.
43. “Tympanometry” means the indirect measurement of the ease of movement of the parts of the middle ear as air pressure in the auditory canal changes.

**R9-13-102. Hearing Screening Population**

- A.** A school administrator shall ensure that the following students have a hearing screening each school year:
1. A student enrolled in preschool, kindergarten, or grade 1, 2, 6, or 9;
  2. A student enrolled in grade 3, 4, or 5, unless there is written documentation that the student had a hearing screening in or after grade 2;
  3. A student enrolled in grade 7 or 8, unless there is written documentation that the student had a hearing screening in or after grade 6;
  4. A student enrolled in grade 10, 11, or 12 unless there is written documentation that the student had a hearing screening in or after grade 9;
  5. A student receiving special education; and
  6. A student who failed a second hearing screening in the prior school year.
- B.** A school administrator shall ensure that a student has a hearing screening at the request of the student, the student’s parent, a schoolteacher, a school nurse, a school psychologist, an audiologist, a physician, a primary care practitioner, a speech language pathologist, or Department staff.
- C.** A hearing screening is not required if a:
1. Student is age 16 years or over;
  2. Student’s parent objects in writing to the screening as allowed under A.R.S. § 36-899.04;
  3. Written diagnosis or evaluation from an audiologist states that a student is deaf or hard of hearing; or
  4. Student has a hearing aid, an assistive listening device, or a cochlear implant.
- D.** In addition to meeting the requirements in subsections (A) and (B), a school administrator shall ensure that a student who meets the criteria specified in State Board of Education rule R7-2-401 has a hearing screening required under R7-2-401.

**R9-13-103. Hearing Screening Requirements**

- A. Before performing a hearing screening, a screener shall visually inspect a student's outer ears for:
  - 1. Fluid or drainage,
  - 2. Blood,
  - 3. An open sore, or
  - 4. A foreign object.
- B. If a screener inspects a student's outer ears and finds any of the conditions in subsection (A), the screener shall not perform a hearing screening.
- C. A screener shall perform a hearing screening in each ear using one of the following hearing screening methods:
  - 1. Four-frequency, pure tone hearing screening that screens at each of the following frequencies and intensities:
    - a. 500 Hz at 25 dB HL,
    - b. 1000 Hz at 20 dB HL,
    - c. 2000 Hz at 20 dB HL, and
    - d. 4000 Hz at 20 dB HL;
  - 2. Three-frequency, pure tone hearing screening with tympanometry that:
    - a. Includes a tympanogram that is generated automatically or is plotted at a minimum of the following three points:
      - i. +100 mm H<sub>2</sub>O,
      - ii. Point of maximum immittance, and
      - iii. -200 mm H<sub>2</sub>O; and
    - b. Screens at each of the following frequencies at 20 dB HL:
      - i. 1000 Hz,
      - ii. 2000 Hz, and
      - iii. 4000 Hz; or
  - 3. Otoacoustic emissions hearing screening using otoacoustic emissions equipment that generates a pass or no pass result:
    - a. Using a minimum of three frequencies,
    - b. At no less than 3 dB above the noise floor, and
    - c. With reproducibility greater than 50%.

**R9-13-104. Criteria for Passing a Hearing Screening; Requirements for Performing a Second Hearing Screening**

- A. A student passes a hearing screening if:

1. During a four-frequency, pure tone hearing screening, the student responds in each ear to each frequency at each intensity listed in R9-13-103(C)(1)(a) through (C)(1)(d);
  2. During a three-frequency, pure tone hearing screening with tympanometry, the student:
    - a. Responds in each ear to each frequency as described in R9-13-103(C)(2)(b); and
    - b. Reaches a point of maximum immittance in each ear within the range of +100mm H<sub>2</sub>O to -200mm H<sub>2</sub>O; or
  3. During an otoacoustic emissions hearing screening, the student receives a pass result in each ear according to R9-13-103(C)(3).
- B.** If a student does not pass a hearing screening according to subsection (A), a screener shall perform a second hearing screening on the student no earlier than 30 days and no later than 45 days from the date of the first hearing screening. The screener shall perform the second hearing screening using the same method as the first hearing screening.

**R9-13-105. Referral; Notification; Follow-up**

- A.** If a school administrator finds that a student does not require a hearing screening under R9-13-102(C)(3) or (C)(4), the school administrator shall provide to the student's parent, within 10 days from the date the finding is made, a referral to have the student's current hearing status evaluated by an audiologist, including an electroacoustic analysis of any hearing aid or assistive listening device, unless there is documentation from an audiologist specifying a different evaluation schedule.
- B.** If a screener finds any of the conditions listed in R9-13-103(A) and a student does not have a hearing screening:
1. A school administrator shall provide to the student's parent, within 10 days from the date the condition is found, a referral to have the student's outer ears evaluated by a physician or primary care practitioner; and
  2. A screener shall perform the hearing screening on the student no earlier than 30 days and no later than 45 days from the date the screener finds the condition.
- C.** If a student does not pass a second hearing screening or does not complete a second hearing screening within the time period required under R9-13-104(B), a school administrator shall provide to the student's parent, within 10 days from the date of the second hearing screening or from the date the period for completing a second hearing screening ends, a referral to have the student's current hearing status evaluated by one of the following:
1. An audiologist, a physician, or a primary care practitioner if the screener used only the four-frequency, pure tone hearing screening method;

2. A physician or primary care practitioner if the student did not pass the tympanometry portion, but passed the three-frequency, pure tone portion of the hearing screening;
  3. An audiologist if the student did not pass the three-frequency, pure tone portion, but passed the tympanometry portion of the hearing screening; or
  4. An audiologist, a physician, or a primary care practitioner if the screener used the otoacoustic emissions hearing screening method.
- D.** A referral identified in subsection (C) is not required if a school-provided audiologist:
1. Assesses a student's hearing status and the condition of the middle ear at the conclusion of a hearing screening; and
  2. Within 10 days from date of the assessment, provides the student's parent with a written diagnosis and recommendation for treatment, if applicable.
- E.** A referral required under subsections (A), (B), or (C), shall include a form requesting the following:
1. The name, address, and telephone number of the student evaluated;
  2. The date of evaluation;
  3. An assessment of the condition of the outer ear, if applicable;
  4. An assessment of hearing status and the condition of the middle ear, if applicable;
  5. A diagnosis and recommendation for treatment, if applicable;
  6. The signature and title of the individual evaluating the student and completing the form; and
  7. A request that the individual completing the form or the student's parent return the completed form to the school.
- F.** Under State Board of Education rule R7-2-401, a school administrator shall ensure that a student referred under subsections (A) or (C) is evaluated.
- G.** If a school receives notice of a diagnosis that a student is deaf or hard of hearing from an audiologist, the school administrator shall notify, within 10 days from the date the notice of diagnosis is received, each of the student's teachers and the person responsible for the school's special education services of the diagnosis.

**R9-13-106. Repealed**

**R9-13-107. Screener Qualifications**

- A.** An audiologist may perform a hearing screening.
- B.** An individual who is not an audiologist may perform a hearing screening only if the individual passes a hearing screener course that:
1. Includes 90 minutes of classroom instruction in the introduction to hearing covering:

- a. Development of speech and language;
  - b. Anatomy and physiology of the ear;
  - c. Signs and prevention of hearing loss in children; and
  - d. A.R.S. Title 36, Chapter 7.2 and 9 A.A.C. 13, Article 1;
2. Includes 120 minutes of classroom instruction in hearing screening covering:
- a. Auditory development,
  - b. Early identification of hearing loss,
  - c. Principles of hearing screening,
  - d. Selection of hearing screening methods, and
  - e. Components of setting-up a hearing screening program;
3. Includes 75 minutes of classroom instruction in referral and reporting covering:
- a. Results of a hearing screening,
  - b. Responses to a hearing screening outcome,
  - c. Procedures for recording and tracking,
  - d. Communication with parents,
  - e. Role of community resources, and
  - f. Reporting hearing screening results;
4. For an individual who will perform a hearing screening using three-frequency or four-frequency, pure tone hearing screening, includes 120 minutes of classroom instruction covering:
- a. Selecting and setting-up a hearing screening site,
  - b. Performing a pure tone hearing screening, and
  - c. Identifying children who need referral and evaluation;
5. For an individual who will perform a hearing screening using tympanometry with three-frequency, pure tone hearing screening, includes 60 minutes of classroom instruction covering:
- a. The anatomy and functions of the middle ear,
  - b. What tympanometry measures and identifies,
  - c. Using a tympanometer,
  - d. Performing a tympanometry hearing screening, and
  - e. Identifying children who need referral and evaluation;
6. For an individual who will perform a hearing screening using otoacoustic emissions hearing screening, includes 60 minutes of classroom instruction covering:
- a. What otoacoustic emissions identify and measure,

- b. Using otoacoustic emissions equipment,
  - c. Performing an otoacoustic emissions hearing screening, and
  - d. Identifying children who need referral and evaluation;
- 7. Requires an individual to pass the course by scoring 80% or more on an examination that tests what the individual has learned;
- 8. Is taught by an individual who:
  - a. Is an audiologist, or
  - b. Meets the screener qualifications in subsection (B) or (C) and has performed at least 50 hearing screenings within 24 months before teaching a hearing screener course; and
- 9. Provides an individual who passes the course with a certificate of completion that includes:
  - a. The individual's name;
  - b. Whether the following were completed:
    - i. Introduction to hearing,
    - ii. Hearing screening,
    - iii. Referral and reporting,
    - iv. Pure tone hearing screening,
    - v. Tympanometry hearing screening, and
    - vi. Otoacoustic emissions hearing screening;
  - c. An attestation that the course meets the requirements in subsection (B) or (C); and
  - d. The name and signature of the individual who taught the course.
- C.** Every five years after completing a hearing screener course described in subsection (B), a screener who is not an audiologist shall pass a hearing screener course that:
  - 1. Includes 195 minutes of classroom instruction covering the material required under subsections (B)(1), (B)(2), and (B)(3);
  - 2. For an individual who will perform a hearing screening using three-frequency or four-frequency, pure tone hearing screening, includes 60 minutes of classroom instruction covering the material required under subsection (B)(4);
  - 3. For an individual who will perform a hearing screening using tympanometry with three-frequency, pure tone hearing screening, includes 30 minutes of classroom instruction covering the material required under subsection (B)(5);

4. For an individual who will perform a hearing screening using otoacoustic emissions hearing screening, includes 30 minutes of classroom instruction covering the material required under subsection (B)(6); and
  5. Meets the requirements in subsections (B)(7), (B)(8), and (B)(9).
- D.** Before performing a hearing screening, an individual who passes a hearing screener course described in subsection (B) or (C) shall give a copy of the certificate of completion described in subsection (B)(9) to the school.
- E.** An individual who does not meet the screener qualifications in subsection (A), (B), or (C) may perform a four-frequency, pure tone hearing screening, other than a second hearing screening required under R9-25-104(B), only under the supervision of an individual who meets the screener qualifications in subsection (A), (B), or (C).

**R9-13-108. Equipment Standards**

- A.** A school administrator shall ensure that a pure tone audiometer used to perform a three-frequency or four-frequency, pure tone hearing screening is:
1. Calibrated every 12 months according to the American National Standard Specification for Audiometers, S3.6-1996, Standards Secretariat, c/o Acoustical Society of America, 120 Wall Street, 32nd Floor, New York, New York 10005-3993, January 12, 1996, incorporated by reference in R9-16-209(B)(1); and
  2. Inspected within 24 hours before use to ensure that:
    - a. The calibration complies with subsection (A)(1),
    - b. The power source and power indicator are working,
    - c. The earphone cords are securely connected and have no breaks,
    - d. Each frequency and intensity required under R9-13-103(C)(1) is present,
    - e. A signal does not cross from one earphone to the other, and
    - f. Each earphone is free of noise or distortion that could interfere with a hearing screening.
- B.** A school administrator shall ensure that a tympanometer used to perform the tympanometry portion of a hearing screening:
1. Is calibrated every 12 months according to the American National Standard Specifications for Instruments to Measure Aural Acoustic Impedance and Admittance, S3.39-1987, Standards Secretariat, Acoustical Society of America, 335 East 45th Street, New York, New York 10017-3483, October 5, 1987, not including any later amendments or editions, incorporated by reference and on file with the Department and the Office of the Secretary of State; and

2. Is inspected within 24 hours before use to ensure that the calibration complies with subsection (B)(1).
- C. A school administrator shall ensure that otoacoustic emissions equipment used to perform an otoacoustic emissions hearing screening is:
1. Calibrated every 12 months according to manufacturer's specifications; and
  2. Inspected within 24 hours before use to ensure that:
    - a. The calibration complies with manufacturer's specifications,
    - b. No obstruction is in the probe microphone, and
    - c. The test signal is present.

**R9-13-109. Recordkeeping, Reporting Requirements**

- A. A school administrator shall retain, for Department review and inspection, a written record of:
1. The date and results of a student's hearing screening for no less than three complete school years beginning on the first July 1 after the student's last date of attendance at the school, and
  2. All calibration dates for a piece of hearing screening equipment currently used in the school.
- B. By June 30th of each year, a school administrator shall submit to the Department the following information for the school year ending that June 30th:
1. On a form available from the Department, the number of students by grade in each of the following categories:
    - a. Were enrolled at the time of a first hearing screening,
    - b. Did not have a first hearing screening under R9-13-102(C),
    - c. Had a first hearing screening,
    - d. Did not pass a first hearing screening,
    - e. Had a second hearing screening,
    - f. Did not pass a second hearing screening,
    - g. Were evaluated by an audiologist,
    - h. Were evaluated by a physician or a primary care practitioner,
    - i. Were first diagnosed as deaf or hard of hearing during the current school year, and
    - j. Were diagnosed as deaf or hard of hearing during a prior school year; and
  2. The name of each individual who performed a hearing screening in the school and:
    - a. The individual's license number to practice audiology, or

- b. Evidence that the individual successfully completed a hearing screening course described in R9-13-107(B) or (C).

## ATTACHMENT B (General and Specific Statutory Authorities)

### 9 A.A.C. 13, Article 1, Hearing Screening

#### 36-132. Department of health services; functions; contracts

A. The department shall, in addition to other powers and duties vested in it by law:

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 the state and the prevention of diseases as may be useful in the discharge of functions of the department not in conflict with the provisions of 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 school children, 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 the state.

## 9 A.A.C. 13, Article 1, Hearing Screening

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 H, 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 of 1938 (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.

## 9 A.A.C. 13, Article 1, Hearing Screening

(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 the developmentally disabled. 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

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.

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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 the state.

6. Exercise general supervision over all matters relating to sanitation and health throughout the state.

When in the opinion of the director it is necessary or advisable, a sanitary survey of the whole or of any part of the 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 the 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 the state, the director may inspect any person or property in transportation through the 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 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.

D. 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.

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

## 9 A.A.C. 13, Article 1, Hearing Screening

a manner designed to assure the accomplishment of recognized local public health activities and delegated functions, powers and duties in accordance with applicable standards of performance. Whenever 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.

E. The compensation of all personnel shall be as determined pursuant to section 38-611.

F. The director may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.

G. Notwithstanding subsection H, 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 no longer than eighteen months.

H. 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, 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 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 assure 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

## 9 A.A.C. 13, Article 1, Hearing Screening

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 that takes place at a workplace, 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 fund-raising 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 and that is displayed in an area of less than ten linear feet.
- (g) Baked and confectionary goods that are not potentially hazardous and that are prepared in a kitchen of a private home for commercial purposes if packaged with a label that clearly states the address of the maker, includes contact information for the maker, lists all the ingredients in the product and discloses that the product was prepared in a home. The label must be given to the final consumer of the product. If the product was made in a facility for developmentally disabled individuals, the label must also disclose that fact. The person preparing the food or supervising the food preparation must obtain a food handler's card or certificate if one is issued by the local county and must register with an online registry established by the department pursuant to paragraph 13 of this subsection. For the purposes of this subdivision, "potentially hazardous" means baked and confectionary goods 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.

5. Prescribe reasonably necessary measures to assure 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.

## 9 A.A.C. 13, Article 1, Hearing Screening

6. Prescribe reasonably necessary measures regarding production, processing, labeling, handling, serving and transportation of bottled water to assure 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 assure that all ice sold or distributed for human consumption or for the preservation or storage of 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 preparation of 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.

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

## 9 A.A.C. 13, Article 1, Hearing Screening

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 food for commercial purposes pursuant to paragraph 4 of this subsection.

I. 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.

J. 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.

K. 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.

L. 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

## 9 A.A.C. 13, Article 1, Hearing Screening

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.

M. Until the department adopts exemptions by rule as required by subsection H, paragraph 4, subdivision (b) of this section, a kitchen in a private home that is used as a cooking school and that prepares and offers food to students is exempt from the rules prescribed in subsection H of this section if all of the following are true:

1. Only one cooking school meal per day is prepared and served.
2. The meal is served to not more than fifteen cooking school students.
3. The students are informed by a statement contained in a published advertisement, mailed brochure and placard posted at the cooking school's registration that the food is prepared in a kitchen that is not regulated and inspected by the department or by a local health authority.

### 36-899. Definitions

In this chapter, unless the context otherwise requires:

1. "Department" means the department of health services.
2. "Director" means the director of the department of health services.
3. "Hearing evaluation services" means services which include the identification, testing, evaluation and initiation of follow-up services as defined in the rules and regulations of the department, as provided by section 36-899.03.
4. "Hearing screening evaluation" means the evaluation of the ability to hear certain frequencies at a consistent loudness.
5. "Private education program" means all programs of private education offering courses of study for grades, kindergarten through the twelfth grade of high school.
6. "Public education program" means all kindergarten, primary and secondary programs of education within the public school system, including but not beyond the twelfth grade of common or high school.

### 36-899.01. Program for all school children; administration

A. A program of hearing evaluation services is established by the department. Such services shall be administered to all children as early as possible, but in no event later than the first year of attendance in any public or private education program, or residential facility for children with disabilities, and thereafter as circumstances permit until the child has attained the age of sixteen years or is no longer enrolled in a public or private education program.

B. The program of hearing evaluation services for children in a public education program shall be administered by the department with the aid of the department of education.

## 9 A.A.C. 13, Article 1, Hearing Screening

### 36-899.02. Powers of the department; limitations

A. The department may, in administering the program of hearing evaluation services:

1. Provide consulting services, establish or supplement hearing evaluation services in local health departments, public or private education programs or other community agencies.
2. Provide for the training of personnel to administer hearing screening evaluations.
3. Delegate powers and duties to other state agencies, county and local health departments, county and local boards of education or boards of trustees of private education programs or other community agencies to develop and maintain periodic hearing evaluation services.
4. Provide services by contractual arrangement for the development and maintenance of periodic hearing evaluation services.
5. Accept reports of hearing evaluation from qualified medical or other professional specialists employed by parents or guardians for hearing evaluation when such reports are submitted to the department.

B. The department shall not replace any qualified existing service.

### 36-899.03. Rules and regulations

The director shall develop rules and regulations governing standards, procedures, techniques and criteria for conducting and administering hearing evaluation services.

### 36-899.04. Parent, guardian may refuse test

No child shall be required to submit to any test required by this chapter if a parent or guardian of the child objects and submits a statement of such objection to the agency administering such hearing evaluation services.

**LOTTERY COMMISSION (F-17-1101)**

Title 19, Chapter 3, Article 4, Design and Operation of On-Line Games



**GOVERNOR'S REGULATORY REVIEW COUNCIL  
ANALYSIS OF FIVE-YEAR REVIEW REPORT**

**MEETING DATE:** November 7, 2017

**AGENDA ITEM:** G-6

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

**FROM:** Council Staff

**DATE :** October 24, 2017

**SUBJECT: LOTTERY COMMISSION (F-17-1101)**  
Title 19, Chapter 3, Article 4, Design and Operation of On-Line Games

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**COMMENTS ON THE FIVE-YEAR-REVIEW REPORT**

**Purpose of the Agency and Number of Rules in the Report**

The Arizona Lottery Commission (Commission) is reviewing twelve rules in A.A.C. Title 19, Chapter 3, Article 4 regarding rules of design and operation of on-line games. These rules pertain to the following: Game Profiles; Ticket Purchases, Characteristics, and Restrictions; Drawings; Determination of a Winning Game Play; Ticket Ownership and Responsibility and Prize Payment; Ticket Validation Requirements; Procedure for Claiming Prizes; Claim Period; Disputes Concerning a Ticket; Prize Fund; and Multi-State Lottery Association Games. While the Commission indicates that some individual rules could be improved, it also finds that the rules, as a whole, impose the least burden and cost to the individuals regulated by them.

The Commission intends to seek an exemption to the rulemaking moratorium to address the concerns addressed in its Five-Year Review Report by April of 2018. This is the Commission's first Five-Year Review Report for these rules.

**Proposed Action**

The Commission plans to request an exemption from the rulemaking moratorium to make changes to address the concerns outlined in this memo. The proposed changes include:

- R19-3-401: The Commission plans to change "internet games" to "games played on the internet" in paragraph 18 to make it consistent with the wording in A.R.S. § 5-554(I). Additionally, the Commission plans to change the term "selection slip" to "play slip" throughout the Article to reflect current practice.

- R19-3-403: To reflect current practice, the Commission plans to change the term “selection slip” to “play slip” throughout the Article and change “hand marked by the player” to “indicated by the player” in section B. Additionally, the Commission plans to change the term “original ticket” to “original ticket or Lottery approved proof of purchase” to allow it to determine what documentation is necessary to show proof of purchase.
- R19-3-406: The Commission plans to include debit cards as a form of payment to conform to current practice of Lottery retailers.
- R19-3-407: The Commission plans to allow a ticket holder to present either a ticket or a Lottery approved proof of ticket purchase.
- R19-3-408: The Commission plans to add language to allow a claimant to present either a ticket or a Lottery approved proof of ticket purchase.

**1. Has the agency analyzed whether the rules are authorized by statute?**

Yes. The Commission cites to both general and specific statutory authority. In particular, the Commission cites to A.R.S. § 5-554(B) as general authority which states that “[t]he commission shall oversee a lottery to produce the maximum amount of net revenue consonant with the dignity of the state.” The statute also gives the director the authority to adopt rules in accordance with A.R.S. Title 41, Chapter 6.

The Commission cites to A.R.S. § 5-554(C) and (D) as specific authority. Section (C) authorizes the director to “issue orders and . . . approve orders issued by the director for the necessary operation of the lottery.” Section (D) authorizes the director, subject to the commission’s approval, to establish policy, procedure or practice relating to online gaming.

**2. Summary of the agency’s economic impact comparison and identification of stakeholders:**

Stakeholders identified include lottery retailers, lottery players, charitable funds supported by lottery proceeds, the Lottery, and the state of Arizona. Economic, small business, and consumer impact comparisons are provided for the Article four rules. Article four has improved the ease of identifying winning lottery tickets; determining prize amounts; managing equipment and supplies provided by the lottery to licensee businesses; and providing new on-line games in a timelier manner.

**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 Commission indicates that while some rules can be improved, overall, they impose the least burden and costs to persons regulated by the rules.

**4. Has the agency received any written criticisms of the rules over the last five years?**

No. The Commission has not received any written criticisms during the last five years pertaining to these rules.

5. **Has the agency analyzed the rules' clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?**

Yes. The Commission indicates that its rules are consistent with other statutes and rules, with the following exceptions:

- R19-3-401: The current wording “internet games” in paragraph 18 is inconsistent with A.R.S. § 5-554(I) which uses “a game played on the internet.” Additionally, the current wording “selection slip” throughout the Article does not accurately reflect current practice.
- R19-3-403: The current wording “selection slip” throughout the Article does not accurately reflect current practice. Additionally, the wording “hand marked by the player” in section (B) does not reflect current game play practice and new lottery technologies.
- R19-3-406: The current rule does not include debit cards as a form of payment, which is permitted in current practice.
- R19-3-407: The Commission finds that limiting a ticket holder to presenting a ticket, instead of also allowing a Lottery approved proof of ticket purchase, does not allow the Lottery to adequately determine the necessary documentation to show proof of purchase, which may or may not include the original ticket.
- R19-3-408: The Commission finds that limiting the claimant to only providing a ticket is not effective because proof of purchase may or may not include the original ticket.

6. **Has the agency analyzed the current enforcement status of the rules?**

Yes. The Commission indicates that it enforces the rules as written and is not aware of any problems with the enforcement of the rules, with the exceptions listed above.

7. **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 that there are no corresponding federal laws to these rules.

8. **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.

**Conclusion**

The Commission plans to request an exemption from the rulemaking moratorium by April of 2018 to make changes to address the concerns outlined in the report. The proposed changes include:

- The Commission plans to change “internet games” to “games played on the internet” throughout the rules to make them consistent with the wording in A.R.S. § 5-554(I).

- The Commission plans to change the term “selection slip” to “play slip” throughout the Article to reflect current practice.
- The Commission plans to amend section D in R19-3-406 to include debit cards as a form of payment to conform to current practice of Lottery retailers.
- The Commission plans to add language to section A to allow a claimant to present either a ticket or a Lottery approved proof of ticket purchase.

This report meets the requirements of A.R.S. § 41-1056 and R1-6-301. Council staff recommends approval.



Douglas A. Ducey  
Governor

Gregory R. Edgar  
Executive Director

August 31, 2017



Nicole A. Ong, Chair  
Governor's Regulatory Review Council  
100 N. 15<sup>th</sup> Avenue # 305  
Phoenix, AZ 85007

RE: Five Year Review Report  
19 A.A.C. 3, Article 4. Design and Operation of On-line Games

Dear Ms. Ong:

Pursuant to A.R.S. § 41-1056, the Lottery has reviewed 19 A.A.C. 3, Article 4 and hereby submits its five-year-review report. Copies of the existing rules and authorizing statutes are attached to the report. The economic impact statement from the 2008 rulemaking on Article 4 is also attached. The Lottery believes the economic impact of this rule has not changed significantly.

The Lottery is in compliance with A.R.S. § 41-1091 that governs the directory of rules and substantive policy statements.

Please contact Valerie Hanna at 480-921-4431, or by email at [vhanna@azlottery.gov](mailto:vhanna@azlottery.gov), with any questions regarding the report.

Sincerely,

A handwritten signature in black ink, appearing to be "Gregory R. Edgar", written over a blue rectangular stamp.

Gregory R. Edgar  
Executive Director

Enclosures

# **ARIZONA LOTTERY**

## **Five-Year-Review Report**

### **19 A.A.C. 3**

#### **Article 4: Design and Operation of On-line Games**

**August 2017**

## HISTORICAL OVERVIEW OF AGENCY

### **Agency Mission:**

To support Arizona programs for the public benefit by maximizing net revenue in a responsible manner.

### **Agency Background:**

The Arizona Lottery was voted into existence by a public initiative in November 1980, becoming the first state west of the Mississippi to have a legal, state-administered lottery. Although the initial approval margin was slim—51 to 49 percent—subsequent referendums showed high public support. In November 1997, 68 percent of the voters approved the Lottery for five years and in November 2002, voters extended the Lottery for another ten years with a 73 percent majority. As a result of legislation passed in the 2010 Legislative 6<sup>th</sup> Special Session, the Lottery will sunset in July 2035.

Lottery sales began July 1, 1981, with a single \$1 “Scratch it Rich” instant game that sold 21.4 million tickets in ten days! Instant ticket games remained the only product until 1984 when the Lottery introduced its first online (draw) game, The Pick. Over the years, additional draw games have periodically been introduced and the number of instant ticket games has grown significantly. The Lottery currently offers seven draw games and has more than 50 instant ticket games in market each year. As a result of legislation in the 2010 Legislative Session, the Lottery also became the provider of instant tab games that are sold by charitable organizations. These organizations earned approximately \$1 million in commissions to help support charitable activities in FY15. Legislation passed in the 2015 Legislative Session authorized the Lottery to sell game products in age-restricted locations, with \$1 million of proceeds allocated to the Internet Crimes Against Children Fund and the Victim’s Rights Enforcement Fund.

Since its inception, the Lottery’s mandate has been to maximize net revenue consonant with the dignity of the state. The Lottery is overseen by an Executive Director appointed by the Governor, in addition to a five-member Commission, also appointed by the Governor. The Lottery is entirely self-supporting, receiving no monies from the state general fund. The Lottery sells products and

redeems prizes through a state-wide network of approximately 2700 licensed retailers, who receive a commission on each ticket sold.

A portion of Lottery proceeds is appropriated to pay for Lottery operating costs, and at least 50% of revenues must be utilized for payment of prizes. Remaining Lottery funds are statutorily directed to various benefiting funds including the state general fund. In FY10, the State issued bonds against future Lottery revenues in the amount of \$450 million. As a result, the Lottery is responsible for meeting bond debt service payments through 2029, in addition to traditional beneficiary obligations.

The Lottery has achieved record sales levels in recent years. In fiscal year 2016, total sales exceeded \$870 million and transfers to statutory beneficiaries totaled \$205,828,826.

## **OVERVIEW OF 5-YEAR REVIEW**

A.R.S. § 5-554 requires the Commission to authorize the Lottery Director to adopt rules in accordance with Title 41, Chapter 6. As provided in A.R.S. § 5-554, rules adopted may include matters necessary or desirable for the efficient and economical operation and administration of the Lottery.

A.A.C. Title 19, Chapter 3, Article 4, Design and Operation of On-Line Games, sets forth requirements and procedures for on-line game creation and operation. The provisions in the rules explain the common components of on-line games: games profiles, ticket purchases, drawings, ticket ownership and responsibilities, identifying a winning ticket, procedures to claim prizes, ticket validation requirements, and disputes concerning a ticket. The most recent amendments to Article 4 were effective in February 2005.

The review of these rules was conducted by Arizona Lottery sales, marketing, claims and legal staff. The rules were reviewed for internal consistency, conformity with Lottery and other statutes, and for overall clarity. The Lottery proposes to retain the majority of the rules as written since they remain consistent with Arizona statute, are consistently enforced, and are sufficiently clear and understandable. These rules continue to protect the interests of Lottery retailers, players, and the state of Arizona. The Lottery will request an exemption in order to complete the amendments by April of 2018.

## **INFORMATION THAT IS IDENTICAL FOR ALL THE RULES**

**3. Written criticisms:**

No written criticisms of the rules have been received in the last five years.

**4. Statutory authority:**

General: A.R.S. § 5-554(B).

Specific: A.R.S. § 5-554 (C) and (D).

**7. Economic, small business and consumer impact comparison:**

These rules allow the Lottery to introduce new on-line games and modify existing on-line games in a timely and cost effective manner, thus providing the State and licensed retailers with a potential to increase sales revenue. The rules also provide an effective method for management of tickets and validations to limit losses to the Lottery.

Lottery licensed retailers are the only businesses affected by these rules. The rules' impact on licensed retailers is to specify how they determine if a ticket is a winning ticket and if so, the prize amount. The rules provide for the effective management of equipment and supplies provided by the Lottery to licensees. These rules allow the Lottery to introduce new on-line games in a timelier manner, thus providing licensed retailers with a potential increase in sales revenue.

**8. Analysis submitted by another person:**

No person has submitted an analysis to the agency that compares the rules' competitive impact on businesses in this state to the impact on businesses in other states.

**9. Previous five-year review:**

This is the first five year rule review for these rules.

**10. Burden and costs to persons regulated by the rule:**

While the review report notes that some individual rules can be improved, the agency believes the rules as a whole impose the least burden and cost to persons regulated by the rules. These rules describe provisions related to the operation of the Lottery's on-line game product, which serve to protect the interests of the Lottery, players, and the state. Operational costs are included in the agency's budget and player participation is voluntary.

**11. Stringency of the rule compared to corresponding federal law:**

There are no federal laws applicable to these rules.

**12. Compliance with § 41-1037 regarding the issuance of permits:**

Not applicable. These rules pertain to provisions for the on-line game product and do not require the issuance of a regulatory permit, license, or agency authorization.

## ANALYSIS OF INDIVIDUAL RULES

### **R19-3-401. Definitions**

**1. Objective:**

The rule defines and clarifies terms that are not self-evident and ensures consistent interpretation of Article requirements.

**2. Effectiveness:**

The rule is effective in ensuring consistency of use and interpretation of terms. The rule ensures that retailers and players understand terms that may not be self-evident and/or are Lottery-specific.

**5. Consistency with statutes and rules:**

The rule has one inconsistency with statute. A.R.S. § 5-554 (I) uses the term “games played on the internet” however the rule uses the term “internet games.” The agency plans to amend the language to be consistent with statute.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable. The term “selection slip” is outdated. The Lottery now uses the term “play slip” with our retailers and players.

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

To be consistent with the wording in A.R.S. § 5-554(I), the Lottery plans to change “internet games” to “games played on the internet” in paragraph 18. To reflect current practice, the agency also plans to change the term “selection slip” to “play slip” throughout the Article.

**R19-3-402. Game Profile**

**1. Objective:**

The rule requires that each on-line game have a game profile and sets forth the game profile requirements. The rule also requires that the Lottery Commission approve the profile before the game is sold to the public.

**2. Effectiveness:**

The rule ensures that all games have consistent game profiles that are reviewed and approved by the Lottery Commission.

**5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable.

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

None.

## **R19-3-403. Ticket Purchases, Characteristics, and Restrictions**

### **1. Objective:**

The rule provides information to players regarding the various methods for selecting play symbols when purchasing an on-line ticket and informs ticket holders that they are responsible for the accuracy of ticket data. It also sets forth the manner in which game plays must be entered and informs players that they must present an original ticket for validation. The purpose is to clarify how to play an on-line game ticket.

### **2. Effectiveness:** The rule is generally effective in providing players with instruction on how to play an on-line game and claim a prize. Section B refers to play slips being “hand marked by the player.” Play slips do not necessarily need to be “hand marked”, selections can be indicated in multiple ways by the player. Section B requires a players to submit the original ticket for validation. The Lottery would like to have the ability to determine what documentation is necessary to show proof of purchase, which may or may not include the original ticket.

### **5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

### **6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable. The term “selection slip” is outdated. The Lottery now uses the term “play slip” with our retailers and players.

### **13. Enforcement:**

The rule is consistently enforced.

### **14. Proposed course of action:**

The Lottery plans to change the term “selection slip” to “play slip” throughout the Article, and amend section B to change “hand marked by the player” to “indicated by the player” to reflect current game play practice and new lottery technologies. In section C, the Lottery plans to change the term “original ticket” to “original ticket or Lottery-approved proof of purchase.” This amendment will allow the Lottery to determine what documentation is necessary to show proof of purchase, which may or may not include the original ticket.

**R19-3-404. Drawings**

**1. Objective:**

The rule requires that game drawings be held at the times and places set forth in the game profile and that the drawings must be made by random selection. The rule ensures a consistent methodology for on-line game drawings.

**2. Effectiveness:**

The rule is effective in ensuring fairness and consistency by requiring that drawing are held at pre-established times and places and winners are chosen randomly.

**5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable.

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

None.

**R19-3-405. Determination of a Winning Game Play**

**1. Objective:**

The rule informs players what qualifies as a winning game play for an on-line game, that a player may win multiple times on a single ticket, and that prizes are determined by the prize structure in the game profile.

**2. Effectiveness:**

The rule ensures that retailers and players understand the parameters for winning a game.

**5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable.

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

None.

**R19-3-406. Ticket Ownership and Responsibility; Prize Payment**

**1. Objective:**

The rule informs players that until a ticket is signed it is owned by its physical possessor and outlines how the Director should determine the owner of a winning ticket. It also sets forth the procedures the Lottery must follow to determine whether a claimant owes a debt to a state agency and ensure that the set-off is paid. It also sets forth how the Lottery may pay prizes.

**2. Effectiveness:**

The rule ensures that players understand the parameters of ticket ownership and prize payment. Section D must be updated to include debit cards as a valid form of payment.

**5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable.

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

The Lottery plans to amend Section D shall to include debit cards as a form of payment to conform to current practice of Lottery retailers.

## **R19-3-407. Ticket Validation Requirements**

**1. Objective:**

The rule requires that tickets be validated before prize payment and informs ticket holders of the requirements a ticket must meet to be eligible for payment.

**2. Effectiveness:**

The rule ensures that retailers and players understand ticket validation requirements. The Lottery would like to have the ability to determine what documentation is necessary to show proof of purchase, which may or may not include the original ticket.

**5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable.

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

The Lottery plans to amend the rule to add language that allows a ticket holder to present either a ticket or a Lottery approved proof of ticket purchase. This amendment will allow the Lottery to determine what documentation is necessary to show proof of purchase, which may or may not include the original ticket.

## **R19-3-408. Procedure for Claiming Prizes**

### **1. Objective:**

The rule sets forth the procedures for claiming a prize on a winning on-line ticket and requires licensed retailers to pay winners up to and including \$100. In the event a prize winner dies prior to receiving full payment, the rule requires the Lottery to pay all remaining prize money to the prize winner's beneficiary or any person designated by a judicial order.

### **2. Effectiveness:**

The rule ensures that players understand how a prize can be claimed and that retailers understand their obligation to pay prizes. It also ensure that the Lottery fully pays all prizes, even in circumstances where the winner dies before receiving full payment. Section A should include language allowing a claimant to present either a ticket or a Lottery approved proof of ticket purchase.

### **5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

### **6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable.

### **13. Enforcement:**

The rule is consistently enforced.

### **14. Proposed course of action:**

The Lottery plan to add language to Section A allowing a claimant to present either a ticket or a Lottery approved proof of ticket purchase.

**R19-3-409. Claim Period**

**1. Objective:**

The rule informs players of the time period during which an on-line winning ticket is valid and may be claimed. It also informs players that the end of an on-line game is determined by the Director.

**2. Effectiveness:**

The rule ensures that players understand that a prize must be claimed within the claim period.

**5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable.

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

None.

**R19-3-410. Disputes Concerning a Ticket**

**1. Objective:**

The rule sets forth, and informs players about, the available remedies in the event of a dispute involving an on-line ticket.

**2. Effectiveness:**

The rule protects the Lottery from liability.

**5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable.

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

None.

**R19-3-411. Prize Fund**

**1. Objective:**

The rule sets forth the requirements for deposit of revenue from on-line games into the prize fund and unclaimed prize fund.

**2. Effectiveness:**

The rule ensures that sufficient revenue is deposited to fund payment of on-line ticket winners.

**5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable.

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

None.

**R19-3-412. Multi-State Lottery Association Games**

**1. Objective:**

The rule notifies the public that the Lottery may participate in multi-state games and that a Commission-approved game profile shall be on file and available for these games.

**2. Effectiveness:**

The rule discloses to players that some on-line games may be multi-state games.

**5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable.

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

None.

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effective September 16, 2005 (05-3).

**R19-3-398. Repealed****Historical Note**

Adopted effective September 13, 1995 (Supp. 95-3). Section repealed by final rulemaking at 11 A.A.R. 3075, effective September 16, 2005 (05-3).

**R19-3-399. Repealed****Historical Note**

Adopted effective September 13, 1995 (Supp. 95-3). Section repealed by final rulemaking at 11 A.A.R. 3075, effective September 16, 2005 (05-3).

**ARTICLE 4. DESIGN AND OPERATION OF ON-LINE GAMES****R19-3-401. Definitions**

Definitions. In this Article, unless the context otherwise requires, these words and terms shall have the following meanings:

1. "Cash Value" means payment of the Division 1 (jackpot) prize pool share amount paid in one lump sum as provided in the prize structure in the game profile.
2. "Drawing" means the process used to randomly select the winning play symbols from the defined game matrix.
3. "On-line Lottery Game" means a game where tickets are purchased through a network of Arizona Lottery-issued computer terminals located in retail outlets. The terminals are linked to a central computer that records the wagers.
4. "Fixed payout" means a set prize dollar amount for that specific prize in the prize structure.
5. "Game board" or "board" means the area of the selection slip which contain a matrix that lists all the offered play symbols. More than one game board may appear on the selection slip.
6. "Game option" means a game feature that is tied to a specific game which the player has a choice to play.
7. "Game play" or "play" means the selected play symbols which appear on a ticket as a single wager. More than one game play may appear on a ticket.
8. "Game profile" means the written document in which the Lottery Commission authorizes the Director to issue an order that contains all of the non-confidential game fundamentals required by these rules for an on-line game.
9. "Game ticket" or "ticket" means a receipt produced by a Lottery-issued terminal evidencing the purchase of a participation in a game or game option. The ticket contains a security code, ticket price, a retailer number, a serial number and the game symbols purchased for one or more specific drawings.
10. "Matrix" means the number of selections a player may choose from a predetermined pool of play symbols.
11. "Multiple winners" means a situation in which more than one claimant redeems an individual share in one wager.
12. "Pari-mutuel" means a system in which those holding winning tickets divide the total prize amount in proportion to their wagers.
13. "Play style" means the description in the game profile of the matrix, play symbols, and the manner of selecting the winning play symbols.
14. "Play symbols" means the numbers, letters, symbols, or pictures used in the matrix to determine if a player is entitled to a prize.
15. "POWERBALL" means a multi-state game that is conducted pursuant to the rules of the Multi-State Lottery Association (MUSL) and approved by a game profile.
16. "Prize category" means the value of a specific prize.

17. "Prize structure" means the chart of the prize value, number of prizes or prize payout percentage, any fixed payments, any pari-mutuel payments, and the odds of winning the prizes.
18. "Prohibited games" mean on-line or electronic keno or internet games.
19. "Quick pick" means the random selection by a terminal of one or more play symbols from the defined game matrix.
20. "Selection slip" means a preprinted set of game boards provided by the Lottery upon which the player selects play symbols and game options. Each selection slip may have multiple game boards.
21. "Share" means any single winning game play, which is equal to any other share in the same prize division.
22. "Terminal" means a device authorized by the Lottery linked to a central computer for the purpose of issuing Lottery tickets and entering, receiving, and processing Lottery transactions.
23. "Winning numbers or winning play symbols" means the numbers or play symbols from the defined game matrix randomly selected at each drawing which determine winning game plays contained on a ticket.

**Historical Note**

Adopted as an emergency effective June 10, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-3). Former Section R4-37-401 adopted as an emergency effective June 10, 1983, now adopted without change as a permanent rule effective September 14, 1983 (Supp. 83-5). Amended subsections (A), (D), (E), (J), (K) effective September 7, 1984 (Supp. 84-4). Amended subsection (K) effective March 14, 1985 (Supp. 85-2). Amended effective September 26, 1986 (Supp. 86-5). Amended effective June 29, 1989 (Supp. 89-2). Amended as an emergency effective September 25, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-3). Emergency expired. Emergency amendments permanently adopted effective March 3, 1992 (Supp. 92-1). Amended effective March 9, 1992 (Supp. 92-1). Amended effective April 4, 1994 (Supp. 94-2). R19-3-401 recodified from R4-37-401 (Supp. 95-1). Amended by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**R19-3-402. Game Profile**

- A. Each game or game option shall have a Game Profile and at a minimum, the Profile shall contain the following information:
  1. Game name or game option name;
  2. Matrix/description of how to play and win;
  3. Retail sales price;
  4. Purchase conditions and characteristics;
  5. Play symbols and prize symbols, if any;
  6. Prize structure, including the approximate odds, the prize amounts available, the prize pool percentage, if alternate prize structures are to be used, any subsection (B) provisions, and any special Division 1 (jackpot) prize specifications;
  7. Special features, if any; and
  8. Prize draw eligibility requirements, including filing period for eligibility in a winners drawing, if applicable.
- B. Each on-line game or option may include specific variants that provide added or alternative methods of winning. Any variants shall be described in the Game Profile.
- C. The Commission shall approve the Game Profile prior to the game being sold to the public.

**Historical Note**

Adopted effective June 27, 1997 (Supp. 97-2). Section repealed; new Section made by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**Exhibit 1. Repealed****Historical Note**

Exhibit 1 adopted effective June 27, 1997 (Supp. 97-2). Repealed by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**Exhibit 2. Repealed****Historical Note**

Exhibit 2 adopted effective June 27, 1997 (Supp. 97-2). Repealed by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**Exhibit 3. Repealed****Historical Note**

Exhibit 3 adopted effective June 27, 1997 (Supp. 97-2). Repealed by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**Exhibit 4. Repealed****Historical Note**

Exhibit 4 adopted effective June 27, 1997 (Supp. 97-2). Repealed by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**Exhibit 5. Repealed****Historical Note**

Exhibit 5 adopted effective June 27, 1997 (Supp. 97-2). Repealed by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**Exhibit 6. Repealed****Historical Note**

Exhibit 6 adopted effective June 27, 1997 (Supp. 97-2). Repealed by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**Exhibit 7. Repealed****Historical Note**

Exhibit 7 adopted effective June 27, 1997 (Supp. 97-2). Repealed by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**Exhibit 8. Repealed****Historical Note**

Exhibit 8 adopted effective June 27, 1997 (Supp. 97-2). Repealed by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**Exhibit 9. Repealed****Historical Note**

Exhibit 9 adopted effective June 27, 1997 (Supp. 97-2). Repealed by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**Exhibit 10. Repealed****Historical Note**

Exhibit 10 adopted effective June 27, 1997 (Supp. 97-2). Repealed by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**Exhibit 11. Repealed****Historical Note**

Exhibit 11 adopted effective June 27, 1997 (Supp. 97-2). Repealed by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**Exhibit 12. Repealed****Historical Note**

Exhibit 12 adopted effective June 27, 1997 (Supp. 97-2). Repealed by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**Exhibit 13. Repealed****Historical Note**

Exhibit 13 adopted effective June 27, 1997 (Supp. 97-2). Repealed by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**Exhibit 14. Repealed****Historical Note**

Exhibit 14 adopted effective June 27, 1997 (Supp. 97-2). Repealed by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**Exhibit 15. Repealed****Historical Note**

Exhibit 15 adopted effective June 27, 1997 (Supp. 97-2). Repealed by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**R19-3-403. Ticket Purchases, Characteristics, and Restrictions**

- A. To play an on-line game, a player shall select the specified number of play symbols from the defined game matrix approved in the Game Profile for input into the terminal. Selection methods include:
1. Communicating the play symbols and game options to a retailer, or
  2. Marking the selection slip and submitting the selection slip to a retailer, or
  3. Requesting a "Quick Pick," or
  4. Marking a "Quick Pick" box on a selection slip.
- B. Game plays must be entered into the Lottery terminal manually or by inserting a Lottery selection slip that is hand marked by the player. Facsimiles, simulations, copies of selection slips, or other materials not printed or approved by the Lottery are prohibited from use.
- C. To claim a prize, a player must submit the original ticket for validation. Selection slips are not proof of purchase.
- D. The ticket holder is responsible for the accuracy of ticket data. The Lottery shall not be liable for ticket errors.

**Historical Note**

Adopted effective April 30, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**R19-3-404. Drawings**

- A. The drawings shall be held at the times and places established in the Game Profile.
- B. The on-line game drawing shall randomly select the winning play symbols from those defined in the Game Profile. Mechanical, electrical, or computerized drawing methods may be used to make the random selection.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 393,

## Arizona State Lottery Commission

effective February 15, 2005 (Supp. 04-4).

**R19-3-405. Determination of a Winning Game Play**

- A. A player shall win the prize(s) indicated in the prize structure by matching the winning play symbols selected at the drawing to the play symbols selected by the player.
- B. Players may win on each game play on a ticket.
- C. There may be multiple winning patterns on a single ticket that match winning patterns described in the Game Profile.
- D. The prize structure ordered in the Game Profile shall determine the pari-mutuel and/or fixed prize amount to be paid on a single winning game play.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**R19-3-406. Ticket Ownership and Responsibility; Prize Payment**

- A. Until a ticket is signed, the ticket is owned by its physical possessor.
- B. The Director shall recognize as the owner of a winning on-line ticket the person whose signature appears upon the ticket in the area designated for that purpose.
  - 1. If more than one signature appears on the ticket, the Director is authorized to require that one or more of those claimants be designated to receive the payment. A claim form shall be submitted by each claimant who is designated to receive a portion of the prize claimed from the winning ticket.
  - 2. Prior to payment of a prize, a claimant who has signed the ticket may designate another claimant to receive the prize by signing a relinquishment of claim statement.
  - 3. When the winning ticket was purchased by a group of players, the group shall designate one of the claimants to sign the ticket for the group. Each claimant shall complete an individual claim form to receive the claimant's portion of the prize.
  - 4. In the event there is an inconsistency in the information submitted on a claim form and as shown on the winning on-line ticket, the Director shall authorize an investigation and withhold all winnings payable to the ticket owner or holder until such time as the Director is satisfied that the proper person is being paid.
- C. Prior to paying the claimant a prize of \$600 or more, the Lottery shall match the winner's name against the lists of persons owing a debt to a participating state agency, furnished to the Lottery under A.R.S. § 5-575.
  - 1. If there is a match on any of the claims submitted with a ticket, the amount that is owed shall be deducted from the prize due the claimant.
  - 2. The claimant shall be notified in writing of the amount of the set-off and the agency to which it shall be paid.
  - 3. If the claimant has two or more agencies which are owed a debt, the Lottery shall pay a pro-rata share to each of the agencies, except that a Department of Economic Security overdue child support set-off shall be paid in full before any amount shall be paid to another agency.
  - 4. The claimant shall be notified in writing that a right to appeal the set-off exists and must be commenced within 30 days of the receipt of this notification. The notification shall include the name and address of the agency with which to file the appeal.
  - 5. If, after deducting withholding taxes and the set-off, a portion of the prize remains then that portion shall be paid to the winner with the notification of set-off.
  - 6. The amount of set-off shall be forwarded to the agency, and that agency shall be responsible for any appeal and

crediting of the payment against the amount owed or refunding any amount to the winner.

- 7. Upon a determination that a set-off is due, the winner loses the right under subsection (B)(2) to assign any portion of the claim.
- D. Prizes shall be paid by cash, check, or if requested by the player, by Lottery tickets.
  - 1. If a ticket contains more than one winning game play, any prize amounts shall be combined and paid in accordance with the prize payment limits specified in Section R19-3-408.
  - 2. Each winning game play wins the prize amount specified in the Game Profile.
- E. The Lottery is not responsible for lost or stolen tickets.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4). Pursuant to authority of A.R.S. § 41-1011(C), Laws 2010, 6th Special Session, Ch. 2, authorizes the transfer of A.R.S. citations. Therefore the A.R.S. citation in subsection (C) was updated. Agency request filed September 24, 2012, Office File No. M12-343 (Supp. 12-3).

**R19-3-407. Ticket Validation Requirements**

- A. Each on-line game ticket shall be validated prior to the payment of a prize.
- B. To be eligible for a prize, a ticket holder must present a ticket meeting all of the following requirements;
  - 1. Issued by the Lottery through a retailer, from a terminal, in an authorized manner;
  - 2. Intact and not mutilated or tampered with in any manner;
  - 3. Not defectively printed;
  - 4. Not a reprinted ticket stating "Not for Sale" on the ticket;
  - 5. Not counterfeit or stolen;
  - 6. Able to pass all other confidential validation tests determined by the Director; and
  - 7. Validated in accordance with the provisions of sections R19-3-406 and R19-3-408.
  - 8. The ticket data is:
    - a. Recorded in the designated central computer system prior to the drawing;
    - b. In agreement with the computer record;
    - c. In the Lottery's official file of winning tickets;
  - 9. Any winning game play on the ticket consists of a selected set of play symbols from the defined game matrix.
  - 10. Has not been previously paid.
- C. If the ticket fails to pass any of the requirements in Section R19-3-407(B), the ticket is void and ineligible for any prize payout.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**R19-3-408. Procedure for Claiming Prizes**

- A. To claim a prize of up to and including \$599, the claimant shall present the ticket to any participating on-line licensed retailer or to a Lottery office, or mail the ticket to a Lottery office for validation. The licensed retailer shall pay a winner a prize up to and including \$100 and may pay a winner a prize up to and including \$599 provided that:
  - 1. All of the ticket validation criteria in Section R19-3-407 has been satisfied; and
  - 2. A proper validation slip, which is an authorization to pay, has been issued by the terminal.

## Arizona State Lottery Commission

- B.** To claim a prize that the retailer does not validate or is not authorized to pay, including all prizes of \$600 or more, the claimant shall submit a claim form, available from any retailer, and the ticket to the Lottery. If the claim is:
1. Verified and validated by the Lottery as a winning ticket, the Lottery shall make payment of the amount due to the claimant, less any authorized debt set-off amounts and/or withheld taxes.
  2. Denied by the Lottery, the claimant shall be notified within 15 days from the day the claim is received in the Lottery office.
- C.** If a prize winner dies prior to receiving full payment, the Lottery shall pay all remaining prize money to the prize winner's beneficiary or to any person designated by an appropriate judicial order.
- D.** The Lottery is discharged of all liability upon payment of the prize money.
- E.** Payment of prize money shall not be accelerated ahead of its normal date of payment.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**R19-3-409. Claim Period**

- A.** In order for the claimant to receive payment, a winning on-line game ticket shall be received by the Lottery or a retailer no later than 5:00 p.m. (Phoenix time) on the 180th calendar day following the game drawing date.
- B.** If a claimant presents a valid winning ticket to a retailer for payment on the 180th calendar day following the game drawing date and is not paid the prize, the Director is authorized to pay the prize if the claimant presents the valid winning ticket to the Lottery no later than 5:00 p.m. (Phoenix time) on the following business day.
- C.** The end of an on-line game shall be designated by the Director and on file at the Lottery.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**R19-3-410. Disputes Concerning a Ticket**

- A.** If a dispute between the Lottery and a claimant occurs concerning a ticket, the Director is authorized to replace the disputed ticket with a ticket of equivalent sales price for any subsequent drawing from the same game.
- B.** If a defective ticket is purchased, the Lottery shall replace the defective ticket with a ticket or tickets of equivalent sales price from the same game.
- C.** Replacement of the disputed ticket is the sole and exclusive remedy for a claimant.
- D.** If a dispute between the Lottery and a claimant occurs concerning the eligibility of an entry into a Grand Prize drawing, the Director is authorized to place any person's eligible entry that was not entered in the Grand Prize drawing into a subsequent Grand Prize drawing or drawings.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**R19-3-411. Prize Fund**

- A.** Not less than 50 percent of the total annual revenue accruing from the sale of on-line game tickets shall be deposited in the state lottery prize fund for payment of prizes to the holders of winning tickets.
- B.** If an on-line game is terminated for any reason, any remaining prize monies shall be held by the Lottery for a period of 180

days from the date of the last drawing and then used for additional prizes in any other Lottery game.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**R19-3-412. Multi-State Lottery Association Games**

- A.** The Arizona Lottery is a participating member of the Multi-State Lottery Association (MUSL) referred to as a "party lottery" in the MUSL game rules.
- B.** A game profile approved by the Commission and conforming to the information required in R19-3-403 shall be on file at the Arizona State Lottery for all MUSL games played in Arizona.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 393, effective February 15, 2005 (Supp. 04-4).

**ARTICLE 5. PROCUREMENTS****R19-3-501. Definitions**

In this Article, unless the context otherwise requires:

1. "Affiliate" means any person whose governing instruments require it to be bound by the decision of another person or whose governing board includes enough voting representatives of the other person to cause or prevent action, whether or not the power is exercised. The term applies to persons doing business under a variety of names, persons in a parent-subsidiary relationship, or persons that are similarly affiliated.
2. "Aggregate dollar amount" means purchase price, including taxes and delivery charges, for the term of the contract and accounting for all allowable extensions and options.
3. "Best and Final Offer" means a revision to an offer submitted after negotiations are completed that contain the offeror's most favorable terms for price, service, and products to be delivered.
4. "Best interests of the Lottery" means advantageous to the Lottery.
5. "Bid" means an offer in response to solicitation.
6. "Business" means a corporation, partnership, individual, sole proprietorship, joint stock company, joint venture, or other private legal entity.
7. "Change order" means a written order that is signed by the procurement officer and that directs the contractor to make changes that the changes clause of the contract authorizes the procurement officer to order.
8. "Contract" means an agreement, regardless of what it is called, for the procurement of Lottery equipment, tickets, and related materials.
9. "Contract amendment" means a written alteration in the terms or conditions of a contract accomplished by mutual action of the parties to the contract or a unilateral exercise of a right contained in the contract.
10. "Contractor" means a person who has a contract with the Lottery.
11. "Cost data" means information concerning the actual or estimated cost of labor, material, overhead, and other cost elements that have been incurred or are expected to be incurred by the contractor in performing the contract.
12. "Cost-plus-a-percentage-of-cost-contract" means the parties to a contract agree that the fee will be a predetermined percentage of the cost of work performed and the contract does not limit the cost and fee before authorization of performance.
13. "Cost reimbursement contract" means a contract under which a contractor is reimbursed for costs that are reason-

5-554. Commission; director; powers and duties; definitions

A. The commission shall meet with the director not less than once each quarter to make recommendations and set policy, receive reports from the director and transact other business properly brought before the commission.

B. The commission shall oversee a state lottery to produce the maximum amount of net revenue consonant with the dignity of the state. To achieve these ends, the commission shall authorize the director to adopt rules in accordance with title 41, chapter 6. Rules adopted by the director may include provisions relating to the following:

1. Subject to the approval of the commission, the types of lottery games and the types of game play-styles to be conducted.
2. The method of selecting the winning tickets or shares for noncomputerized online games, except that no method may be used that, in whole or in part, depends on the results of a dog race, a horse race or any sporting event.
3. The manner of payment of prizes to the holders of winning tickets or shares, including providing for payment by the purchase of annuities in the case of prizes payable in installments, except that the commission staff shall examine claims and may not pay any prize based on altered, stolen or counterfeit tickets or based on any tickets that fail to meet established validation requirements, including rules stated on the ticket or in the published game rules, and confidential validation tests applied consistently by the commission staff. No particular prize in a lottery game may be paid more than once, and in the event of a binding determination that more than one person is entitled to a particular prize, the sole remedy of the claimants is the award to each of them of an equal portion of the single prize.
4. The method to be used in selling tickets or shares, except that no elected official's name may be printed on such tickets or shares. The overall estimated odds of winning some prize or some cash prize, as appropriate, in a given game shall be printed on each ticket or share.
5. The licensing of agents to sell tickets or shares, except that a person who is under eighteen years of age shall not be licensed as an agent.
6. The manner and amount of compensation to be paid licensed sales agents necessary to provide for the adequate availability of tickets or shares to prospective buyers and for the convenience of the public, including provision for variable compensation based on sales volume.
7. Matters necessary or desirable for the efficient and economical operation and administration of the lottery and for the convenience of the purchasers of tickets or shares and the holders of winning tickets or shares.

C. The commission shall authorize the director to issue orders and shall approve orders issued by the director for the necessary operation of the lottery. Orders issued under this subsection may include provisions relating to the following:

1. The prices of tickets or shares in lottery games.
2. The themes, game play-styles, and names of lottery games and definitions of symbols and other characters used in lottery games, except that each ticket or share in a lottery game shall bear a unique distinguishable serial number.
3. The sale of tickets or shares at a discount for promotional purposes.
4. The prize structure of lottery games, including the number and size of prizes available. Available prizes may include free tickets in lottery games and merchandise prizes.
5. The frequency of drawings, if any, or other selections of winning tickets or shares, except that:
  - (a) All drawings shall be open to the public.
  - (b) The actual selection of winning tickets or shares may not be performed by an employee or member of the

commission.

(c) Noncomputerized online game drawings shall be witnessed by an independent observer.

6. Requirements for eligibility for participation in grand drawings or other runoff drawings, including requirements for the submission of evidence of eligibility within a shorter period than that provided for claims by section 5-568.

7. Incentive and bonus programs designed to increase sales of lottery tickets or shares and to produce the maximum amount of net revenue for this state.

8. The method used for the validation of a ticket, which may be by physical or electronic presentation of a ticket.

D. Notwithstanding title 41, chapter 6 and subsection B of this section, the director, subject to the approval of the commission, may establish a policy, procedure or practice that relates to an existing online game or a new online game that is the same type and has the same type of game play-style as an online game currently being conducted by the lottery or may modify an existing rule for an existing online game or a new online game that is the same type and has the same type of game play-style as an online game currently being conducted by the lottery, including establishing or modifying the matrix for an online game by giving notice of the establishment or modification at least thirty days before the effective date of the establishment or modification.

E. The commission shall maintain and make the following information available for public inspection at its offices during regular business hours:

1. A detailed listing of the estimated number of prizes of each particular denomination expected to be awarded in any instant game currently on sale.

2. After the end of the claim period prescribed by section 5-568, a listing of the total number of tickets or shares sold and the number of prizes of each particular denomination awarded in each lottery game.

3. Definitions of all play symbols and other characters used in each lottery game and instructions on how to play and how to win each lottery game.

F. Any information that is maintained by the commission and that would assist a person in locating or identifying a winning ticket or share or that would otherwise compromise the integrity of any lottery game is deemed confidential and is not subject to public inspection.

G. The commission, in addition to other games authorized by this article, may establish multistate lottery games to be conducted concurrently with other lottery games authorized under subsection B of this section. The monies for prizes, for operating expenses and for payment to the state general fund shall be accounted for separately as nearly as practicable in the lottery commission's general accounting system. The monies shall be derived from the revenues of multistate lottery games.

H. The commission, in addition to other games authorized by this article, shall establish special instant ticket games with play areas protected by paper tabs designated for use by charitable organizations. The monies for prizes and for operating expenses shall be accounted for separately as nearly as practicable in the lottery commission's general accounting system. Monies saved from the revenues of the special games, by reason of operating efficiencies, shall become other revenue of the lottery commission and revert to the state general fund, except that the commission shall transfer the proceeds from any games that are sold from a vending machine in an age-restricted area to the state treasurer for deposit in the following amounts:

1. Nine hundred thousand dollars each fiscal year in the internet crimes against children enforcement fund established by section 41-199.

2. One hundred thousand dollars each fiscal year in the victims' rights enforcement fund established by section 41-1727.

3. Any monies in excess of the amounts listed in paragraphs 1 and 2 of this subsection, in the state lottery fund established by section 5-571.

I. The commission or director shall not establish or operate any online or electronic keno game or any game played on the internet.

J. The commission or director shall not establish or operate any lottery game or any type of game play-style, either individually or in combination, that uses gaming devices or video lottery terminals as those terms are used in section 5-601.02, including monitor games that produce or display outcomes or results more than once per hour.

K. The director shall print, in a prominent location on each lottery ticket or share, a statement that help is available if a person has a problem with gambling and a toll-free telephone number where problem gambling assistance is available. The director shall require all licensed agents to post a sign with the statement that help is available if a person has a problem with gambling and the toll-free telephone number at the point of sale as prescribed and supplied by the director. The requirements of this subsection apply to tickets and shares printed after July 18, 2000.

L. For the purposes of this section:

1. "Charitable organization" means any nonprofit organization, including not more than one auxiliary of that organization, that has operated for charitable purposes in this state for at least two years before submitting a license application under this article.

2. "Game play-style" means the process or procedure that a player must follow to determine if a lottery ticket or share is a winning ticket or share.

3. "Matrix" means the odds of winning a prize and the prize payout amounts in a given game.

**G-7**

**LOTTERY COMMISSION (F-17-1102)**  
Title 19, Chapter 3, Article 6, Annuity Assignments



**GOVERNOR'S REGULATORY REVIEW COUNCIL  
ANALYSIS OF FIVE-YEAR REVIEW REPORT**

**MEETING DATE: November 7, 2017**

**AGENDA ITEM: G-7**

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

**FROM:** Council Staff

**DATE :** October 24, 2017

**SUBJECT: LOTTERY COMMISSION (F-17-1102)**  
Title 19, Chapter 3, Article 6, Annuity Assignments

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**COMMENTS ON THE FIVE-YEAR-REVIEW REPORT**

**Purpose of the Agency and Number of Rules in the Report**

The Arizona State Lottery Commission (Commission) oversees the Arizona Lottery (Lottery) and is charged with maximizing net revenue while maintaining the dignity of the state. See A.R.S. § 5-554(B). There is one rule under review in this report, R19-3-601, which governs the assignment of annuity instalment prizes. The rule in this article was first adopted in 1986, and was most recently amended in July of 2005.

The previous five-year review report for this rule proposed changing a statutory citation, but no substantive changes. That citation was successfully changed in September 2012. The Commission has certified its compliance with A.R.S. § 41-1091.

**Proposed Action**

At this time, the Commission does not propose any action on this rule.

**1. Has the agency analyzed whether the rules are authorized by statute?**

Yes. The Commission cites to both general and specific statutory authority. Under A.R.S. § 5-554(B), the Commission shall "oversee a state lottery to produce the maximum amount of net revenue consonant with the dignity of the state." Additionally, the Commission cites specifically to A.R.S. § 5-563(A)(3), which states that "a voluntary assignment, the remainder of any annuity, or a portion of the remainder of the annuity, may be assigned by a prize winner" if all specified conditions are met.

2. **Summary of the agency’s economic impact comparison and identification of stakeholders:**

Stakeholders identified include lottery players, the Commission, the Arizona Attorney General’s Office, and the State. An economic, small business, and consumer impact comparison is provided. The article clarified administrative tasks for lottery administrative staff and the Attorney General’s Office allowing for faster and efficient case processing. The effect of this rule continues to be as expected in the 2005 economic impact statement. Further, previous rule changes established a \$235 fee paid by prize winners to cover administrative costs, which the agency continues to believe covers all needed administrative expenses.

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?**

Yes. The Commission indicates that the rule imposes the least burden and costs on the lottery, and the assignment of a lottery prize is voluntary.

4. **Has the agency received any written criticisms of the rules over the last five years?**

No. The Commission has not received any written criticisms of the rule during the last five years.

5. **Has the agency analyzed the rules’ clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?**

Yes. The Commission indicates that the rule is generally clear, concise, and understandable, consistent with statutes, and effective.

6. **Has the agency analyzed the current enforcement status of the rules?**

Yes, the Commission indicates that the rule is enforced as written.

7. **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 Commission indicates there are no applicable federal laws.

8. **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?**

No. The Commission indicates that the rule does not require the issuance of a permit or license.

**9. Conclusion**

As noted above, the Commission does not intend to make any amendments to the rule. The report meets the requirements of A.R.S. § 41-1056 and R1-6-301, and this analyst recommends that the report be approved.



**Douglas A. Ducey**  
*Governor*

**Gregory R. Edgar**  
*Executive Director*

August 31, 2017

Nicole A. Ong, Chair  
Governor's Regulatory Review Council  
100 N. 15<sup>th</sup> Avenue # 305  
Phoenix, AZ 85007

RE: Five Year Review Report  
19 A.A.C. 3, Article 6. Annuity Assignments

Dear Ms. Ong:

Pursuant to A.R.S. § 41-1056, the Lottery has reviewed 19 A.A.C. 3, Article 6 and hereby submits its five-year-review report. Copies of the existing rules and authorizing statutes are attached to the report. The economic impact statement from the 2005 rulemaking on Article 6 is also attached. The Lottery believes the economic impact of this rule has not changed significantly.

The Lottery is in compliance with A.R.S. § 41-1091 that governs the directory of rules and substantive policy statements.

Please contact Valerie Hanna at 480-921-4431, or by email at [vhanna@azlottery.gov](mailto:vhanna@azlottery.gov), with any questions regarding the report.

Sincerely,

Gregory R. Edgar  
Executive Director

Enclosures

# **ARIZONA LOTTERY**

## **Five-Year-Review Report**

### **19 A.A.C. 3**

#### **Article 6: Annuity Assignments**

**August 2017**

## HISTORICAL OVERVIEW OF AGENCY

### **Agency Mission:**

To support Arizona programs for the public benefit by maximizing net revenue in a responsible manner.

### **Agency Background:**

The Arizona Lottery was approved by a statewide public initiative in November 1980, becoming the first state west of the Mississippi to have a legal, state-administered lottery. Although the initial approval margin was slim—51 to 49 percent—subsequent referendums showed high public support. In November 1997, 68 percent of the voters approved the Lottery for five years and in November 2002, 73 percent of Arizonans voted to extend the Lottery for an additional 10 years. As a result of legislative action in the 2010 Legislative 6<sup>th</sup> Special Session, the original voter-established Lottery was replaced by a legislatively-established Lottery. This “new” Lottery began operations July 2012 and will be subject to sunset in 2035.

Lottery sales began July 1, 1981, with a single \$1 “Scratch it Rich” instant game that sold out 21.4 million tickets in 10 days! Scratchers remained the only product until 1984 when the Lottery introduced its first on-line (drawing) game, The Pick. Over the years, additional drawing games have been introduced and the number of instant ticket games has grown significantly. The Lottery currently offers seven drawing games, plus a periodic Raffle, and has more than 50 instant ticket games in market each year. As a result of legislation in the 2010 Legislative Session, the Lottery also became the provider of instant tab games that are sold by charitable organizations. These organizations earned approximately \$650,000 in commissions to help support charitable activities in FY12.

Since its inception, the Lottery’s mandate has been to maximize net revenue consonant with the dignity of the state. The Lottery is overseen by an Executive Director appointed by the Governor, in addition to a 5-member Commission, also appointed by the Governor. The Lottery is entirely self-supporting, receiving no General Fund monies. The Lottery sells products and redeems

prizes through a state-wide network of approximately 2800 licensed retailers, who receive a commission on each ticket sold.

A portion of Lottery proceeds is appropriated to pay for Lottery operating costs, and at least 50% of revenues must be utilized for payment of prizes. Remaining Lottery funds are statutorily directed to various benefiting funds including the General Fund. In FY10, the State issued bonds against future Lottery revenues in the amount of \$450 million. As a result, the Lottery is responsible for meeting bond debt service payments through 2029, in addition to traditional beneficiary obligations.

The Lottery has achieved record sales levels in recent years. In fiscal year 2016, total sales exceeded \$870 million and transfers to statutory beneficiaries exceeded \$205,000,000.

## **OVERVIEW OF 5-YEAR REVIEW**

A.R.S. § 5-554(B) requires the Commission to authorize the Lottery Director to adopt rules in accordance with Title 41, Chapter 6. Rules adopted may include matters necessary or desirable for the efficient and economical operation and administration of the Lottery, as provided in A.R.S. § 5-554(B)(7). The Lottery may also adopt rules relating to the payment of prizes, including the purchase of annuities, as provided in A.R.S. § 5-554(B)(3). A.R.S. § 5-563(A)(3) specifically addresses the voluntary assignment of a Lottery annuity to another party and authorizes a fee paid to the Lottery to defray the cost of processing the assignment.

19 A.A.C. 3, Article 6 became effective in July 2005 and has not been amended since that time. The rule sets forth provisions regarding the voluntary assignment of an annuity, including a fee due to the Lottery when a prize winner requests an assignment of all or a portion of the remaining installments of an annuity. The fee represents the Lottery's cost to process the assignment.

The review of this rule was conducted by Arizona Lottery legal staff. As a result of the evaluation, the agency proposes to retain the rule as currently written.

## ANALYSIS OF INDIVIDUAL RULES

### **R19-3-601. Voluntary Assignment of Prizes Paid in Installments**

**1. Objective:**

This rule explains the procedures for a Lottery prize winner to request an assignment of all or a portion of the remaining installments of an annuity.

**2. Effectiveness:**

The rule is effective in informing Lottery prize winners regarding the procedure for requesting a voluntary assignment of an annuity.

**3. Written criticisms:**

No written criticisms of the rule have been received in the last five years.

**4. Statutory authority:**

General: A.R.S. §§ 5-554(B)

Specific: A.R.S. §§ 5-563(A)(3)

**5. Consistency with state and federal statutes and rules:**

This rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is clear, concise and understandable.

**5. Agency enforcement of the rule:**

The Lottery adheres to the rule as written. The rule is fairly and consistently enforced.

**7. Economic, small business and consumer impact comparison:**

The last economic impact statement was prepared when this rule was initially filed with Council in March 2005. Upon review, the Lottery believes the actual economic impact of this rule has not differed significantly from the economic impact statement submitted in 2005. The rule continues to primarily affect the agency and the prize winner (or assignee of the prize winner) requesting an annuity assignment. Costs to the Lottery include time spent by Lottery administrative staff and the Attorney General's Office to process the assignment. The established fee of \$235 was based on the average cost per assignment and after review, remains sufficient for the Lottery to recover administrative costs. The Attorney General's time no longer requires the use of a legal assistant due to the decreased volume of assignment cases. Although the Assistant Attorney General now handles all aspects of annuity assignments, the reduced volume allows for faster and

more efficient processing per case. The Lottery's processing time has also decreased slightly due to the automation of previously more manual procedures.

The rule does not have an economic impact on political subdivisions of the state, private and public employment, or Lottery retailers. Consistent with the previous economic impact statement, the impact on state revenues has been minimal.

**8. Analysis submitted by another person regarding business competitiveness:**

No person has submitted an analysis to the agency regarding the rule's competitive impact on businesses in this state compared to the competitive impact on businesses in other states.

**9. Previous five-year review:**

The previous five-year review for this Article submitted in December 2012 and was approved by Council in March 2013. The rule was updated in 2012 to reflect a change in a statutory citation. No changes were made as a result of the 2012 five-year review.

**10. Burden and costs to persons regulated by the rule:**

The agency believes the rule imposes the least burden and cost to persons regulated by the rule. The assignment of a Lottery prize is voluntary and at the discretion of the prize winner. Annuity assignments create additional work and expenses for the Lottery that would not otherwise be incurred; the fee allows the agency to recover these costs.

**11. Stringency of the rule compared to corresponding federal law:**

There are no federal laws applicable to this rule.

**12. Compliance with § 41-1037 regarding the issuance of permits:**

This rule does not require the issuance of a regulatory permit, license, or agency authorization.

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

None.

effective November 21, 2016 (Supp. 16-4).

**R19-3-569. Guidance**

If a procedure is not provided by these rules, the procurement officer may issue a written determination using for guidance A.R.S. § 41-2501 through § 41-2591 or 2 A.A.C. 7, including, but not limited to a procurement utilizing a cooperative contract.

**Historical Note**

New Section R19-3-569 renumbered from R19-3-568 and amended by final rulemaking at 22 A.A.R. 2966, effective November 21, 2016 (Supp. 16-4).

**ARTICLE 6. ANNUITY ASSIGNMENTS**

**R19-3-601. Voluntary Assignment of Prizes Paid in Installments**

- A. A prize winner may request a voluntary assignment of an annuity or a portion of the remaining installments of the annuity by filing an action in a court of competent jurisdiction requesting judicial approval of the assignment. The prize winner and the purchaser of the annuity shall name the state of Arizona as a defendant in the action and shall bear all costs associated with filing the request for judicial approval of the assignment.
- B. A prize winner shall include in the request for judicial approval under subsection (A) the following:
  1. The affidavit required under A.R.S. § 5-563(A)(3);
  2. A copy of the signed assignment agreement between the prize winner and the assignee; and
  3. Proof that the fee under subsection (D) has been paid to the Lottery.
- C. After the court approves the assignment, the prize winner shall send the written judicial approval to the Lottery. Upon receipt of judicial approval of the voluntary assignment, the Director shall direct the insurance company to make future annuity payments as provided in the Court order.
- D. The prize winner or assignee shall pay a fee of \$235.00 to the Lottery to process the voluntary assignment.

**Historical Note**

Adopted as an emergency effective October 31, 1986, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 86-5). Adopted without change as a permanent rule effective February 25, 1987 (Supp. 87-1). Amended effective May 7, 1993 (Supp. 93-2). R19-3-601 recodified from R4-37-601 (Supp. 95-1). Repealed effective June 14, 1997 (Supp. 97-2). New Section made by final rulemaking at 11 A.A.R. 2028, effective July 2, 2005 (Supp. 05-2). Pursuant to authority of A.R.S. § 41-1011(C), Laws 2010, 6th Special Session, Ch. 2, authorizes the transfer of A.R.S. citations. Therefore the A.R.S. citation in subsection (B)(1) was updated. Agency request filed September 24, 2012, Office File No. M12-343 (Supp. 12-3).

**ARTICLE 7. DESIGN AND OPERATION OF INSTANT GAMES**

**R19-3-701. Definitions**

In this Article, unless the context otherwise requires:

1. "Caption" means the printed characters appearing below a play symbol or prize symbol that verify and correspond with that symbol. No more than one caption will appear under a symbol.
2. "Game profile" means the written document in which the Lottery Commission authorizes the Director to issue an order that contains all of the non-confidential game fundamentals required by these rules for an instant game.

3. "Instant game" means a game that is played by removing the protective covering from a ticket to reveal the play symbols, or prize symbols, or both that determine if a ticket holder is entitled to a prize or prizes.
4. "Instant scratch game" means an instant game where the protective covering is made of latex or another substance that is scratched off.
5. "Instant tab game" means an instant game where the protective covering is a perforated paper tab that is opened.
6. "Pack" means a group of tickets bearing a common identification number.
7. "Pack-ticket number" means a unique multi-digit number that includes a game number, a pack number, and a ticket number which distinguishes each ticket from every other ticket within an instant game.
8. "PIN" means the designated characters within the validation number that allows an on-line terminal to validate an instant ticket.
9. "Play area" means the portion or portions of the ticket which contains the play symbol or symbols. More than one play area may appear on a ticket.
10. "Play symbols" means the printed image or images that appear within the defined play area of the ticket that determine if the ticket holder is entitled to a prize or prizes.
11. "Prize structure" means the estimated number of prizes, prize values, and odds of winning prizes for an individual game.
12. "Prize symbol" means the printed image or images that indicates the prize or prizes available in that game.
13. "Retailer validation code" means the multiple letters in the play area, under the protective covering that verify prizes less than \$600.
14. "Validation code" means the unique multi-positional code on each ticket that is used to authenticate winning tickets.

**Historical Note**

Adopted effective October 25, 1996 (Supp. 96-4). Amended by final rulemaking at 13 A.A.R. 1031, effective April 27, 2007 (Supp. 07-1). Amended by final rulemaking at 17 A.A.R. 53, effective December 28, 2010 (Supp. 10-4).

**R19-3-702. Game Profile**

- A. Each game shall have a Game Profile and at a minimum, the Profile shall contain the following information:
  1. Game name;
  2. Game number;
  3. Prize structure;
  4. Game Playstyle;
  5. Play symbols;
  6. Retailer validation codes, if any;
  7. Special features, if any;
  8. Retail sales price;
  9. How to play and win instructions; and
  10. Prize draw eligibility requirements, including filing period for eligibility in a winners drawing, if applicable.
- B. The Commission shall approve the individual Game Profile prior to the game being sold to the public.

**Historical Note**

Adopted effective October 25, 1996 (Supp. 96-4). Amended by final rulemaking at 13 A.A.R. 1031, effective April 27, 2007 (Supp. 07-1). Amended by final rulemaking at 17 A.A.R. 53, effective December 28, 2010 (Supp. 10-4).

**R19-3-703. Game Playstyle**

5-554. Commission; director; powers and duties; definitions

A. The commission shall meet with the director not less than once each quarter to make recommendations and set policy, receive reports from the director and transact other business properly brought before the commission.

B. The commission shall oversee a state lottery to produce the maximum amount of net revenue consonant with the dignity of the state. To achieve these ends, the commission shall authorize the director to adopt rules in accordance with title 41, chapter 6. Rules adopted by the director may include provisions relating to the following:

1. Subject to the approval of the commission, the types of lottery games and the types of game play-styles to be conducted.
2. The method of selecting the winning tickets or shares for noncomputerized online games, except that no method may be used that, in whole or in part, depends on the results of a dog race, a horse race or any sporting event.
3. The manner of payment of prizes to the holders of winning tickets or shares, including providing for payment by the purchase of annuities in the case of prizes payable in installments, except that the commission staff shall examine claims and may not pay any prize based on altered, stolen or counterfeit tickets or based on any tickets that fail to meet established validation requirements, including rules stated on the ticket or in the published game rules, and confidential validation tests applied consistently by the commission staff. No particular prize in a lottery game may be paid more than once, and in the event of a binding determination that more than one person is entitled to a particular prize, the sole remedy of the claimants is the award to each of them of an equal portion of the single prize.
4. The method to be used in selling tickets or shares, except that no elected official's name may be printed on such tickets or shares. The overall estimated odds of winning some prize or some cash prize, as appropriate, in a given game shall be printed on each ticket or share.
5. The licensing of agents to sell tickets or shares, except that a person who is under eighteen years of age shall not be licensed as an agent.
6. The manner and amount of compensation to be paid licensed sales agents necessary to provide for the adequate availability of tickets or shares to prospective buyers and for the convenience of the public, including provision for variable compensation based on sales volume.
7. Matters necessary or desirable for the efficient and economical operation and administration of the lottery and for the convenience of the purchasers of tickets or shares and the holders of winning tickets or shares.

C. The commission shall authorize the director to issue orders and shall approve orders issued by the director for the necessary operation of the lottery. Orders issued under this subsection may include provisions relating to the following:

1. The prices of tickets or shares in lottery games.

2. The themes, game play-styles, and names of lottery games and definitions of symbols and other characters used in lottery games, except that each ticket or share in a lottery game shall bear a unique distinguishable serial number.
  3. The sale of tickets or shares at a discount for promotional purposes.
  4. The prize structure of lottery games, including the number and size of prizes available. Available prizes may include free tickets in lottery games and merchandise prizes.
  5. The frequency of drawings, if any, or other selections of winning tickets or shares, except that:
    - (a) All drawings shall be open to the public.
    - (b) The actual selection of winning tickets or shares may not be performed by an employee or member of the commission.
    - (c) Noncomputerized online game drawings shall be witnessed by an independent observer.
  6. Requirements for eligibility for participation in grand drawings or other runoff drawings, including requirements for the submission of evidence of eligibility within a shorter period than that provided for claims by section 5-568.
  7. Incentive and bonus programs designed to increase sales of lottery tickets or shares and to produce the maximum amount of net revenue for this state.
  8. The method used for the validation of a ticket, which may be by physical or electronic presentation of a ticket.
- D. Notwithstanding title 41, chapter 6 and subsection B of this section, the director, subject to the approval of the commission, may establish a policy, procedure or practice that relates to an existing online game or a new online game that is the same type and has the same type of game play-style as an online game currently being conducted by the lottery or may modify an existing rule for an existing online game or a new online game that is the same type and has the same type of game play-style as an online game currently being conducted by the lottery, including establishing or modifying the matrix for an online game by giving notice of the establishment or modification at least thirty days before the effective date of the establishment or modification.
- E. The commission shall maintain and make the following information available for public inspection at its offices during regular business hours:
1. A detailed listing of the estimated number of prizes of each particular denomination expected to be awarded in any instant game currently on sale.
  2. After the end of the claim period prescribed by section 5-568, a listing of the total number of tickets or shares sold and the number of prizes of each particular denomination awarded in each lottery game.
  3. Definitions of all play symbols and other characters used in each lottery game and instructions on how to play and how to win each lottery game.

F. Any information that is maintained by the commission and that would assist a person in locating or identifying a winning ticket or share or that would otherwise compromise the integrity of any lottery game is deemed confidential and is not subject to public inspection.

G. The commission, in addition to other games authorized by this article, may establish multistate lottery games to be conducted concurrently with other lottery games authorized under subsection B of this section. The monies for prizes, for operating expenses and for payment to the state general fund shall be accounted for separately as nearly as practicable in the lottery commission's general accounting system. The monies shall be derived from the revenues of multistate lottery games.

H. The commission, in addition to other games authorized by this article, shall establish special instant ticket games with play areas protected by paper tabs designated for use by charitable organizations. The monies for prizes and for operating expenses shall be accounted for separately as nearly as practicable in the lottery commission's general accounting system. Monies saved from the revenues of the special games, by reason of operating efficiencies, shall become other revenue of the lottery commission and revert to the state general fund, except that the commission shall transfer the proceeds from any games that are sold from a vending machine in an age-restricted area to the state treasurer for deposit in the following amounts:

1. Nine hundred thousand dollars each fiscal year in the internet crimes against children enforcement fund established by section 41-199.
2. One hundred thousand dollars each fiscal year in the victims' rights enforcement fund established by section 41-1727.
3. Any monies in excess of the amounts listed in paragraphs 1 and 2 of this subsection, in the state lottery fund established by section 5-571.

I. The commission or director shall not establish or operate any online or electronic keno game or any game played on the internet.

J. The commission or director shall not establish or operate any lottery game or any type of game play-style, either individually or in combination, that uses gaming devices or video lottery terminals as those terms are used in section 5-601.02, including monitor games that produce or display outcomes or results more than once per hour.

K. The director shall print, in a prominent location on each lottery ticket or share, a statement that help is available if a person has a problem with gambling and a toll-free telephone number where problem gambling assistance is available. The director shall require all licensed agents to post a sign with the statement that help is available if a person has a problem with gambling and the toll-free telephone number at the point of sale as prescribed and supplied by the director. The requirements of this subsection apply to tickets and shares printed after July 18, 2000.

L. For the purposes of this section:

1. "Charitable organization" means any nonprofit organization, including not more than one auxiliary of that organization, that has operated for charitable purposes in this state for at least two years before submitting a license application under this article.
2. "Game play-style" means the process or procedure that a player must follow to determine if a lottery ticket or share is a winning ticket or share.

3. "Matrix" means the odds of winning a prize and the prize payout amounts in a given game.

5-563. Right to prize not assignable; exceptions

A. The right of any person to a prize is not assignable, except that:

1. Payment of any prize drawn or the remainder of any annuity purchased may be paid to any of the following:

- (a) The estate of a deceased prize winner.
- (b) The beneficiary of a deceased prize winner.
- (c) A person pursuant to an appropriate judicial order.

2. Payments to winners in an amount of six hundred dollars or more are subject to setoff pursuant to section 5-575.

3. In the event of a voluntary assignment, the remainder of any annuity, or a portion of the remainder of the annuity, may be assigned by a prize winner pursuant to an appropriate judicial order if all of the following conditions are met:

- (a) The prize winner provides an affidavit to the court to the effect that the affiant is of sound mind, is not acting under duress and has received independent financial and tax advice concerning the assignment.
- (b) The assignee pays the prize winner a lump sum for all amounts that are due to the prize winner under the assignment agreement on or before the date that the assignment takes effect.
- (c) The parties to the assignment pay a fee to the commission to defray the expenses incurred by the commission in processing the assignment. The commission shall determine the amount of the fee. Monies collected by the commission pursuant to this subdivision shall be deposited in the state lottery fund established by section 5-571.

B. On receipt of a court order that meets the requirements of subsection A, paragraph 3 of this section, the director shall make the voluntary assignment.

C. The commission and director shall be discharged of all further liability upon payment of a prize pursuant to this section.

**LOTTERY COMMISSION (F-17-1103)**

Title 19, Chapter 3, Article 7, Design and Operation of Instant Games



**GOVERNOR'S REGULATORY REVIEW COUNCIL  
ANALYSIS OF FIVE-YEAR REVIEW REPORT**

**MEETING DATE: November 7, 2017**

**AGENDA ITEM: G-8**

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**TO:** Members of the Governor's Regulatory Review Council (Council)  
**FROM:** Council Staff  
**DATE :** October 24, 2017  
**SUBJECT: LOTTERY COMMISSION (F-17-1103)**  
Title 19, Chapter 3, Article 7, Design and Operation of Instant Games

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**COMMENTS ON THE FIVE-YEAR-REVIEW REPORT**

**Purpose of the Agency and Number of Rules in the Report**

The Arizona State Lottery Commission (Commission) oversees the Arizona Lottery (Lottery) and is charged with maximizing net revenue while maintaining the dignity of the state. See A.R.S. § 5-554(B). There are nine rules under review in this report that govern the design and operation of instant games. All of the rules were amended in 2007, and six rules were further amended in December 2010.

This is the first five-year review report for these rules. The Commission has certified its compliance with A.R.S. § 41-1091.

**Proposed Action**

The Commission plans to make the following amendments:

- **R19-3-701:** Remove the words "within the validation number."
- **R19-3-702:** Remove paragraphs six and ten from section A to clarify that validation codes are no longer used.
- **R19-3-705:** Remove the term "retailer validation code" from paragraph C.1.
- **R19-3-706:** To align with current practice, debit, electronic transfer, and gift card will each be added as an acceptable form of payment.
- **R19-3-708:** Amend the rule to reflect retailers may elect to pay all claims up to and including \$100, instead of requiring payment by retailers.

**1. Has the agency analyzed whether the rules are authorized by statute?**

Yes. The Commission cites to both general and specific statutory authority. Under A.R.S. § 5-554(B), the Commission shall “oversee a state lottery to produce the maximum amount of net revenue consonant with the dignity of the state.” Additionally, the Commission cites specifically to A.R.S. § 5-554(C), which states “[t]he commission shall authorize the director to issue orders and shall approve orders issued by the director for the necessary operation of the lottery. Orders issued under this subsection may include . . . [t]he themes, game play-styles, and names of lottery games and definitions of symbols and other characters used in lottery games, except that each ticket or share in a lottery game shall bear a unique distinguishable serial number.”

**2. Summary of the agency’s economic impact comparison and identification of stakeholders:**

Stakeholders identified include lottery retailers, lottery players, charitable funds supported by lottery proceeds, the Commission, and the State. An economic, small business, and consumer impact comparison is provided for article 7. It was identified that the rules in article 7 continue to benefit the State and licensed retailers. This benefit is created from the introduction of new instant games, which provides greater sales revenue potential.

**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?**

Yes. The Commission indicates that even though some rules can be improved, overall, they impose the least burden and costs to persons regulated by the rules.

**4. Has the agency received any written criticisms of the rules over the last five years?**

No. The Commission has not received any written criticisms of the rules during the last five years.

**5. Has the agency analyzed the rules’ clarity, conciseness, and understandability, consistency with other rules and statutes, and effectiveness?**

Yes. The Commission indicates that the rules are generally clear, concise, and understandable.

**6. Has the agency analyzed the current enforcement status of the rules?**

Yes. The Commission indicates that the rules are enforced as written.

**7. 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 Commission indicates that there are no applicable federal laws.

**8. 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?**

No. The Commission indicates that the rules do not require the issuance of a permit or license.

**9. Conclusion**

As noted above, the Commission intends to amend five of the rules by August 1, 2018, making minor changes. The report meets the requirements of A.R.S. § 41-1056 and R1-6-301, and this analyst recommends that the report be approved.



**Douglas A. Ducey**  
*Governor*

**Gregory R. Edgar**  
*Executive Director*

August 31, 2017

Nicole A. Ong, Chair  
Governor's Regulatory Review Council  
100 N. 15<sup>th</sup> Avenue # 305  
Phoenix, AZ 85007

RE: Five Year Review Report  
19 A.A.C. 3, Article 7. Design and Operation of Instant Games

Dear Ms. Ong:

Pursuant to A.R.S. § 41-1056, the Lottery has reviewed 19 A.A.C. 3, Article 7 and hereby submits its five-year-review report. Copies of the existing rules and authorizing statutes are attached to the report. The economic impact statement from the 2010 rulemaking on Article 7 is also attached. The Lottery believes the economic impact of this rule has not changed significantly.

The Lottery is in compliance with A.R.S. § 41-1091 that governs the directory of rules and substantive policy statements.

Please contact Valerie Hanna at 480-921-4431, or by email at [vhanna@azlottery.gov](mailto:vhanna@azlottery.gov), with any questions regarding the report.

Sincerely,

Gregory R. Edgar  
Executive Director

Enclosures

# **ARIZONA LOTTERY**

## **Five-Year-Review Report**

### **19 A.A.C. 3**

#### **Article 7: Design and Operation of Instant Games**

**August 2017**

## HISTORICAL OVERVIEW OF AGENCY

### **Agency Mission:**

To support Arizona programs for the public benefit by maximizing net revenue in a responsible manner.

### **Agency Background:**

The Arizona Lottery was voted into existence by a public initiative in November 1980, becoming the first state west of the Mississippi to have a legal, state-administered lottery. Although the initial approval margin was slim—51 to 49 percent—subsequent referendums showed high public support. In November 1997, 68 percent of the voters approved the Lottery for five years and in November 2002, voters extended the Lottery for another ten years with a 73 percent majority. As a result of legislation passed in the 2010 Legislative 6<sup>th</sup> Special Session, the Lottery will sunset in July 2035.

Lottery sales began July 1, 1981, with a single \$1 “Scratch it Rich” instant game that sold 21.4 million tickets in ten days! Instant ticket games remained the only product until 1984 when the Lottery introduced its first online (draw) game, The Pick. Over the years, additional draw games have periodically been introduced and the number of instant ticket games has grown significantly. The Lottery currently offers seven draw games and has more than 50 instant ticket games in market each year. As a result of legislation in the 2010 Legislative Session, the Lottery also became the provider of instant tab games that are sold by charitable organizations. These organizations earned approximately \$1 million in commissions to help support charitable activities in FY15. Legislation passed in the 2015 Legislative Session authorized the Lottery to sell game products in age-restricted locations, with \$1 million of proceeds allocated to the Internet Crimes Against Children Fund and the Victim’s Rights Enforcement Fund.

Since its inception, the Lottery’s mandate has been to maximize net revenue consonant with the dignity of the state. The Lottery is overseen by an Executive Director appointed by the Governor, in addition to a five-member Commission, also appointed by the Governor. The Lottery is entirely self-supporting, receiving no monies from the state general fund. The Lottery sells products and

redeems prizes through a state-wide network of approximately 2700 licensed retailers, who receive a commission on each ticket sold.

A portion of Lottery proceeds is appropriated to pay for Lottery operating costs, and at least 50% of revenues must be utilized for payment of prizes. Remaining Lottery funds are statutorily directed to various benefiting funds including the state general fund. In FY10, the State issued bonds against future Lottery revenues in the amount of \$450 million. As a result, the Lottery is responsible for meeting bond debt service payments through 2029, in addition to traditional beneficiary obligations.

The Lottery has achieved record sales levels in recent years. In fiscal year 2016, total sales exceeded \$870 million and transfers to statutory beneficiaries totaled \$205,828,826.

## **OVERVIEW OF 5-YEAR REVIEW**

A.R.S. § 5-554 requires the Commission to authorize the Lottery Director to adopt rules in accordance with Title 41, Chapter 6. As set forth in A.R.S. § 5-554, rules adopted may include matters necessary or desirable for the efficient and economical operation and administration of the Lottery.

The review of these rules was conducted by Arizona Lottery sales, marketing, claims and legal staff. The rules were reviewed for internal consistency, conformity with Lottery and other statutes, and for overall clarity. The Lottery proposes to retain the majority of the rules as written since they remain consistent with Arizona statute, are consistently enforced, and are sufficiently clear and understandable. These rules continue to protect the interests of Lottery retailers, players, and the state of Arizona. The Lottery will request an exemption in order to complete the amendments, but recognizes that it may not sufficiently meet the requirements set forth in the Executive Order.

## **INFORMATION THAT IS IDENTICAL FOR ALL THE RULES**

**3. Written criticisms:**

No written criticisms of the rules have been received in the last five years.

**4. Statutory authority:**

General: A.R.S. § 5-554(B).

Specific: A.R.S. § 5-554 (C).

**7. Economic, small business and consumer impact comparison:**

These rules provide for the effective management of instant ticket products and allow the Lottery to introduce new instant games in a timely manner, thus providing the State and licensed retailers with the potential to increase sales revenue. These rules allow the Lottery to introduce new instant games in a timely manner, thus providing licensed retailers with a potential increase in sales revenue.

**8. Analysis submitted by another person regarding business competitiveness:**

No person has submitted an analysis to the agency that compares the rules' competitive impact on businesses in this state compared to the competitive impact on businesses in other states.

**9. Previous five-year review:**

This is the first five year rule review for these rules.

**10. Burden and costs to persons regulated by the rule:**

While the review report notes that some individual rules can be improved, the agency believes the rules as a whole impose the least burden and cost to persons regulated by the rules. These rules describe provisions related to the operation of the Lottery's instant game product, which serve to protect the interests of the Lottery, players, and the state. Operational costs are included in the agency's budget and player participation is voluntary.

**11. Stringency of the rule compared to corresponding federal law:**

There are no federal laws applicable to these rules.

**12. Compliance with § 41-1037 regarding the issuance of permits:**

Not applicable. These rules pertain to provisions for the instant game product and do not require the issuance of a regulatory permit, license, or agency authorization.

## ANALYSIS OF INDIVIDUAL RULES

### **R19-3-701. Definitions**

**1. Objective:**

The rule defines and clarifies terms that are not self-evident and ensures consistent interpretation of Article requirements.

**2. Effectiveness:**

The rule ensures that retailers and players understand terms that may not be self-evident and/or are Lottery-specific.

**5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable.

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

The agency plans to amend paragraph 8 by removing the words “within the validation number.” Depending on the game, the PIN may be located in different areas, so this amendment will reflect current practice. The Lottery also plans to remove paragraph 13, which defines retailer validation code. The Lottery has discontinued the use of a retailer validation code.

## **R19-3-702. Game Profile**

**1. Objective:**

The rule requires that each instant game have a game profile and sets forth the game profile requirements. The rule also requires that the Lottery Commission approve the profile before the game is sold to the public.

**2. Effectiveness:**

The rule ensures that all games have consistent game profiles that are reviewed and approved by the Lottery Commission.

**5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

The Lottery plans to remove paragraphs 6 and 10 from section A. The Lottery no longer uses retailer validation codes, and prize draw eligibility requirements are contained in the promotion profile, not the game profile.

**R19-3-703. Game Playstyle**

**1. Objective:**

The rule requires that the playstyle for an individual game be described in the game profile and sets forth the allowed the methods of play.

**2. Effectiveness:**

The rule informs players regarding the playstyles that can be used for instant games.

**5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

None.

**R19-3-704. Determination of a Winning Ticket**

**1. Objective:**

The rule informs players how a winning ticket is determined for each playstyle.

**2. Effectiveness:**

The rule ensures that players know how to win an instant game prize for a particular playstyle.

**5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

None.

## **R19-3-705. Ticket Validation and Confirmation Requirements**

**1. Objective:**

The rule requires that an instant game ticket be validated prior to payment of a prize. The rule informs players of prize eligibility requirements and that tickets that fail to meet the listed requirements are not eligible for prize payout.

**2. Effectiveness:**

The rule ensures that players understand the requirements for ticket validation and confirmation.

**5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

The Lottery plans to remove “retailer validation code” from paragraph C.1. The Lottery has discontinued the use of retailer validation codes.

## **R19-3-706. Ticket Ownership and Responsibility; Prize Payment**

**1. Objective:**

The rule informs players that until a ticket is signed it is owned by its physical possessor and outlines how the Director should determine the owner of a winning ticket. It also sets forth the procedures the Lottery must follow to determine whether a claimant owes a debt to a state agency and ensure that the set-off is paid. It also sets forth how the Lottery may pay prizes.

**2. Effectiveness:**

The rule ensures that players understand the parameters of ticket ownership and prize payment.

**5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable.

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

To conform with current practice, the Lottery plans to amend paragraph D to add “debit, electronic transfer, and gift card” as acceptable forms of payment.

**R19-3-707. Claim Period**

**1. Objective:**

The rule informs players of the time period that an instant game winning ticket is valid and may be claimed. It also informs players that the end of an instant game is determined by the Director.

**2. Effectiveness:**

The rule ensures that players understand that a prize must be claimed within the claim period.

**5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

None.

**R19-3-708. Procedure for Claiming Prizes**

**1. Objective:**

The rule sets forth the procedures for claiming a prize on a winning instant ticket and requires licensed retailers to pay winners up to and including \$100. In the event a prize winner dies prior to receiving full payment, the rule requires the Lottery to pay all remaining prize money to the prize winner's beneficiary or any person designated by a judicial order.

**2. Effectiveness:**

The rule ensures that players understand how a prize can be claimed and that retailers understand their obligation to pay prizes. It also ensure that the Lottery fully pays all prizes, even in circumstances where the winner dies before receiving full payment.

**5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

The Lottery plans to amend paragraph A to reflect that a licensed retailer may pay all claims up to and including \$100.” The rule currently requires retailer to pay all claims up to \$100. This change is consistent with the Lottery's current practice.

**R19-3-709. Disputes Concerning a Ticket**

**1. Objective:**

The rule sets forth, and informs players about, the available remedies in the event of a dispute involving an instant ticket.

**2. Effectiveness:**

The rule protects the Lottery from liability.

**5. Consistency with statutes and rules:**

The rule is consistent with Lottery rules and Arizona statutes.

**6. Clarity, conciseness and understandability:**

The rule is generally clear, concise and understandable

**13. Enforcement:**

The rule is consistently enforced.

**14. Proposed course of action:**

None.

effective November 21, 2016 (Supp. 16-4).

**R19-3-569. Guidance**

If a procedure is not provided by these rules, the procurement officer may issue a written determination using for guidance A.R.S. § 41-2501 through § 41-2591 or 2 A.A.C. 7, including, but not limited to a procurement utilizing a cooperative contract.

**Historical Note**

New Section R19-3-569 renumbered from R19-3-568 and amended by final rulemaking at 22 A.A.R. 2966, effective November 21, 2016 (Supp. 16-4).

**ARTICLE 6. ANNUITY ASSIGNMENTS**

**R19-3-601. Voluntary Assignment of Prizes Paid in Installments**

- A. A prize winner may request a voluntary assignment of an annuity or a portion of the remaining installments of the annuity by filing an action in a court of competent jurisdiction requesting judicial approval of the assignment. The prize winner and the purchaser of the annuity shall name the state of Arizona as a defendant in the action and shall bear all costs associated with filing the request for judicial approval of the assignment.
- B. A prize winner shall include in the request for judicial approval under subsection (A) the following:
  1. The affidavit required under A.R.S. § 5-563(A)(3);
  2. A copy of the signed assignment agreement between the prize winner and the assignee; and
  3. Proof that the fee under subsection (D) has been paid to the Lottery.
- C. After the court approves the assignment, the prize winner shall send the written judicial approval to the Lottery. Upon receipt of judicial approval of the voluntary assignment, the Director shall direct the insurance company to make future annuity payments as provided in the Court order.
- D. The prize winner or assignee shall pay a fee of \$235.00 to the Lottery to process the voluntary assignment.

**Historical Note**

Adopted as an emergency effective October 31, 1986, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 86-5). Adopted without change as a permanent rule effective February 25, 1987 (Supp. 87-1). Amended effective May 7, 1993 (Supp. 93-2). R19-3-601 recodified from R4-37-601 (Supp. 95-1). Repealed effective June 14, 1997 (Supp. 97-2). New Section made by final rulemaking at 11 A.A.R. 2028, effective July 2, 2005 (Supp. 05-2). Pursuant to authority of A.R.S. § 41-1011(C), Laws 2010, 6th Special Session, Ch. 2, authorizes the transfer of A.R.S. citations. Therefore the A.R.S. citation in subsection (B)(1) was updated. Agency request filed September 24, 2012, Office File No. M12-343 (Supp. 12-3).

**ARTICLE 7. DESIGN AND OPERATION OF INSTANT GAMES**

**R19-3-701. Definitions**

In this Article, unless the context otherwise requires:

1. "Caption" means the printed characters appearing below a play symbol or prize symbol that verify and correspond with that symbol. No more than one caption will appear under a symbol.
2. "Game profile" means the written document in which the Lottery Commission authorizes the Director to issue an order that contains all of the non-confidential game fundamentals required by these rules for an instant game.

3. "Instant game" means a game that is played by removing the protective covering from a ticket to reveal the play symbols, or prize symbols, or both that determine if a ticket holder is entitled to a prize or prizes.
4. "Instant scratch game" means an instant game where the protective covering is made of latex or another substance that is scratched off.
5. "Instant tab game" means an instant game where the protective covering is a perforated paper tab that is opened.
6. "Pack" means a group of tickets bearing a common identification number.
7. "Pack-ticket number" means a unique multi-digit number that includes a game number, a pack number, and a ticket number which distinguishes each ticket from every other ticket within an instant game.
8. "PIN" means the designated characters within the validation number that allows an on-line terminal to validate an instant ticket.
9. "Play area" means the portion or portions of the ticket which contains the play symbol or symbols. More than one play area may appear on a ticket.
10. "Play symbols" means the printed image or images that appear within the defined play area of the ticket that determine if the ticket holder is entitled to a prize or prizes.
11. "Prize structure" means the estimated number of prizes, prize values, and odds of winning prizes for an individual game.
12. "Prize symbol" means the printed image or images that indicates the prize or prizes available in that game.
13. "Retailer validation code" means the multiple letters in the play area, under the protective covering that verify prizes less than \$600.
14. "Validation code" means the unique multi-positional code on each ticket that is used to authenticate winning tickets.

**Historical Note**

Adopted effective October 25, 1996 (Supp. 96-4). Amended by final rulemaking at 13 A.A.R. 1031, effective April 27, 2007 (Supp. 07-1). Amended by final rulemaking at 17 A.A.R. 53, effective December 28, 2010 (Supp. 10-4).

**R19-3-702. Game Profile**

- A. Each game shall have a Game Profile and at a minimum, the Profile shall contain the following information:
  1. Game name;
  2. Game number;
  3. Prize structure;
  4. Game Playstyle;
  5. Play symbols;
  6. Retailer validation codes, if any;
  7. Special features, if any;
  8. Retail sales price;
  9. How to play and win instructions; and
  10. Prize draw eligibility requirements, including filing period for eligibility in a winners drawing, if applicable.
- B. The Commission shall approve the individual Game Profile prior to the game being sold to the public.

**Historical Note**

Adopted effective October 25, 1996 (Supp. 96-4). Amended by final rulemaking at 13 A.A.R. 1031, effective April 27, 2007 (Supp. 07-1). Amended by final rulemaking at 17 A.A.R. 53, effective December 28, 2010 (Supp. 10-4).

**R19-3-703. Game Playstyle**

- A. The playstyle for an individual game shall be fully described in the Game Profile and shall be one of the following methods of play unless a different method is prescribed by another rule:
1. Match Two,
  2. Match Three,
  3. Add-up,
  4. Tic-Tac-Toe,
  5. Key Symbol or Symbols Match,
  6. Key Symbol or Symbols Beat,
  7. Symbols in Sequence,
  8. Spell Outs,
  9. In Between,
  10. Bingo,
  11. Pattern,
  12. Legend,
  13. Coordinates,
  14. Find,
  15. Maze,
  16. Grid,
  17. Elimination,
  18. Sets.
- B. More than one game and more than one playstyle may appear on a ticket.

**Historical Note**

Adopted effective October 25, 1996 (Supp. 96-4).  
Amended by final rulemaking at 13 A.A.R. 1031, effective April 27, 2007 (Supp. 07-1).

**R19-3-704. Determination of a Winning Ticket**

- A. The play symbols are the only determining factor for prize eligibility for a valid ticket.
- B. For each play area on an individual ticket, the player shall remove the protective covering to find the play symbols, or the play and prize symbols. Eligibility to win a prize is based on compliance with the designated playstyle as follows:
1. Match Two. The player shall win the prize or prizes indicated by uncovering two identical play symbols on a play area.
  2. Match Three. The player shall win the prize or prizes indicated by uncovering three identical play symbols on a play area.
  3. Add-Up. The player shall win the prize or prizes indicated in either of the following ways:
    - a. The player adds up the play symbols and the amount is greater than or equal to the designated key symbol on the ticket, or
    - b. The player adds up the play symbols designated for the player and the total is greater than or equal to the control key symbol or symbols.
  4. Tic-Tac-Toe. The player shall win the prize or prizes indicated by uncovering three identical play symbols, in any row, or any column, or any diagonal, on a multi-symbol grid on the play area.
  5. Key Symbol or Symbols Match. The player shall win the prize or prizes indicated by uncovering the play symbol or symbols identical to the designated key play symbol or symbols.
  6. Key Symbol or Symbols Beat. The player shall win the prize or prizes indicated by uncovering the play symbol or symbols designated for the player in the ticket play area which is greater than the control play symbol or symbols.
  7. Symbols in Sequence. The player shall win the prize or prizes indicated by uncovering the designated play symbols in the specified sequential order.
  8. Spell Outs. The player shall win the prize or prizes indicated by uncovering the play symbols to form the designated word or words.
  9. In Between. The player shall win the prize or prizes indicated by uncovering the play symbol or symbols designated for the player with a value less than the highest control play symbol or symbols and greater than the play lowest control play symbol or symbols.
  10. Bingo. The player shall win the prize or prizes indicated by uncovering the play symbols on the designated play area or areas that are identical to the play symbols uncovered on the control play area to form the specified pattern or patterns.
  11. Pattern. The player shall win the prize or prizes indicated by uncovering the play symbol or symbols on a multi-symbol play area that follow a designated pattern.
  12. Legend. The player shall win the prize or prizes indicated by uncovering the designated number or type of play symbols that correspond to a legend.
  13. Coordinates. The player shall win the prize or prizes indicated by uncovering a play symbol or symbols that direct the player to a location on the play area to reveal the specified play symbol, or the number or pattern of play symbols.
  14. Find. The player shall win the prize or prizes indicated by uncovering the designated play or prize symbol.
  15. Maze. The player shall win the prize or prizes indicated by uncovering the directional symbols to make a path or paths leading to a designated prize symbol.
  16. Grid. The player shall win the prize or prizes indicated by uncovering a specified number or pattern of play symbols on a grid on the play area.
  17. Elimination. The player shall win the prize indicated by uncovering the corresponding prize or symbol on a prize table to eliminate all but one remaining prize amount or symbol.
  18. Sets. The player shall win the prize or prizes indicated by uncovering the designated group or groups of play symbols, without repetition or deletion of any play symbol, within a specified location of the play area.
- C. Each of the playstyles described in subsection (B) may include one or more special features such as "automatic win," "multiplier," "wild," "win all," "extra chance," or "free space" that provides an added or alternative method of winning.

**Historical Note**

Adopted effective October 25, 1996 (Supp. 96-4).  
Amended by final rulemaking at 13 A.A.R. 1031, effective April 27, 2007 (Supp. 07-1).

**R19-3-705. Ticket Validation and Confirmation Requirements**

- A. Each instant game ticket shall be validated prior to payment of a prize.
- B. To be eligible for a prize, a ticket holder shall present a ticket meeting all of the following requirements:
1. The ticket shall not be stolen or appear on any list of omitted tickets on file with the Lottery;
  2. The ticket shall not be counterfeit or forged, in whole or in part;
  3. The ticket shall not be mutilated, altered, unreadable, reconstituted, or tampered with in any manner;
  4. The ticket shall not be blank, partially blank, misregistered, defective, or printed or produced in error;
  5. The play and prize symbols shall have the captions that confirm and agree with those applicable to that instant game;

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6. The ticket shall have been issued by the Lottery in an authorized manner;
  7. The ticket shall have been legally obtained;
  8. The ticket shall pass all other confidential validation tests determined by the Director;
  9. The ticket shall be validated in accordance with the provisions of R19-3-706 and R19-3-708;
  10. The display printed on the ticket shall correspond precisely with the approved artwork on file at the Lottery;
  11. All of the ticket symbols originally printed on the ticket shall appear in the play area on the ticket and shall correspond to those shown in the Game Profile; and
  12. The play and prize symbols shall have the required captions that confirm and agree with those of the appropriate instant game.
- C.** In addition to the requirements in subsection (B), each instant scratch game ticket shall meet the following:
1. The ticket shall contain a game number, a pack-ticket number, a retailer validation code, and where applicable, a PIN number, and at least one ticket validation code; and
  2. The validation code of a winning ticket shall appear in the Lottery's official file of validation codes of winning tickets and shall not have been previously paid.
- D.** In addition to the requirements in subsection (B), each instant tab game ticket shall meet the following:
1. The ticket shall contain a game number and a serial number, and
  2. A winning tab ticket shall contain the necessary prize and win symbol captions to enable visual confirmation of a prize.
- E.** If the ticket fails to pass any of the requirements in subsections (B) and (C) for instant scratch games, or subsections (B) and (D) for instant tab games, the ticket is void and ineligible for any prize payout.
- ticket owner or holder until such time as the Director is satisfied that the proper person is being paid.
- C.** Prior to paying the claimant a prize of \$600 or more, the Lottery shall match the winner's name against the lists of persons owing a debt to a participating state agency, furnished to the Lottery under A.R.S. § 5-575.
1. If there is a match on any of the claims submitted with a ticket, the amount that is owed shall be deducted from the prize due the claimant.
  2. The claimant shall be notified in writing of the amount of the setoff and the agency to which it shall be paid.
  3. If the claimant has two or more agencies which are owed a debt, the Lottery shall pay a pro-rata share to each of the agencies, except that a Department of Economic Security overdue child support setoff shall be paid in full before any amount shall be paid to another agency.
  4. The claimant shall be notified in writing that a right to appeal the setoff exists. The notification shall include the name and address of the agency with which to file the appeal and that the appeal shall commence within 30 days of receipt of the notification.
  5. If, after deducting withholding taxes and the setoff, a portion of the prize remains, then that portion shall be paid to the winner with the notification of setoff.
  6. The setoff amount shall be forwarded to the agency, and that agency shall be responsible for any appeal and crediting of the payment against the amount owed or refunding any amount to the winner.
  7. Upon a determination that a setoff is due, the winner loses the right under subsection (B)(2) to assign any portion of the claim.
- D.** Prizes shall be paid by cash, check, money order, or if requested by the player, by Lottery tickets.
1. If a ticket contains more than one winning game play, any prize amounts shall be combined and paid in accordance with the prize payment limits specified in R19-3-708.
  2. Each winning game play wins the prize amount specified in the Game Profile.
- E.** The Lottery is not responsible for lost or stolen tickets.

**Historical Note**

Adopted effective October 25, 1996 (Supp. 96-4).  
Amended by final rulemaking at 13 A.A.R. 1031, effective April 27, 2007 (Supp. 07-1). Amended by final rulemaking at 17 A.A.R. 53, effective December 28, 2010 (Supp. 10-4).

**R19-3-706. Ticket Ownership and Responsibility; Prize Payment**

- A.** Until a ticket is signed, the ticket is owned by its physical possessor.
- B.** The owner of a winning instant ticket is the person whose signature appears upon the ticket, if an area has been designated for that purpose.
1. If more than one signature appears on the ticket, the Director is authorized to require that one or more of those claimants be designated to receive the payment. A claim form shall be submitted by each claimant who is designated to receive a portion of the prize claimed from the winning ticket.
  2. Prior to payment of a prize, a claimant who has signed the ticket may designate another claimant to receive the prize by signing a relinquishment of claim statement.
  3. When the winning ticket was purchased by a group of players, the group shall designate one of the claimants to sign the ticket for the group. Each claimant shall complete an individual claim form to receive the claimant's portion of the prize.
  4. In the event there is an inconsistency in the information submitted on a claim form, when required, and as shown on the winning instant ticket, the Director shall authorize an investigation and withhold all winnings payable to the

**Historical Note**

Adopted effective October 25, 1996 (Supp. 96-4).  
Amended by final rulemaking at 13 A.A.R. 1031, effective April 27, 2007 (Supp. 07-1). Amended by final rulemaking at 17 A.A.R. 53, effective December 28, 2010 (Supp. 10-4). Pursuant to authority of A.R.S. § 41-1011(C), Laws 2010, 6th Special Session, Ch. 2, authorizes the transfer of A.R.S. citations. Therefore the A.R.S. citation in subsection (C) was updated. Agency request filed September 24, 2012, Office File No. M12-343 (Supp. 12-3).

**R19-3-707. Claim Period**

- A.** For the claimant to receive payment, a winning instant scratch game ticket shall be received by the Lottery or a retailer no later than 5:00 p.m. (Phoenix time) on the 180th calendar day following the announced end of the instant game.
1. If a claimant presents a valid winning instant scratch ticket to a retailer for payment on the 180th calendar day following the announced end of the instant scratch game and is not paid the prize, the Director is authorized to pay the prize if the claimant presents the valid winning ticket to the Lottery no later than 5:00 p.m. (Phoenix time) on the following business day.
  2. In the case of a drawing prize associated with an instant scratch game, the claimant shall claim the prize no later

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than 5:00 p.m. (Phoenix time) on the final day designated by the Director and on file at the Lottery.

- B.** The end of an instant game shall be designated by the Director and on file at the Lottery.

**Historical Note**

Adopted effective October 25, 1996 (Supp. 96-4). Amended by final rulemaking at 13 A.A.R. 1031, effective April 27, 2007 (Supp. 07-1). Amended by final rulemaking at 17 A.A.R. 53, effective December 28, 2010 (Supp. 10-4).

**R19-3-708. Procedure for Claiming Prizes**

- A.** To claim an instant scratch ticket prize of up to and including \$599, the claimant shall present the ticket to any participating licensed retailer or to a Lottery office, or mail the ticket to a Lottery office for validation. The licensed retailer shall pay all winning prizes up to and including \$100 and may pay all winning prizes from \$101 up to and including \$599 provided that:
1. All of the ticket validation criteria in Section R19-3-705 have been satisfied; and
  2. A proper validation slip, which is an authorization to pay, has been generated by the terminal.
- B.** To claim an instant scratch ticket prize that the retailer does not validate or is not authorized to pay, including all prizes of \$600 or more, the claimant shall submit a claim form, available from any retailer, and the ticket to the Lottery. If the claim is:
1. Verified and validated by the Lottery as a winning ticket, the Lottery shall make payment of the amount due to the claimant, less any authorized debt setoff amounts, or withheld taxes, or both.
  2. Denied by the Lottery, the claimant shall be notified within 15 days from the day the claim is received in the Lottery office.
- C.** If an instant scratch ticket prize winner dies prior to receiving full payment, the Lottery shall pay all remaining prize money to the prize winner's beneficiary or to any person designated by an appropriate judicial order.
- D.** To claim an instant tab ticket prize, the claimant shall present the ticket to the selling retailer. The selling retailer shall pay all winning prizes provided that:
1. All of the ticket validation criteria in R19-3-705(A) and (B)(1) through (8) have been satisfied; and
  2. The retailer has performed a visual confirmation of the winning play, prize, and win symbol captions.
- E.** Payment of prize money shall not be accelerated ahead of its normal date of payment.
- F.** The Lottery is discharged of all liability upon payment of the instant scratch ticket prize money.
- G.** The retailer has sole responsibility to pay prizes on instant tab tickets. The Lottery is discharged of all liability to pay prizes on instant tab tickets.

**Historical Note**

Adopted effective October 25, 1996 (Supp. 96-4). Amended by final rulemaking at 13 A.A.R. 1031, effective April 27, 2007 (Supp. 07-1). Amended by final rulemaking at 17 A.A.R. 53, effective December 28, 2010 (Supp. 10-4).

**R19-3-709. Disputes Concerning a Ticket**

- A.** If a dispute between the Lottery and a claimant occurs concerning a ticket, the Director is authorized to replace the disputed ticket with a ticket or tickets of equivalent sales price from any current instant game.

- B.** If a defective ticket is purchased, the Lottery shall replace the defective ticket with a ticket or tickets of equivalent sales price from any current instant game.
- C.** Replacement of the disputed ticket is the sole and exclusive remedy for a claimant.
- D.** If a dispute between the Lottery and a claimant occurs concerning the eligibility of an entry into a grand prize, second chance or promotional drawing, the Director is authorized to place any person's eligible entry that was not entered in that drawing into any subsequent drawing or drawings.

**Historical Note**

Adopted effective October 25, 1996 (Supp. 96-4). Amended by final rulemaking at 13 A.A.R. 1031, effective April 27, 2007 (Supp. 07-1). Amended by final rulemaking at 17 A.A.R. 53, effective December 28, 2010 (Supp. 10-4).

**ARTICLE 8. RESERVED****ARTICLE 9. RESERVED****ARTICLE 10. PROMOTIONS****R19-3-1001. Definitions**

In this Article, unless the context otherwise requires:

1. "Category" means player, consumer, retailer, vendor, or other person who participates in the promotion.
2. "Charitable organization" means a non-profit organization organized and operated exclusively for charitable purposes and is qualified under § 502(c)(3) of the United States Internal Revenue Code.
3. "Media" means the method of communication, as in television, radio, print, outdoor, or Internet, with wide reach and influence.
4. "Prize type" means cash, free ticket or tickets, coupon or coupons, merchandise, retailer or vendor product or service, or discount on retailer or vendor product or service.
5. "Promotion" means a program designed to increase awareness of the Lottery, Lottery beneficiaries, and Lottery games that is intended to increase the sale of Lottery tickets to produce the maximum amount of net revenue for the state.
6. "Promotion playstyle" means the type of process or procedure used to control the promotion.
7. "Promotion Profile" means the written document in which the Lottery Commission authorizes the Director to issue an order that contains all of the non-confidential promotion fundamentals required by these rules for a promotion.
8. "Promotional merchandise" means Lottery related goods, consumer products, or services provided by the Lottery for use in a promotion.
9. "Promotional ticket" means a Lottery ticket from a current, active game or a specially designed game provided by the Lottery for use in a promotion.
10. "Targeted game or targeted games" means the specific game or games a promotion is intended to increase sales or awareness of.
11. "Tickets" means one or more Lottery game plays from the targeted game or games.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 1077, effective March 3, 2000 (Supp. 00-1). Amended by final rulemaking at 13 A.A.R. 2775, effective September 15, 2007 (Supp. 07-3).

**R19-3-1002. Promotion Profile**

5-554. Commission; director; powers and duties; definitions

A. The commission shall meet with the director not less than once each quarter to make recommendations and set policy, receive reports from the director and transact other business properly brought before the commission.

B. The commission shall oversee a state lottery to produce the maximum amount of net revenue consonant with the dignity of the state. To achieve these ends, the commission shall authorize the director to adopt rules in accordance with title 41, chapter 6. Rules adopted by the director may include provisions relating to the following:

1. Subject to the approval of the commission, the types of lottery games and the types of game play-styles to be conducted.
2. The method of selecting the winning tickets or shares for noncomputerized online games, except that no method may be used that, in whole or in part, depends on the results of a dog race, a horse race or any sporting event.
3. The manner of payment of prizes to the holders of winning tickets or shares, including providing for payment by the purchase of annuities in the case of prizes payable in installments, except that the commission staff shall examine claims and may not pay any prize based on altered, stolen or counterfeit tickets or based on any tickets that fail to meet established validation requirements, including rules stated on the ticket or in the published game rules, and confidential validation tests applied consistently by the commission staff. No particular prize in a lottery game may be paid more than once, and in the event of a binding determination that more than one person is entitled to a particular prize, the sole remedy of the claimants is the award to each of them of an equal portion of the single prize.
4. The method to be used in selling tickets or shares, except that no elected official's name may be printed on such tickets or shares. The overall estimated odds of winning some prize or some cash prize, as appropriate, in a given game shall be printed on each ticket or share.
5. The licensing of agents to sell tickets or shares, except that a person who is under eighteen years of age shall not be licensed as an agent.
6. The manner and amount of compensation to be paid licensed sales agents necessary to provide for the adequate availability of tickets or shares to prospective buyers and for the convenience of the public, including provision for variable compensation based on sales volume.
7. Matters necessary or desirable for the efficient and economical operation and administration of the lottery and for the convenience of the purchasers of tickets or shares and the holders of winning tickets or shares.

C. The commission shall authorize the director to issue orders and shall approve orders issued by the director for the necessary operation of the lottery. Orders issued under this subsection may include provisions relating to the following:

1. The prices of tickets or shares in lottery games.
2. The themes, game play-styles, and names of lottery games and definitions of symbols and other characters used in lottery games, except that each ticket or share in a lottery game shall bear a unique distinguishable serial number.
3. The sale of tickets or shares at a discount for promotional purposes.
4. The prize structure of lottery games, including the number and size of prizes available. Available prizes may include free tickets in lottery games and merchandise prizes.
5. The frequency of drawings, if any, or other selections of winning tickets or shares, except that:
  - (a) All drawings shall be open to the public.
  - (b) The actual selection of winning tickets or shares may not be performed by an employee or member of the

commission.

(c) Noncomputerized online game drawings shall be witnessed by an independent observer.

6. Requirements for eligibility for participation in grand drawings or other runoff drawings, including requirements for the submission of evidence of eligibility within a shorter period than that provided for claims by section 5-568.

7. Incentive and bonus programs designed to increase sales of lottery tickets or shares and to produce the maximum amount of net revenue for this state.

8. The method used for the validation of a ticket, which may be by physical or electronic presentation of a ticket.

D. Notwithstanding title 41, chapter 6 and subsection B of this section, the director, subject to the approval of the commission, may establish a policy, procedure or practice that relates to an existing online game or a new online game that is the same type and has the same type of game play-style as an online game currently being conducted by the lottery or may modify an existing rule for an existing online game or a new online game that is the same type and has the same type of game play-style as an online game currently being conducted by the lottery, including establishing or modifying the matrix for an online game by giving notice of the establishment or modification at least thirty days before the effective date of the establishment or modification.

E. The commission shall maintain and make the following information available for public inspection at its offices during regular business hours:

1. A detailed listing of the estimated number of prizes of each particular denomination expected to be awarded in any instant game currently on sale.

2. After the end of the claim period prescribed by section 5-568, a listing of the total number of tickets or shares sold and the number of prizes of each particular denomination awarded in each lottery game.

3. Definitions of all play symbols and other characters used in each lottery game and instructions on how to play and how to win each lottery game.

F. Any information that is maintained by the commission and that would assist a person in locating or identifying a winning ticket or share or that would otherwise compromise the integrity of any lottery game is deemed confidential and is not subject to public inspection.

G. The commission, in addition to other games authorized by this article, may establish multistate lottery games to be conducted concurrently with other lottery games authorized under subsection B of this section. The monies for prizes, for operating expenses and for payment to the state general fund shall be accounted for separately as nearly as practicable in the lottery commission's general accounting system. The monies shall be derived from the revenues of multistate lottery games.

H. The commission, in addition to other games authorized by this article, shall establish special instant ticket games with play areas protected by paper tabs designated for use by charitable organizations. The monies for prizes and for operating expenses shall be accounted for separately as nearly as practicable in the lottery commission's general accounting system. Monies saved from the revenues of the special games, by reason of operating efficiencies, shall become other revenue of the lottery commission and revert to the state general fund, except that the commission shall transfer the proceeds from any games that are sold from a vending machine in an age-restricted area to the state treasurer for deposit in the following amounts:

1. Nine hundred thousand dollars each fiscal year in the internet crimes against children enforcement fund established by section 41-199.

2. One hundred thousand dollars each fiscal year in the victims' rights enforcement fund established by section 41-1727.

3. Any monies in excess of the amounts listed in paragraphs 1 and 2 of this subsection, in the state lottery fund established by section 5-571.

I. The commission or director shall not establish or operate any online or electronic keno game or any game played on the internet.

J. The commission or director shall not establish or operate any lottery game or any type of game play-style, either individually or in combination, that uses gaming devices or video lottery terminals as those terms are used in section 5-601.02, including monitor games that produce or display outcomes or results more than once per hour.

K. The director shall print, in a prominent location on each lottery ticket or share, a statement that help is available if a person has a problem with gambling and a toll-free telephone number where problem gambling assistance is available. The director shall require all licensed agents to post a sign with the statement that help is available if a person has a problem with gambling and the toll-free telephone number at the point of sale as prescribed and supplied by the director. The requirements of this subsection apply to tickets and shares printed after July 18, 2000.

L. For the purposes of this section:

1. "Charitable organization" means any nonprofit organization, including not more than one auxiliary of that organization, that has operated for charitable purposes in this state for at least two years before submitting a license application under this article.

2. "Game play-style" means the process or procedure that a player must follow to determine if a lottery ticket or share is a winning ticket or share.

3. "Matrix" means the odds of winning a prize and the prize payout amounts in a given game.