

NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by 1st submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication.

Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for adoption, amendment, or repeal of any rule. A.R.S. §§ 41-1013 and 41-1022.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

PREAMBLE

- Sections Affected**

	Rulemaking Action
R9-22-342	Amend
R9-22-701	Amend
R9-22-702	Amend
R9-22-703	Amend
R9-22-705	Amend
R9-22-706	Amend
R9-22-707	Amend
R9-22-709	Amend
R9-22-710	Amend
R9-22-711	Amend
R9-22-715	Amend
R9-22-717	Amend
- The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

Authorizing statute: A.R.S. § 36-2903.01(H)

Implementing statutes: A.R.S. §§ 36-2903(N); 36-2903.01(F), (J), (K), (L), (N), and (O); 36-2904(A), (B), (C), (D), (G), (H), (I), (J), (K), and (M); 36-2908; 36-2909; and 41-1005(A)(9).
- The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name: Cheri Tomlinson

Address: AHCCCS
801 East Jefferson, MD4200
Phoenix, Arizona 85034

Telephone: 602-417-4198

Fax: 602-256-6756
- An explanation of the rule, including the agency's reasons for initiating the rule:**

The changes proposed for R9-22-342 simplify the process for determining the effective date for capitation payments made for newborns born to enrolled members. Beginning October 1, 1997, the effective date for capitation payments for newborns will be the date the Administration receives notification from the contractor.

The proposed rules to Article 7 resulted from a 5-year review report which identified non-substantive revisions which would make the language more clear, concise, and understandable. In addition, these proposed rules reflect an administrative policy change that requires the contractors, effective October 1, 1997, to be responsible for medically necessary services provided to members back to the date of eligibility.

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

Not applicable.

6. **The preliminary summary of the economic, small business, and consumer impact:**

The economic impact of R9-22-342 is zero to minimal for persons directly affected. The proposed changes simplify the process by which the effective date for capitation payments made on behalf of newborns born to enrolled members is determined, and continue to provide contractors the opportunity to receive capitation payments effective from the date of birth. This simplification will be beneficial to the Administration.

The impact of the proposed changes to the 11 sections in Article 7 R9-22-701 through R9-22-703, R9-22-705 through R9-22-707, R9-22-709 through R9-22-711, R9-22-715, and R9-22-717 will result in:

- Deleting the reference to deferred liability. As of October 1, 1994, deferred liability coverage is included in contractor capitation rates.
- Deletion of language regarding hospital payment methodology for dates of service prior to March 1, 1993.
- Addition of copayment requirements for non-emergency use of emergency transportation, pursuant to SB 1283.
- Exclusion of many hospital payment requirements for hospitals and contractors participating in the managed care pilot program.
- Addition of language regarding retroactive period coverage responsibilities for contractors. Effective October 1, 1997, contractors will be responsible for medically necessary services provided to members back to the date of eligibility. Coverage for these services will be included in contractor capitation rates.
- Modification of language to enhance clarity and conciseness of the rule language.

The impact of the proposed changes are minimal. The revisions proposed in this package do not change the payment rates or payment methodology for services provided to AHCCCS eligible persons and members. This proposed revision will potentially benefit all persons directly affected by the rule (e.g., Arizona Health Care Cost Containment System (AHCCCS), Department of Economic Security (DES), providers, contractors, and taxpayers) by enhancing the clarity and conciseness of the rule language.

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

Name: Cheri Tomlinson
Address: AHCCCS
801 East Jefferson, MD4200
Phoenix, Arizona 85034
Telephone: (602) 417-4198
Fax: (602) 256-6756

8. **The time, place, and nature of the proceedings for the adoption, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:**

A public hearing will be held in Phoenix on May 23, 1997, at 9 a.m. The public hearing will be held at the AHCCCS Administration, Gold Room, 3rd Floor, 701 East Jefferson, Phoenix, Arizona. A person may submit written comments on the proposed rules. The written comments should be submitted no later than 5 p.m., May 23, 1997, to the following person:

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

Not applicable.

10. **Incorporation by reference and their location in the rules:**

42 CFR 447.205 - R9-22-710(B)
42 CFR 447.331-332 - R9-22-710(B)

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

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TITLE 9. HEALTH SERVICES

**CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
ADMINISTRATION**

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-22-342. Newborn Enrollment

ARTICLE 7. STANDARDS FOR PAYMENT

- R9-22-701. ~~Scope of the Administration's Liability; Payments to Contractors~~ Scope of the Administration's liability; payments to contractors
- R9-22-702. ~~Prohibitions Against Charges to Members or Eligible Persons~~ Prohibition against charges to members or eligible persons
- R9-22-703. Claims
- R9-22-705. Payments by Contractors
- R9-22-706. Payments by the Administration for Services Provided to Eligible Persons
- R9-22-707. Payments for Newborns
- R9-22-709. Contractor's Liability to Hospitals for the Provision of Emergency and Subsequent Care
- R9-22-710. Capped Fee-for-service Payments for Non-Hospital
- R9-22-711. Copayments
- R9-22-715. Hospital Rate Negotiations
- R9-22-717. Hospital Claims Review

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-22-342. Newborn Enrollment

- A. A newborn baby is eligible for AHCCCS as specified in R9-22-339 only when the mother is eligible for AHCCCS-covered services on the date of the newborn baby's birth.
- B. Contractors shall notify the Administration of all newborn babies born to enrolled members. ~~For capitation purposes, the effective date of the newborn's enrollment is the date the Administration receives notification, as specified in R9-22-708, mothers who are eligible and enrolled with them on the date of the newborn's birth.~~
1. ~~If the contractor notifies the Administration within three days after the date of birth, enrollment and capitation shall begin on the baby's date of birth.~~
 2. ~~If the contractor notifies the Administration after the third day but before the 31st day following birth, enrollment and capitation shall begin on the date of notification.~~
 3. ~~If the contractor notifies the Administration more than 30 days following birth, enrollment and capitation shall begin on the third day after the date of notification.~~
- C. If the mother is enrolled with a different contractor on the newborn's date of birth than on the date of notification: ~~1. the newborn shall be enrolled with the mother's contractor on date of notification, notification effective the third day after notification.~~
2. ~~The newborn's enrollment with the mother's contractor on the date of birth shall not exceed the duration of the mother's enrollment with that contractor.~~
 3. ~~For mothers enrolled with a different contractor on the newborn's date of birth than on date of notification, any period between termination of the newborn initial enrollment and enrollment with the mother's contractor shall be covered on a fee for service basis.~~
- D. ~~If the mother is not enrolled with a contractor at the time of the notification:~~

1. ~~Categorically eligible mothers shall be allowed a period of time, not to exceed 12 working days, to choose a contractor for the newborn.~~
 2. ~~Newborns of indigent and medically needy mothers shall be assigned to a contractor. Enrollment and capitation shall begin on the third day after the date of notification.~~
- E. ~~Hospitals shall notify the Administration of all newborns of mothers who are eligible for AHCCCS and not enrolled with a contractor on the newborn's date of birth.~~
1. ~~If the mother is enrolled with a contractor by the date of notification, the newborn shall be enrolled with the mother's contractor and capitation shall begin three days after notification.~~
 2. ~~The period from date of birth to date of enrollment with a contractor shall be covered on a fee for service basis.~~

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-701. ~~Scope of the Administration's Liability; Payments to Contractors~~ Scope of the Administration's liability; payments to contractors

- A. The Administration shall bear no liability for the provision of covered services or the completion of a plan of treatment to any member or eligible person beyond the date of termination of such individual's eligibility and enrollment.
- B. All payments to contractors shall be made pursuant to the terms and conditions of contracts executed between the contractor and the Administration and in accordance with these rules.
- C. The Administration shall bear no liability for subcontracts which the contractor may execute with other parties for the provision of either administrative or management services, medical services, covered health care services or for any other purpose. The contractor shall indemnify and hold the Administration harmless from any and all liability arising from these subcontracts and shall bear all costs of defense of any litigation over such liability and shall satisfy in full any judgment entered against the Administration in such connection.
- D. Prepayments shall be made monthly to those capitated contractors who have either posted required performance bonds or have otherwise provided security sufficient to the Director.
- E. ~~The Director shall consider the following criteria when extending the deferred liability period specified in Article 3 of these rules:~~
1. ~~Hospitalization of the eligible person.~~
 2. ~~The effective date of enrollment.~~
 3. ~~The type and location of medical care being provided.~~
 4. ~~The expected date of delivery for high risk pregnancies.~~
- F. ~~Where applicable, providers and nonproviders shall submit claims to the Administration at rates not to exceed negotiated rates.~~

R9-22-702. ~~Prohibitions Against Charges to Members or Eligible Persons~~ Prohibition against charges to members or eligible persons

- A. No contractor, subcontractor, or other provider of care or services shall charge, submit a claim, demand, or otherwise collect payment from a member or eligible person acting on behalf of a member or eligible person for any covered service except to collect authorized ~~copayments, co-payments~~ or payment for additional services. Prepaid capitated contractors

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shall have the right to recover from a member that portion of payment made by a 3rd third party to the member when such payment duplicates AHCCCS paid benefits and has not been assigned to the prepaid contractor. Claims made under this provision by prepaid capitated contractors shall not exceed the actual, reasonable cost for the provision of covered services.

- B. Providers shall not bill or make any attempt to collect payment, directly or through a collection agency, from an individual a person claiming to be AHCCCS eligible without 1st receiving verification from the Administration that the individual person was ineligible for AHCCCS on the date of services or that services provided were not covered by AHCCCS.
- C. A provider, including a noncontracting provider, may bill an eligible person for medical expenses incurred during a period of time when the eligible person willfully withholds material information from the provider or provides false information to the provider pertaining to his AHCCCS eligibility or enrollment status that results in denial of payment due to the failure to disclose such information or the provision of false information.

R9-22-703. Claims

- A. Claims submission to contractors. All claims for services rendered to members enrolled with a prepaid contractor, contractor including services rendered during the retroactive period for which the prepaid contractor is responsible, shall be submitted to such contractor.
- B. Claims submission to the AHCCCS Administration.
1. Claims for covered services provided to AHCCCS eligible persons and enrolled members must be initially received by the AHCCCS Claims Administration not later than 2 nine-months from the date of service. Claims not received within the initial 2 nine-month period from the date of service shall be denied. If the claim meets the 2 nine-month limitation, contractors, providers, noncontracting providers and nonproviders shall file a clean claim which is received by the AHCCCS Claims Administration not later than 12 months from the date of service.
 2. Exceptions to the 9-month and 12-month rules are:
 - a. Reinsurance claims shall not be considered for payment unless the claims are received by the AHCCCS Claims Administration not later than 2 nine months from the close of the contract year in which the claim was incurred. If the claim meets the 2 nine-month limitation, contractors shall file a clean claim which is received by the AHCCCS Claims Administration not later than 12 months from the close of the contract year in which the claim was incurred.
 - b. The 2 nine-month deadline for hospitals will be keyed to the date of discharge on each individual claim.
- C. Claims processing.
1. Claims which contain erroneous or conflicting information, exceed parameters, fail to process correctly, do not match the AHCCCS files, or require manual review in order to resolve the claims shall be reported to the provider with a remittance advice, a claim correction letter (CCL).
 2. Hospital claims shall be processed pursuant to R9-22-706 R9-22-712.
- D. Overpayments for AHCCCS services. When an AHCCCS overpayment is made to a provider, noncontracting provider, nonprovider or contractor, the Administration may recover the overpayment from future payments, or the provider, noncontracting provider, nonprovider or contractor may is responsible to return the incorrect payment.

R9-22-705. Payments by Contractors

- A. Contractors shall pay for all covered services rendered to their members where such services or admissions have been arranged by their agents or employees, subcontracting providers or other individuals acting on the contractor's behalf and for which necessary authorization has been obtained. ~~Contractors shall not require prior authorization for medically necessary covered services provided during any retroactive period for which the contractor is responsible.~~ Contractors are not required to pay claims for covered services that are submitted more than 6 six months after the date of the service for which payment is claimed or that are submitted as clean claims more than 12 months after the date of the service for which payment is claimed.
1. ~~Contractors shall reimburse subcontracting and noncontracting providers for the provision of medically necessary health care services to their members, within the time period specified by contract between a contractor and a subcontracting entity or within 60 days of receipt of valid clean claims if a time period is not specified.~~
 2. ~~Contractors shall provide written notice to claimants whose claims are denied or reduced by the contractor within 60 days of receipt of such claims. This notice shall include a statement describing the provider's right to:~~
 - a. ~~Grieve the contractor's rejection or reduction of the claim.~~
 - b. ~~Submit the grievance to the Administration pursuant to Article 8 of these rules.~~
 3. ~~The contractor's date of receipt of inpatient or outpatient hospital claims is the date the claim was received by the contractor (date of receipt) as indicated by the date stamp on the claim, the claim reference number or the date-specific number system assigned by the contractor. Hospital claims will be considered paid on the date indicated on disbursement checks. Denied claims will be considered adjudicated on the date of their denial. Claims that are denied and are resubmitted will receive new dates of receipt. Claims that are pending for additional supporting documentation from hospitals will receive new dates of receipt upon receipt of the additional supporting documentation, except as provided under R9-22-717. Timeframes for submittal of claims and the definition of clean claim, for purposes of this subsection, shall be consistent with A.R.S. § 36-2904. A contractor and a hospital may, through a contract approved in accordance with R9-22-715(A) adopt a method for identifying, tracking and adjudication of claims different from subsection (A)(3).~~
- B. Payment for medically necessary outpatient services.
1. ~~Contractors shall reimburse subcontracting and noncontracting providers for the provision of medically necessary health care services to their members, within the time period specified by contract between a contractor and a subcontracting entity or within 60 days of receipt of valid accrued claims if a time period is not specified.~~
 - 2.1. Contractors shall reimburse subcontracting and noncontracting providers for the provision of outpatient hospital services rendered on or after March 1, 1993, at either a rate specified by subcontract or, in absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by allowed charges (billed charges that represent covered services and are medically necessary) set forth in A.R.S. § 36-2903.01(J)(4) and R9-22-712. Subcontract rates, terms and conditions are subject to review, approval or disapproval pursuant to A.R.S. § 36-2904(K)(1)(b) and R9-22-715.

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2. Contractors shall pay for all emergency care services rendered to their members by noncontracting providers or nonproviders when such services:
 - a. Conform to the definitions of emergency medical and acute mental health services defined in Article 1, and
 - b. Conform to the notification requirements set forth in Article 2.
- C. Payment for inpatient hospital services. Contractors shall reimburse out-of-state hospitals for the provision of hospital services at negotiated discounted rates, the Arizona average cost-to-charge ratio multiplied by allowed charges or, if reasonably and promptly available, the Medicaid rate that is in effect at the time services are provided in the state in which the hospital is located, whichever is lowest. Contractors shall reimburse in-state subcontractors and noncontracting providers for the provision of inpatient hospital services rendered with an admission date on or after March 1, 1993, at either a rate specified by subcontract or, in absence of a subcontract, the prospective tiered-per-diem amount set forth in A.R.S. § 36-2903.01 and R9-22-712. Subcontract rates, terms and conditions are subject to review, approval or disapproval pursuant to A.R.S. § 36-2904(K)(1)(b) and R9-22-715. This subsection (C) does not apply to contractors participating in the pilot program pursuant to R9-22-718.
 1. ~~Contractors shall pay for all emergency care services rendered their members by noncontracting providers or nonproviders when such services:~~
 - a. ~~Conform to the definitions of emergency medical and acute mental health services defined in Article 1, and~~
 - b. ~~Conform to the notification requirements set forth in Article 2.~~
 2. ~~Contractors shall provide written notice to claimants whose claims are denied or reduced by the contractor within 30 days of receipt of such claims. This notice shall include a statement describing the provider's right to:~~
 - a. ~~Grieve the contractor's rejection or reduction of the claim.~~
 - b. ~~Submit the grievance to the Administration pursuant to Article 8 of these rules.~~
- D. Payment for observation days. Contractors may reimburse subcontracting and noncontracting providers for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, at the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered allowed charges, charges (billed charges that represent covered services and are medically necessary).
- E. Review of hospital claims.
 1. If a contractor and a hospital do not agree on reimbursement levels, terms, and conditions, the reimbursement levels established pursuant to A.R.S. § 36-2903.01 and R9-22-712 or R9-22-718 shall apply. In these cases, this case, hospitals shall obtain prior authorization from the appropriate contractor for nonemergency admissions. The contractor shall consider medical condition of the member, length of stay and other factors when issuing its prior authorization. Contractors shall not require prior authorization for medically necessary services provided during any retroactive period that the contractor is responsible. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of their contract regarding utilization control activities that may include prior authorization of nonemergency admissions. Failure to obtain prior authorization shall be cause

of nonpayment or denial of the claim. Furthermore, hospitals shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and make the hospitals' medical records, specific to a member enrolled with the contractor, available for review.

2. Regardless of prior authorization or concurrent review activities, all hospital claims, to include outlier claims, are subject to prepayment medical review and post-payment review by the contractor. Post-payment reviews shall be consistent with A.R.S. § 36-2903.01(O), and erroneously paid claims are subject to recoupment. If prior authorization was given for a specific level of care, but medical review of the claim indicates that a different level of care was appropriate, the contractor may adjust the claim to reflect the most appropriate level of care, such adjustment to be effective on the date when the different level of care was medically appropriate.
3. A contractor and a hospital may enter into a contract that includes hospital claims review criteria and procedures different from this subsection which binds both parties and provided such contract meets the requirements of R9-22-715.
- F. Timeliness of hospital claim payment. ~~4. Payment by the contractor for inpatient hospital admissions and outpatient hospital services on and after March 1, 1993, shall be subject to Laws 1993, Ch. 6, § 29, 29; as amended by Laws 1995, Ch. 5 § 8; Laws 1992, Chapter 302, § 14, as amended by Laws 1993, Chapter 6, § 27, as amended by Laws 1995, Ch. 5 § 6; and A.R.S. § 36-2903.01(J)(6).~~
 2. ~~The contractor's date of receipt of inpatient or outpatient hospital claims is the date the claim was received by the contractor (date of receipt) as indicated by the date stamp on the claim, the claim reference number or the date specific number system assigned by the contractor. Hospital claims will be considered paid on the date indicated on disbursement checks. Denied claims will be considered adjudicated on the date of their denial. Claims that are denied and are resubmitted will receive new dates of receipt. Claims that are pending for additional supporting documentation from hospitals will receive new dates of receipt upon receipt of the additional supporting documentation, except as provided under R9-22-717. Timeframes for submittal of claims and the definition of clean claim, for purposes of this subsection, shall be consistent with A.R.S. § 36-2904. A contractor and a hospital may, through a contract approved in accordance with R9-22-715(A) adopt a method for identifying, tracking and adjudication of claims different from this paragraph.~~

R9-22-706. Payments by the Administration for Services Provided to Eligible Persons

- A. Payment for emergency and medically necessary non-hospital outpatient services. Payments made by the Administration for emergency and medically necessary non-hospital services provided to eligible persons will be made pursuant to R9-22-710.
 1. Emergency services provided to the indigent, the medically needy and eligible low-income children for which the Administration is liable from the date of notification pursuant to R9-22-313 to the date of enrollment with a prepaid capitated contractor shall be paid at the capped fee-for-service rate or billed charges, whichever is lower. On the date of notification to the AHCCCS Administration, the county shall notify the AHCCCS Administration of the amount of medical expenses necessary to satisfy the spend down requirement of R9-22-321 and incurred by the household, if any, during the period of the Administration's retroactive liability.

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2. Medically necessary services provided to categorically eligible persons and eligible assistance children for which the Administration is liable from the effective date of eligibility to the date of enrollment with a prepaid capitated contractor shall be paid at the capped fee-for-service rate or billed charges, whichever is lower.
 3. Payment will be made at the capped fee for service rate or billed charges, whichever is lower, for AHCCCS covered services provided to categorically eligible individuals for a three month retroactive period as specified in Article 3 of these rules.
 4. Eligible persons residing in areas that are not served by AHCCCS contracting providers shall be eligible for AHCCCS covered services. Payment for medically necessary services provided to such individuals shall be made at the capped fee for service rate or billed charges, which is lower.
 5. Payment for services provided to eligible persons whose enrollment has been deferred as specified in Article 3 of these rules will be made at the capped fee for service rate or billed charges, whichever is lower.
 6. Medically necessary services provided to eligible persons by out of state providers shall be paid at the capped fee for service rate pursuant to R9-22-710 or the Medicaid rate that is in effect at the time services are provided in the state in which the provider is located, whichever is lower.
- B.** Payment for emergency services provided prior to May 5, 1984.
1. Noncontracting providers furnishing emergency hospitalization services and continuing medically necessary inpatient care to eligible persons will be reimbursed at 95% of billed charges as filed with the Department of Health Services until the person is discharged, transferred, or enrolled with a prepaid capitated provider.
 2. Nonproviders. Nonproviders furnishing emergency and continuing medically necessary inpatient care to an eligible person will be reimbursed at 80% of billed charges as filed with the Department of Health Services until the person is discharged, transferred or enrolled with a prepaid capitated provider but not longer than three days from the time the person was admitted for care. Payment for care required beyond three days will be made at the capped fee for service rate if lower than 80% of billed charges. As a condition for payment, nonprovider hospitals must designate a primary care physician to act as coordinator of services provided to eligible persons until they are discharged, transferred or enrolled with an AHCCCS contractor.
 3. Retroactive payment for emergency services provided to categorically eligible individuals will be made at the capped fee for service rates.
 4. Retroactive payment for emergency services provided to indigent or medically needy individuals will be made at the rates identified in (B)(1) and (2) of this Section for a maximum of five days prior to the date of eligibility determination, provided that notification requirements specified in Article 3 of these rules are met. Emergency services will be covered from the time a person registered for services within the five day retroactive coverage period to the time the person is discharged or enrolled with a prepaid contractor.
- C.** For covered hospital services provided to AHCCCS eligible persons prior to May 5, 1984, the following shall apply: The maximum allowable rate is 105% of the Medicare Periodic Interim Payment per diem rate as of October 1, 1983 (the Medicare Periodic Interim Payment Schedule is incorporated by reference and on file in the Office of the Secretary of State), for inpatient care and 80% of billed charges for clinics and nonemergency services provided in emergency rooms. If the public and/or academic nature of a hospital enables the hospital to adequately demonstrate proof that its operations are publicly subsidized and that its ratio of costs to billed charges is greater than or equal to one then the maximum allowable inpatient rate shall be billed charges and the clinic and emergency rooms rate shall be 95% of billed charges.
- D.** For covered hospital services provided to AHCCCS eligible persons on or after May 5, 1984, until October 1, 1985.
1. Hospital inpatient, outpatient and emergency services provided to AHCCCS eligible persons by out of state hospitals will be paid at the Medicaid rate that is in effect at the time the services are provided in the state in which the hospital is located.
 2. Payment for hospital inpatient, outpatient and emergency services provided to AHCCCS eligible persons by in-state, nonfederal hospitals will be based on the schedule of rates and charges that hospitals had in effect on April 1, 1984, as filed with the Department of Health Services.
 - a. A hospital which had filed for a rate increase with the Department of Health Services on or before May 1, 1984, but which had not implemented such rate increase by May 1, 1984, shall be allowed a one-time only increase in its adjusted billed charge as follows:
 - i. The allowable increase in the adjusted billed charge for any hospital which implemented its last previous rate increase before April 30, 1983, shall be 10% or the increase in rates filed with the Department of Health Services, whichever is less.
 - ii. The allowable increase in the adjusted billed charge for any hospital which implemented its last previous rate increase on or after April 30, 1983, but before October 1, 1983, shall be 5% or the increase in rates recommended by the Department of Health Services, whichever is less.
 - b. No other increase in adjusted billed charges shall be allowed.
 3. Claims for services rendered on or after the date of implementation of any rate increase filed with the Department of Health Services after May 1, 1984, shall be paid at the applicable adjusted billed charges determined in (D)(2) above.
 4. For services rendered before October 1, 1984, the Administration shall not pay a hospital's charges on a fee for service basis in excess of 85% of the hospital's adjusted billed charges.
 5. The date for purposes of determining the timeliness discount of adjusted billed charges that will be paid is the date the claim is determined to be a clean claim by the Administration. For services rendered on or after October 1, 1984, but until October 1, 1985, the Administration shall not pay a hospital's adjusted billed charges in excess of the following:
 - a. If the hospital's bill is paid within 30 days of the date the bill was received, 85% of the adjusted billed charges.
 - b. If the hospital's bill is paid any time after 30 days through 60 days of the date the bill was received, 95% of the adjusted billed charges.
 - c. If the hospital's bill is paid any time after 60 days of

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the date the bill was received, 100% of the adjusted billed charges.

6. The date of receipt of hospital claims is the date the clean claim is received by the Administration as indicated by the date stamp on the claim and the claim reference number. Hospital claims will be considered paid on the date indicated on disbursement checks. Denied claims will be considered adjudicated on the date of their denial. Claims that are rejected or require additional supporting documentation from providers will receive new date stamps. Only valid clean claims that are submitted in accordance with AHCCCS rules and represent charges for the provision of hospital services to individuals who have been determined AHCCCS eligible will be processed.
- E.** For covered hospital services provided to AHCCCS eligible persons on or after October 1, 1985, until October 1, 1986.
1. Hospital inpatient, outpatient and emergency services provided to AHCCCS eligible persons by out-of-state hospitals will be paid at the Medicaid rate that is in effect at the time the services are provided in the state in which the hospital is located.
 2. Payment for hospital inpatient, outpatient and emergency services provided to AHCCCS eligible persons by in-state, nonfederal hospitals will be based on the schedule of rates and charges that hospitals had in effect on April 1, 1984, as filed with the Department of Health Services, or on one of the following if applicable:
 - a. The schedule of rates and charges for a hospital which became effective after May 31, 1984, but prior to July 2, 1984, if the hospital's previous rate schedule became effective prior to April 30, 1983.
 - b. The schedule of rates and charges for a hospital which became effective after May 31, 1984, but prior to July 2, 1984, limited to 5% over the hospital's previous rate schedule, and if the hospital's previous rate schedule became effective on or after April 30, 1983, but prior to October 1, 1983.
 3. The date for purposes of determining the timeliness discount of adjusted billed charges that will be paid is the date the claim is determined to be clean by the Administration. For services rendered on or after October 1, 1985, but until October 1, 1986, the Administration shall not pay a hospital's adjusted billed charges in excess of the following:
 - a. If the hospital's bill is paid within 30 days of the date the bill was received, 85% of the adjusted billed charges.
 - b. If the hospital's bill is paid any time after 30 days through 60 days of the date the bill was received, 95% of the adjusted billed charges.
 - c. If the hospital's bill is paid any time after 60 days of the date the bill was received, 100% of the adjusted billed charges.
 4. The date of receipt of hospital claims is the date the claim was received by the Administration as indicated by the date stamp on the claim and the claim reference number. Hospital claims will be considered paid on the date indicated on disbursement checks. Denied claims will be considered adjudicated on the date of their denial. Claims that are rejected or require additional supporting documentation from providers will receive new date stamps. Only valid clean claims that are submitted in accordance with AHCCCS rules and represent charges for the provision of hospital services to individuals who have been determined AHCCCS eligible will be processed.
- F.** For covered hospital services provided to AHCCCS eligible persons on or after October 1, 1986, until January 1, 1991.
1. Hospital inpatient, outpatient and emergency services provided to AHCCCS eligible persons by out-of-state hospitals shall be paid at negotiated discounted rates, 80% of billed charges or the Medicaid rate that is in effect at the time services are provided in the state in which the hospital is located, whichever is lowest.
 2. Payment of hospital inpatient, outpatient and emergency services provided to AHCCCS eligible persons by in-state, nonfederal hospitals will be based on the reimbursement level in effect on October 1, 1985, increased by 4%, according to the requirements set forth in A.R.S. § 36-2903.01(J).
 3. The date for purposes of determining the timeliness discount of adjusted billed charges that will be paid is the date the claim is determined to be clean by the Administration. For services rendered on or after October 1, 1986, the Administration shall not pay a hospital's adjusted billed charges in excess of the following:
 - a. If the hospital's bill is paid within 30 days of the date the bill was received, 85% of the adjusted billed charges.
 - b. If the hospital's bill is paid any time after 30 days through 60 days of the date the bill was received, 95% of the adjusted billed charges.
 - c. If the hospital's bill is paid any time after 60 days of the date the bill was received, 100% of the adjusted billed charges.
 4. The date of receipt of hospital claims is the date the claim was received by the Administration as indicated by the date stamp on the claim and the claim reference number. Hospital claims will be considered paid on the date indicated on disbursement checks. Denied claims will be considered adjudicated on the date of their denial. Claims that are rejected or require additional supporting documentation from hospitals will receive new date stamps. Only valid clean claims that are submitted in accordance with AHCCCS rules and represent charges for the provision of hospital services to individuals who have been determined AHCCCS eligible will be processed.
 5. Payments pursuant to subsections (F)(2) and (3) shall not exceed the schedule of rates and charges that hospitals had in effect, as filed with the Department of Health Services, as of the date of service.
- G.** For covered hospital services provided to AHCCCS eligible persons on or after January 1, 1992, until March 1, 1993.
1. Hospital inpatient, outpatient and emergency services provided to AHCCCS eligible persons by out-of-state hospitals shall be paid at negotiated discounted rates, 80% of billed charges or the Medicaid rate that is in effect at the time services are provided in the state in which the hospital is located.
 2. Payment of hospital inpatient, outpatient and emergency services provided to AHCCCS eligible persons by in-state, nonfederal hospitals will be based on the reimbursement level in effect on December 31, 1990, increased by 2 1/2%, and according to the requirements set forth in A.R.S. § 36-2903.01(J).
 3. For services rendered on or after January 1, 1991, the Administration shall not pay a hospital's adjusted billed charges in excess of the following:
 - a. If the hospital's bill is paid within 30 days of the date the bill was received, 85% of the adjusted billed charges.
 - b. If the hospital's bill is paid any time after 30 days

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through 60 days of the date the bill was received, 95% of the adjusted billed charges.

- e. ~~If the hospital's bill is paid any time after 60 days of the date the bill was received, 100% of the adjusted billed charges.~~
4. ~~The date of receipt of hospital claims shall be the date the claim was received by the Administration as indicated by the date stamp on the claim and the claim reference number. Hospital claims shall be considered paid on the date indicated on disbursement checks. Denied claims shall be considered adjudicated on the date of their denial. Claims that are denied or that are pending through the claims correction process, because they are incorrect or incomplete, shall receive new date stamps when all requirements are met.~~
5. ~~Payments pursuant to paragraphs (2) and (3) shall not exceed the schedule of rates and charges that hospitals had in effect, as filed with the Department of Health Services, as of the date of service.~~

H.B. Indian Health Service. The maximum allowable rates paid to IHS for AHCCCS-covered services provided in IHS facilities shall be the same as the all-inclusive inpatient, outpatient, or ambulatory surgery rates published in the Federal Register. Except as provided in R9-22-708, IHS medical service referrals for eligible Native Americans made to off-reservation contractors, providers, noncontracting providers or nonproviders shall be prior authorized.

R9-22-707. Payments for Newborns

If the mother is enrolled on the date of the newborn baby's birth, the contractor shall be financially liable under the mother's capitation to provide all AHCCCS-covered services to the newborn baby from the date of birth to the date of the mother's disenrollment or the date of the baby's enrollment, whichever occurs first. However, if the mother is eligible for AHCCCS as an indigent or medically needy individual, the contractor shall be liable for a minimum of 30 days and a maximum of then have a maximum liability of 60 days under the mother's capitation.

B. Deferred liability. ~~Deferred liability for sick newborns shall commence with the date of enrollment and shall be governed by the provisions specified in R9-22-336.~~

R9-22-709. Contractor's Liability to Hospitals for the Provision of Emergency and Subsequent Care

- A. For purposes of program and contractor liability, an emergency medical or acute mental health condition shall be subject to reimbursement only until such time as the member's patient's condition is stabilized and the member patient is transferable, or until the member patient is discharged following stabilization subject to the requirements of A.R.S. § 36-2909(E) and Article 2 of these rules.
- B. Subject to subsection (A), in the event that a member cannot be transferred to a facility which has a subcontract with the contractor of record following stabilization, the contractor of record shall pay for all appropriately documented, prior authorized in accordance with R9-22-705 and medically necessary treatment provided such member prior to date of discharge or transfer in accordance with payment standards in R9-22-705.
- C. In the event that a member refuses transfer from a nonprovider or noncontracting hospital to a hospital affiliated with the member's contractor of record, neither the Administration nor the contractor shall be liable for any costs incurred subsequent to the date of refusal when:
1. Subsequent to consultation with his contractor of record, the member continues to refuse the transfer, transfer, and
 2. The member has been provided and signs a written statement, prior to the date of transfer of liability, informing

him of the medical and financial consequences of such refusal. If the member refuses to sign a written statement, then a statement signed by 2 two witnesses indicating that the member was informed may be substituted.

R9-22-710. Capped Fee-for-service Payments for Non-Hospital Services

- A. Service codes. A current copy of the following code manuals shall be maintained on file at the central office of the Administration for reference use during customary business hours:
1. The Physicians' Current Procedural Terminology (CPT) and Health Care Financing Administration Common Procedure Procedures Coding System (HCPCS) shall be utilized to identify medical services and procedures performed by physicians and other providers.
 2. ~~The Code on Dental Procedures and Nomenclature, as published in the Journal of the American Dental Association, shall be utilized to identify dental procedures.~~
 - 3.2. The AHCCCS Transportation, Supply, Equipment, and Appliance codes shall be utilized to identify the applicable service or supplied item.
 - 4.3. The International Classification of Diseases.
 - 5.4. ~~Nationally recognized pharmacy coding manual, American Druggist Blue Book.~~
- B. Fee schedule. The Administration shall pay providers, including noncontracting providers at the lesser of billed charges or the capped fee-for-service rates specified below unless a different fee is specified by contracts between the Administration and the provider, or as otherwise required by law. Notice of changes in methods and standards for setting payment rates for services shall be in accordance with 42 CFR 447.205, effective December 19, 1983, October 1, 1987, incorporated by reference and on file with the Office of the Secretary of State.
1. Physician services. Payment shall be in accordance with fee schedules which are on file at the central office of the Administration for reference use during customary business hours.
 2. ~~Hospital services. Hospital services provided to eligible persons shall be paid pursuant to R9-22-712.~~
 - 3.2. Pharmacy services. Payment for pharmacy services shall be in accordance with fee schedules which are exempt from rule making procedures pursuant to A.R.S. § 41-1005, but are subject to 42 CFR 447.331 through 447.332, effective July 31, 1987, incorporated by reference herein and on file with the Administration and the Office of Secretary of State. ~~These incorporations by reference contain no further editions or amendments.~~
 - 4.3. Dental services. Payment shall be in accordance with fee schedules which are on file at the central office of the Administration for reference use during customary business hours.
 - 5.4. Transportation services:
 - a. Ground ambulance services. Payment for ambulance services shall be made in accordance with fee schedules which are on file at the central office of the Administration for reference use during customary business hours. For ambulance providers that have charges established by the Arizona Department of Health Services (ADHS), the fee schedule amount is 80% of the ambulance provider's ADHS-approved fees for covered services. For ambulance providers whose fees are not established by ADHS, payment shall be made at 80% of the ambulance provider's billed charges or the capped fee-for-service amount for covered services, whichever is less.
 - b. Air Ambulance services. Payment for air ambulance services shall be made in accordance with fee

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schedules which are on file at the central office of the Administration for reference use during customary business hours.

- c. Nonambulance services. Payment for nonambulance services shall be made in accordance with fee schedules which are on file at the central office of the Administration for reference use during customary business hours.

6-5. Medical equipment. Payment for medical equipment shall be in accordance with fee schedules which are on file at the central office of the Administration for reference use during customary business hours. Providers shall be reimbursed once for durable medical equipment (DME) during any given 2 two-year period, unless the Administration determines that DME replacement within that period is medically necessary for the member. Unless authorized by the Administration, no more than 1 one repair and adjustment shall be reimbursed during any 2 two-year period.

7-6. Early and periodic screening, diagnosis and treatment services (EPSDT). ~~The maximum allowable rate for EPSDT screening and diagnostic services provided in conjunction with the Periodicity Schedule is \$30.00.~~

8. ~~Physician home visit. The maximum allowable rate for a medically necessary physician home visit shall be the capped fee for service rate.~~

C. Capped fee-for-service cost pool and payment. A capped fee-for-service medical cost pool may be established for each county in which there are capped fee-for-service physician contractors. All fees shall be paid out of this pool. ~~15% Fifteen percent~~ of allowable physician fees shall be withheld in the pool. At the end of the contract period, any surplus or deficit remaining in the pool shall be divided evenly between the Administration and the participating physicians subject to the following:

1. The physician's withhold shall be used to offset the physician's portion of any deficit. The physicians shall not be responsible for any deficit greater than the aggregate amount withheld. All withholds not needed to fund a deficit will be returned to the physician on a pro rata basis.
2. The physician portion of any surplus shall be divided such that 2/3 goes to primary care physicians and 1/3 to referral physicians. These portions shall then be divided pro rata among the physicians in each category subject to an upper limit. The physician's portion of any surplus is limited so that a referral physician can receive no more than 115% of the Administration's maximum allowable fees for their services and a primary care physician no more than 130%.

D. Distribution of funds. Annual settlements shall be done on an incurred basis. Incurred medical costs for the contract period shall be estimated for settlement purposes when 3 ~~three~~ full months of paid claim data can be summarized following the end of the contract period. The settlement shall occur within 105 days following the end of the contract period.

E. The Administration reserves the right to adjust the percentage of withholding for any individual physician whose utilization rates are deemed to be excessive based on historical physician profiles.

R9-22-711. Copayments

A. Contractors shall be responsible for the collection of copayments from members. The following are excluded from copayment requirements:

1. Prenatal care including all obstetrical visits;
2. Well-baby, EPSDT care;

3. Members in nursing facilities and intermediate care facilities for the mentally retarded;
4. Visits scheduled by a primary care physician or practitioner, and not at the request of a member;
5. Drugs and medications beginning October 1, 1985.

B. Except as provided in subsection (A), contractors and members shall comply with the following copayment schedules:

1. Categorically eligible members

<u>COVERED SERVICES</u>	<u>COPAYMENT</u>
Doctor's office or home visit and diagnostic and rehabilitative x-ray and laboratory services associated with such visit.	\$1.00
Nonemergency surgery per procedure	\$5.00 per procedure
Nonemergency use of the emergency room	\$5.00 per visit
Nonemergency use of emergency transportation	\$5.00 per service

2. Indigent, medically needy, eligible assistance children, and eligible low-income children members:

<u>COVERED SERVICES</u>	<u>COPAYMENT</u>
Doctor's office or home visit and all diagnostic and laboratory services associated with such visit.	\$5.00 per visit
Nonemergency surgery	\$5.00 per procedure
Nonemergency use of the emergency room	\$5.00 per visit
Nonemergency use of emergency transportation	\$5.00 per service

C. Members shall not be denied services because of their inability to pay a copayment.

R9-22-715. Hospital Rate Negotiations

A. Effective for inpatient hospital admissions and outpatient hospital services on or after March 1, 1993, contractors that negotiate with hospitals for inpatient or outpatient services shall reimburse hospitals for member care based on the prospective tiered-per-diem amount or the AHCCCS hospital-specific outpatient cost-to-change ratio multiplied by allowed charges set forth in A.R.S. § 36-2903.01 and R9-22-712 or at the negotiated rate that, when considered in the aggregate with other hospital reimbursement levels, does not exceed what would have been paid pursuant to A.R.S. § 36-2903.01 and R9-22-712. This subsection does not apply to hospitals participating in the pilot program pursuant to R9-22-718.

1. Contractors may engage in rate negotiations with hospitals at any time during the contract period.
2. Within 7 days of the completion of the agreement process, contractors shall submit copies of their negotiated rate agreements, to include all rates, terms and conditions, with hospitals to the Administration for approval. Contractors shall demonstrate to the Administration that the effect of their negotiated rate agreement will, when considered in the aggregate, be the same as or will produce greater dollar savings than what would have been paid pursuant to A.R.S. § 36-2903.01 and R9-22-712.
 - a. To demonstrate the aggregate effect of its negotiated rate agreement, contractors shall present their

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assumptions related to projected utilization of various hospitals to the Administration. The contractor may consider inpatient assumptions related to:

- i. Member mix;
- ii. Admissions by AHCCCS-specified tiers;
- iii. Average length of stay by tier and pattern of admissions, excluding emergency admissions;
- iv. Outliers; and
- v. Risk-sharing arrangements. The contractor also may consider outpatient assumptions related to member mix and outpatient service utilization. The Administration reserves the right to approve, deny, or require mutually-agreed-to modifications to these assumptions.

- b. When contractors adjust or modify their assumptions, the reason for the adjustment or modification shall be included, as well as the new assumptions. Any change in assumption is subject to approval, denial, or mutually-agreed-to modification by the Administration.
- c. To determine whether the negotiated rate agreement produced reimbursement levels that did not in the aggregate exceed what would have been paid pursuant to A.R.S. § 36-2903.01 and R9-22-712, contractors shall require their independent auditors to evaluate the reasonableness of their assumptions as part of the annual audit. The independent auditor's audit program shall be consistent with AHCCCS audit requirements and shall be prior approved by the Administration.
- d. Negotiated inpatient or outpatient rate agreements with hospitals with which a contractor has a related party interest are subject to additional related party disclosure and evaluation. These evaluations are in addition to the procedures described in subsection (A)(2)(c) and shall be performed by the contractor's independent auditors, or, at the contractor's option, additional evaluations may be performed by the Administration.
- e. The Administration may subject a contractor's independent auditor's report to any examination or review necessary to ensure accuracy of any or all findings related to aggregate rate determinations.
- f. The Administration shall use its standards, consistent with the Request for Proposals and R9-22-502, to determine whether a contractor's inpatient or outpatient hospital subcontractors will limit the availability or accessibility of services. The Administration reserves the right to reject hospital subcontracts that limit a member's availability or accessibility of services.

- B. The Administration may negotiate or contract with hospitals on behalf of contractors for discounted hospital rates and may require that the negotiated discounted rates be included in contracts between contractors and hospitals.
- C. The Director shall apportion any cost avoidance in the hospital component of provider capitation rates between the Administration and provider. The Administration's portion of the cost avoidance shall be reflected in reduced capitation rates paid to providers.

R9-22-717. Hospital Claims Review

- A. The Administration and its contractors shall review hospital claims which are timely received as specified in R9-22-703(B).
- B. Charges for hospital services provided to eligible persons during a time when the eligible person was not the financial responsibility of the entity receiving the claim shall be denied.
- C. Personal care items supplied by the hospitals, including but not limited to the following, are not covered services:
 1. Patient care kits; kits;
 2. Toothbrushes; ~~Toothbrushes,~~
 3. Toothpaste; ~~Toothpaste,~~
 4. Petroleum jelly; ~~jelly,~~
 5. Deodorant; ~~Deodorant,~~
 6. Septi soap; ~~soap,~~
 7. Razors; ~~Razors,~~
 8. Shaving cream; ~~cream,~~
 9. Slippers; ~~Slippers,~~
 10. Mouthwash; ~~Mouthwash,~~
 11. Disposable razors; ~~razors,~~
 12. Shampoo; ~~Shampoo,~~
 13. Powder; ~~Powder,~~
 14. Lotion; ~~Lotion,~~
 15. Combs; ~~Combs, and~~
 16. Patient gowns.
- D. The following hospital supplies and equipment, if medically necessary and utilized, shall be covered services:
 1. Arm Boards; ~~Boards,~~
 2. Diapers; ~~Diapers,~~
 3. Underpads; ~~Underpads,~~
 4. Special mattresses and special beds; ~~beds,~~
 5. Gloves; ~~Gloves,~~
 6. Wrist restraints; ~~restraints,~~
 7. Limb holders; ~~holders,~~
 8. Disposable items used in lieu of durable items; ~~items,~~
 9. Universal precautions; ~~precautions,~~
 10. Stat charges; ~~charges, and~~
 11. Portable charges.
- E. The hospital claims review shall determine if services rendered were:
 1. AHCCCS-covered services;
 2. Medically necessary;
 3. Provided in the most appropriate, cost-effective, least restrictive setting; and
 4. 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(J) or 36-2904(K), whichever is applicable.
- F. If a claim is denied by either the Administration or its contractors at least 35 days prior to the expiration of the 12-month time period specified in A.R.S. § 36-2904(H), then the grievance challenging such denial must be filed against the entity denying the claim no later than 12 months from the date of service. If the claim is denied less than 35 days prior to the expiration of the 12-month time period, the provider shall have 35 days from the date of the denial to file a grievance. Any grievance challenging a postpayment review recoupment action must be filed by the provider no later than 35 days from the date of the notice of recoupment.
- G. ~~For claims with dates of admission before March 1, 1993, and subject to the foregoing, charges for medically necessary hospital services shall not exceed charges on file with the Arizona Department of Health Services.~~

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

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

PREAMBLE

1. **Sections Affected**
R9-28-507
- Rulemaking Action**
Amend
2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**
Authorizing statute: A.R.S. § 36-2932(P)
Implementing statutes: A.R.S. §§ 36-2932(E)(3) and 36-2943
3. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**
Name: Cheri Tomlinson
Address: AHCCCS
Office of Policy Analysis and Coordination
801 East Jefferson, MD4200
Phoenix, Arizona 85034
Telephone: (602) 417-4198
Fax: (602) 256-6756
4. **An explanation of the rule, including the agency's reasons for initiating the rule:**
These proposed rules result from a 5 year review report which identified non-substantive revisions which would make the language more clear, concise, and understandable. In addition, these proposed rules reflect an administrative policy change that requires the contractors, effective October 1, 1997, to be responsible for medically necessary services provided to members back to the date of eligibility according to R9-22-705.
5. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**
Not applicable.
6. **The preliminary summary of the economic, small business, and consumer impact:**
Changes are proposed to R9-28-507 that deal with Program Contractor General Requirements. The proposed changes are:
 - Enhance the clarity and conciseness of existing language through minor changes to wording and grammar.
 - Add language regarding retroactive period coverage responsibilities for Program Contractors. Effective October 1, 1997, contractors will be responsible for medically necessary services provided to members back to the date of eligibility. Coverage for these services will be included in capitation rates paid to Program Contractors. Current rule language states that Program Contractors are responsible for providing services beginning 2 days after the receipt of notification of enrollment by the Administration.Minimal operational changes will be required for the assignment of retroactive coverage responsibilities to contractors. The small business community will be unaffected by the change and AHCCCS will collaborate with ALTCS program contractors and ALTCS providers (some of whom could be considered small businesses) to assure that bills for medically necessary covered services provided during this retroactive period are properly sent to the contractor that is financially responsible rather than to AHCCCS. Over the long term, this should benefit all involved parties by streamlining the processing of services provided to AHCCCS members.
7. **The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:**
Name: Cheri Tomlinson
Address: AHCCCS
Office of Policy Analysis and Coordination
801 East Jefferson, MD4200
Phoenix, Arizona 85034
Telephone: (602) 417-4198

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Fax: (602) 256-6756

8. The time, place, and nature of the proceedings for the adoption, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: May 23, 1997

Time: 9 a.m.

Location: AHCCCS
701 E. Jefferson, 3rd Floor
Gold Conference Room
Phoenix, Arizona 85034

Nature: Public hearing on proposed rules to receive oral and written comments.

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

10. Incorporations by reference and their location in the rules:
Not applicable.

11. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

**CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
ARIZONA LONG-TERM CARE SYSTEM**

**ARTICLE 5. PROGRAM CONTRACTOR AND PROVIDER
STANDARDS**

R9-28-507. ~~Program contractor general requirements Program Contractor General Requirements~~

**ARTICLE 5. PROGRAM CONTRACTOR AND PROVIDER
STANDARDS**

R9-28-507. ~~Program contractor general requirements Program Contractor General Requirements~~

- A. ALTCS program contractors shall ensure that providers of service meet the requirements of this Article.
- B. Each ALTCS program contractor shall maintain member service records. These shall include, at a minimum, the case management plan, medical records, encounter data, grievances, complaints, and service information for each ALTCS member. The program contractor shall ensure that all member service records are retained for ~~five~~ 5 years. ALTCS member service records or copies of member service records shall be provided to the Administration upon request.
- C. ALTCS program contractors shall produce and distribute information materials to each enrolled ALTCS member or designated representative within ~~ten~~ 10 days after receipt of notification of enrollment from the Administration. The information shall ~~include a~~ include:
1. ~~A description of all available services, an services;~~
 2. ~~An explanation of service limitations and exclusions. The information shall also contain an exclusions;~~
 3. ~~An explanation of the procedure for obtaining services, including a notice stating that the program contractor is~~

liable only for those services authorized by an ALTCS member's case manager. ~~The information shall contain procedures manager;~~

4. ~~Procedures for obtaining emergency services and services;~~
 5. ~~Procedures for filing a grievance or complaint. complaint; and~~
 6. All information shall be approved by the Administration prior to distribution.
- D. The ALTCS program contractor shall submit encounter reports on services rendered to each enrolled member within 120 days after the month of service, except for services with Medicare coverage, which shall be submitted within 180 days after the month of service.
- E. ALTCS program contractors shall collect the member share of cost and report the amount collected to the Administration.
- F. ALTCS program contractors shall monitor trust fund accounts for institutionalized ALTCS members to verify that expenditures from a member's trust fund are in compliance with federal regulations.
- G. Institutionalized ALTCS members who are transferred to an acute care facility for services shall whenever possible be returned to the original institution upon completion of acute care.
- H. Institutionalized ALTCS members who are granted therapeutic leave shall be returned to the same bed in their original institution upon completion of a therapeutic leave.
- I. Program contractors are responsible for providing services to ~~eligible individuals beginning two days after the receipt of notification of enrollment by the Administration, according to R9-22-705(A)(1).~~

NOTICE OF PROPOSED RULEMAKING

TITLE 18. ENVIRONMENTAL QUALITY

CHAPTER 4. DEPARTMENT OF ENVIRONMENTAL QUALITY
SAFE DRINKING WATER

PREAMBLE

1. **Sections Affected** **Rulemaking Action**
R18-4-224 New Section
2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**
Authorizing statutes: A.R.S. §§ 49-104(B)(4), 49-202, and 49-203
Implementing statutes: A.R.S. § 49-353

3. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**
Name: Margaret L. McClelland or Martha L. Seaman
Address: Department of Environmental Quality
3033 North Central Avenue
Phoenix, Arizona 85012
Telephone: (602) 207-2222
Fax: (602) 207-2251

4. **An explanation of the rule, including the agency's reasons for initiating the rule:**

The purpose of this rulemaking is to adopt a new section, R18-4-224, establishing interim monitoring relief for monitoring of regulated and unregulated synthetic organic chemicals (SOCs) for community water systems (CWS) and nontransient, noncommunity water systems (NTNCWS) serving 10,000 or fewer persons. The interim period will last from the date of effectiveness of this rule until August 6, 1999, or until permanent monitoring relief rules are put in place by the Department, whichever occurs first.

In accordance with provisions of the Safe Drinking Water Act Amendments of 1996 (PL 104-182), the rule provides that after a sample taken during this interim monitoring period which fails to detect the presence of SOC's in the ground water supplying the CWS or NTNCWS, additional quarterly monitoring for those contaminants, during the interim monitoring relief period, is not required. Detection is determined in accordance with the requirements of R18-4-216(H) for single point of entry samples or Appendix B of 18 A.A.C. 4 for composited samples.

SOCs are man-made chemicals primarily consisting of pesticides and herbicides. The use of these chemicals throughout the state varies considerably, depending on type of industry located within the various regions of the state. These chemicals are not likely to be found in the groundwater in regions where there is no industry which uses those chemicals, or where the chemicals have not been used to the extent that the levels would be detected through testing.

Currently, many drinking water systems are required to conduct 4 consecutive quarterly tests for SOC's, regardless of the regions in which the system is located. Each quarter of SOC testing costs the drinking water system \$2,365, per point of entry, for laboratory analysis. The interim monitoring relief program would provide the opportunity for systems which do not detect these chemicals, in the sample taken at the beginning of the period to forego further sampling during the interim monitoring relief period.

The interim monitoring relief program would continue to protect the public health and the environment, but, at the same time, would provide financial relief to those systems which are required to continue to test for chemicals which are extremely unlikely to be found.

This rule is de-regulatory and participation in the program is voluntary. Only those owners and operators who chose to avail themselves of this option are subject to the rule.

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

Not applicable.

6. **The preliminary summary of the economic, small business and consumer impact:**

According to data collected by the Compliance and Enforcement Unit of the ADEQ Safe Drinking Water Section, the average cost per point of entry for sample testing of SOC's is \$2,365. Each CWS or NTNCWS owner/operator whose initial test results indicate no detection is likely to realize savings of about \$7,100 for the entire interim monitoring relief period. It is estimated that there are 953 CWS or NTNCWS in Arizona, about 25% of which have already conducted sampling which would qualify them for reduced monitoring or waivers. If three-quarters of those which still must test have initial test results showing non-detect levels, the total

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cost savings statewide, over the interim monitoring relief period, could be as much as \$3.5 million; however, laboratories which would have received those testing fees will not receive them.

The proposed rulemaking decreases monitoring burdens on agencies, political subdivisions, businesses or persons. This rulemaking will decrease the costs of implementation and enforcement. Therefore, in accordance with A.R.S. § 41-1055(D)(3), the Department is not required to prepare an economic, small business, and consumer impact statement.

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

Name: Margaret L. McClelland or Martha L. Seaman
Address: Department of Environmental Quality
3033 North Central Avenue
Phoenix, AZ 85012
Telephone: (602) 207-2222
Fax: (602) 207-2251

9. **The time, place, and nature of the proceedings for the adoption, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:**

The Department shall hold oral proceedings to receive public comments in accordance with A.R.S. § 41-1023. The time, place, and location of the hearings are listed below:

Date: May 5, 1997
Time: 10 a.m.
Location: Department of Environmental Quality
3033 North Central Avenue
Public Meeting Room
Phoenix, Arizona 85012

Date: May 6, 1997
Time: 10 a.m.
Location: State Office Complex
Room 222
Corporation Commission Hearing Room
400 West Congress
Tucson, Arizona

The Department will accept oral or written comments which are received by 5 p.m. on May 8, 1997, or postmarked not later than that date. The close of record shall occur on May 9, 1997.

The Department is committed to complying with the Americans with Disabilities Act. If any individual with a disability needs any type of accommodation, please contact the Department at least 72 hours before the hearing.

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

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

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

TITLE 18. ENVIRONMENTAL QUALITY

CHAPTER 4. DEPARTMENT OF ENVIRONMENTAL QUALITY

SAFE DRINKING WATER

ARTICLE 2. MAXIMUM CONTAMINANT LEVELS AND MONITORING REQUIREMENTS

R18-4-224. Interim Monitoring Relief

ARTICLE 2. MAXIMUM CONTAMINANT LEVELS AND MONITORING REQUIREMENTS

R18-4-224. Interim Monitoring Relief

- A. The ADEQ establish an interim monitoring relief period during which some monitoring requirements for certain CWS or NTNCWS shall be modified in accordance with subsection (B). The interim monitoring relief period shall begin on the effective date of this Section and shall end on August 6, 1999, or on the effective date of permanent monitoring relief rules promulgated by ADEQ, whichever comes 1st.
- B. A CWS or NTNCWS system which serves 10,000 or fewer persons and which chooses to participate in interim monitoring relief, shall conduct monitoring for 1 quarter, for regulated and unregulated synthetic organic chemicals (SOCs) listed in

R18-4-215, from sites specified in R18-4-218. The CWS or NTNCWS shall not be required to conduct further monitoring for SOCs, if during the interim relief period all of the following requirements have been met:

1. Monitoring results taken during the interim monitoring relief period, certified and reported to ADEQ by the CWS or NTNCWS in accordance with R18-4-104, fail to detect the presence of SOCs in the groundwater supplying the CWS or NTNCWS. Detection shall be determined in accordance with the requirements of R18-4-216(H) for single point of entry samples, or Appendix B of 18 A.A.C. 4 for composited samples.
2. The CWS or NTNCWS certifies in writing to the Department that the depth to groundwater at the source is greater than 20 feet.
3. The Director determines in writing that, based on the certification of the CWS or NTNCWS required in subsection (B)(2), SOCs are unlikely to be detected by further quarterly monitoring during the interim monitoring relief period.