

**NOTICES OF FINAL RULEMAKING**

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* 1st as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Arizona Administrative Register* after the final rules have been submitted for filing and publication.

**NOTICE OF FINAL RULEMAKING**

**TITLE 6. ECONOMIC SECURITY**

**CHAPTER 6. DEPARTMENT OF ECONOMIC SECURITY - DEVELOPMENTAL DISABILITIES**

**PREAMBLE**

- | <b><u>1. Sections Affected</u></b> | <b><u>Rulemaking Action</u></b> |
|------------------------------------|---------------------------------|
| R6-6-1004.01                       | New Section                     |
| R6-6-1004.02                       | New Section                     |
| R6-6-1004.03                       | New Section                     |
| R6-6-1004.04                       | New Section                     |
| R6-6-1004.05                       | New Section                     |
| R6-6-1104.01                       | New Section                     |
| R6-6-1104.02                       | New Section                     |
| R6-6-1104.03                       | New Section                     |
| R6-6-1104.04                       | New Section                     |
| R6-6-1104.05                       | New Section                     |
| R6-6-1504.01                       | New Section                     |
| R6-6-1504.02                       | New Section                     |
| R6-6-1504.03                       | New Section                     |
| R6-6-1504.04                       | New Section                     |
| R6-6-1504.05                       | New Section                     |
- 2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**  
A.R.S. §§ 41-1954(A)(1)(i), (A)(1)(j), (A)(3); 46-134(12); 36-552; 36-554; 36-591 through 36-595; 36-596.54(A); 41-1072 through 41-1076
- 3. The effective date of the rules:**  
February 1, 1998
- 4. A list of all previous notices appearing in the Register addressing the final rule:**  
Notice of Rulemaking Docket Opening: 2 A.A.R. 5087, December 27, 1996  
Notice of Proposed Rulemaking: 3 A.A.R. 1451, June 6, 1997
- 5. The name and address of agency personnel with whom persons may communicate regarding the rule:**  
Name: Vista Thompson Brown  
Address: 1789 West Jefferson, Site Code 837A  
Phoenix, Arizona 85007  
or  
P.O. Box 6123, Site Code 837A  
Phoenix, Arizona 85005  
Telephone: (602) 542-6555  
Fax: (602) 542-6000
- 6. An explanation of the rule, including the agency's reason for initiating the rule:**  
Laws 1996, Ch. 102, Section 42 requires agencies to adopt rules establishing certain time-frames for the granting or denial of licenses. The rules must specify:
1. An "administrative completeness time-frame" (the time it takes the agency to determine if an application is complete);
  2. A "substantive review time-frame" (the time it takes the agency to review the application and determine if the applicant meets the substantive criteria for licensure); and
  3. An "overall time-frame" (a combination of the administrative completeness and substantive review time-frames).

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"License" includes certifications and approvals issued by an agency.

The law also requires an agency to adopt rules to specify separate time-frames for administrative completeness and substantive review if the agency already has time-frames for licensing, but the time-frames do not mirror the requirements of the law.

In addition, the agency is required to notify applicants within the established time-frames, whether the application is complete (administrative completeness) and whether a license or certification is being issued (substantive review).

These rules will establish the required time-frames for licensing Child Developmental Foster Homes (foster care for children) and Adult Developmental Homes (care for adults with developmental disabilities), and certification of Home and Community-Based Service Providers. The rules describe the contents of a completed application and the activities performed under substantive review. The rules also prescribe the notification procedure for the administrative review time-frames and the division's duty to notify an applicant who has been denied a license of the following:

1. The reason for the denial with citation to supporting statutes or rules,
2. The applicant's right to appeal the denial, and
3. The time periods for appealing the denial.

As a result of identifying the time-frames for licensing and certification, the Division determined that the contents of an application package needed to be clarified. The rules also identify those specific types of information and documentation that is required for a completed application.

7. **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

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

Service providers for Adult Developmental Homes, Child Developmental Foster Homes, and Home and Community-Based Services are considered small businesses. The proposed amendments will provide an intangible benefit for these service providers by identifying the time-frames in which the Division will approve or deny licenses and certificates.

Consumers may also receive an intangible benefit through the potential increase in service providers due to the identification of specific time limits for processing licenses and certificates.

The cost involved to implement the amendments will be borne by the Division. The costs will include an increase in notices, mailing, and staff to track and monitor the new time-frames. These additional costs are attributable to statutory requirements the rules are implementing.

9. **A description of the changes between the proposed rules, including supplemental notices, and final rules:**

Based on public comment and division staff review, the following changes have been made to the proposed rules:

R6-6-1004.02(F)

New section added identifying where an applicant is to send the application package.

R6-6-1004.03(1)(c)(iv)

Added the phrase, "occupation".

R6-6-1004.04(1)(b)(vi)

Deleted this section.

R6-6-1004.04(1)(c)(iv)

Added the phrase, "occupation".

R6-6-1104.02(F)

New section added identifying where an applicant is to send the application package.

R6-6-1104.03(1)(c)(iv)

Added the phrase, "occupation".

R6-6-1104.04(1)(b)(vi)

Deleted this section.

R6-6-1104.04(1)(c)(iv)

Added the phrase, "occupation".

R6-6-1504.01

Added time-frames for renewal and amended applications.

R6-6-1504.02(F)

New section added identifying where an applicant is to send the application package.

R6-6-1504.03(2)(h)

Added the term "applicable".

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R6-6-1504.03(2)(l)(iii)  
Added the phrase "if applicable".

R6-6-1504.04(1)(b)  
Added the term "applicable".

The effective date of the rules was changed from January 1, 1998, to February 1, 1998, to allow for implementation.

*General Changes:* In addition to the changes listed above, technical changes were made throughout the rules to improve clarity, grammar, and consistency.

**10. A summary of the principal comments and the agency response to them:**

The Arc of Arizona, the Arizona Consortium for Children with Chronic Illness and the Arizona Association of Providers for People with Disabilities jointly submitted 1 written statement of comments. Most of the comments concerned the contents of the application rather than the time-frames. The following indicates the comments made and the Division's response to these issues:

1. Comment: Request that the Division remove the sections in the application for Adult Developmental Homes and Child Developmental Foster Homes asking applicants to state their reasons for wanting to provide foster care or care to an adult.

Response: The division needs to know an applicant's motivation for providing care. It is important that applicants truly want to provide care and not have a strictly financial motive to apply. The division also needs to understand whether the applicant's expectations of being a foster care parent are realistic and to determine if the family has considered the demands of entering into a long-term relationship with persons who are non-family members. Therefore, the division believes that this question is critical to recruitment and retention of foster parents.

2. Comment: Take out the question asking about discipline techniques used by the applicant and other family members.

Response: In Title 6, Chapter 6, Articles 9, 10, and 11, the Division has existing rules which prohibit specific disciplinary measures, including corporal punishment and any other punishment prohibited by statute. Therefore, the Division needs to understand how the family and other household members who may be left alone with a client, use discipline.

3. Comment: Remove the requirement to submit a monthly budget.

Response: The Division needs this information to ensure that the applicant meets the requirements under R6-6-1001(E)(2).

4. Comment: The requirement for immunizations is already required for public school attendance and is redundant.

Response: The requirement already exists under R6-6-1001(E)(5) and R6-6-1101(E)(5) and is included in the time-frames rules as a part of the application packet to conform to these other current rules.

5. Comment: Remove safety inspections for vehicles transporting foster children and adults with developmental disabilities.

Response: R6-6-1012 and R6-6-1112 require that vehicles used to transport foster children and adults with developmental disabilities are maintained in safe operating condition and meet certain other requirements stated in (C) and (D) of R6-6-1012 and R6-6-1112. The requirement for a safety inspection is the method used to ensure that applicants meet this requirement.

6. Comment: Remove the requirement for stating the financial contributions made by a household member to the applicant.

Response: Agreed. This language is removed.

7. Comment: Remove the requirement to report on children who do not live with the applicant.

Response: It is important to know about the entire family, even if all members are not living in the same house. It provides information about the applicant's experience raising children and about individuals who may be visiting the home.

8. Comment: What is the time-frame in which the division would act on a negative report received on a licensed individual?

Response: The time-frames being adopted under these rules apply to issuance of a license and not to disciplinary matters concerning an individual who is already licensed.

9. Comment: There are redundancies in the information collected by AHCCCS and the division for HCBS certification.

Response: AHCCCS has delegated to the Division the responsibility for HCBS certification. There is no redundancy in the collection of this information.

10. Comment: For HCBS certificates, require the applicant submit only licenses applicable to the specific service or services for which the applicant wishes to obtain certification.

Response: The Division agrees and has added the word "applicable" before license.

11. Comment: For HCBS certificates, remove the requirement for a fax.

Response: In order to clarify the language, the term "if applicable" was added after requesting the applicant's fax number.

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

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12. Incorporations by reference and their location in the rules:  
Not applicable
13. Adoption as an emergency rule and text changes between adoption as an emergency and the adoption of these final rules:  
Not applicable
14. The full text of the rules follows:

**TITLE 6. ECONOMIC SECURITY**

**CHAPTER 6. DEPARTMENT OF ECONOMIC SECURITY - DEVELOPMENTAL DISABILITIES**

**ARTICLE 10. CHILD DEVELOPMENTAL FOSTER HOME LICENSE**

Section

- R6-6-1004.01. Time-Frame for Granting or Denying a License  
R6-6-1004.02. Administrative Completeness and Substantive Review Process  
R6-6-1004.03. Contents of a Complete Application Package - Initial License  
R6-6-1004.04. Contents of a Complete Application Package - Renewal License  
R6-6-1004.05. Contents of a Complete Request for an Amended License

**ARTICLE 11. ADULT DEVELOPMENTAL HOME LICENSE**

- R6-6-1104.01. Time-Frame for Granting or Denying a License  
R6-6-1104.02. Administrative Completeness and Substantive Review Process  
R6-6-1104.03. Contents of a Complete Application Package - Initial License  
R6-6-1104.04. Contents of a Complete Application Package - Renewal License  
R6-6-1104.05. Contents of a Complete Request for an Amended License

**ARTICLE 15. STANDARDS FOR CERTIFICATION OF HOME AND COMMUNITY-BASED SERVICE (HCBS) PROVIDERS**

- R6-6-1504.01. Time-Frame for Granting or Denying a Certificate  
R6-6-1504.02. Administrative Completeness and Substantive Review Process  
R6-6-1504.03. Contents of a Complete Application Package - Initial Certificate  
R6-6-1504.04. Contents of a Complete Application Package - Renewal Certificate  
R6-6-1504.05. Contents of a Complete Request for an Amended Certificate

**ARTICLE 10. CHILD DEVELOPMENTAL FOSTER HOME LICENSE**

R6-6-1004.01. Time-Frame for Granting or Denying a License  
For the purpose of A.R.S. § 41-1073, the Division establishes the following licensing time-frames:

1. Administrative completeness review time-frame:
  - a. For an initial license, 90 days;
  - b. For a renewal license, 30 days; and
  - c. For an amended license, 30 days.
2. Substantive review time-frame:
  - a. For an initial license, 30 days;
  - b. For a renewal license, 31 days; and
  - c. For an amended license, 10 days.
3. Overall time-frame:
  - a. For an initial license, 120 days;

- b. For a renewal license, 61 days; and
- c. For an amended license, 40 days.

R6-6-1004.02. Administrative Completeness and Substantive Review Process

- A. The Division shall send the license applicant a written notice within the administrative completeness review time frame indicating that the application package is either complete or incomplete.
- B. If the application package is incomplete, the Division shall list the missing information in the notice and ask the license applicant to supply the missing information within 60 days from the date of notice. If the license applicant fails to do so, the Division may close the file.
- C. A license applicant whose file has been closed and who later wishes to become licensed may reapply to the Division. The administrative completeness time-frame starts over when the Division receives the written request to reapply.
- D. When the application is complete, the Division shall complete a substantive review of the license applicant's qualifications. The Division shall:
  1. Review the application form and all required documents to ensure compliance with this Article.
  2. Complete a home study as prescribed in R6-6-1001(D), and
  3. Gather additional information needed to determine the license applicant's fitness to serve as a foster parent and ability to comply with foster care requirements, which may include:
    - a. Interviewing the license applicant;
    - b. Contacting references;
    - c. Verifying information provided in the application;
    - d. Visiting the license applicant's home; and
    - e. Requesting additional information, assessments, or tests as prescribed in R6-6-1001(F) and R6-6-1003(C).
- E. If a license is denied, the Division shall send a notice to the license applicant as prescribed in R6-6-1018(F) and A.R.S. § 41-1076.
- F. An applicant shall submit a license application package to DES/DDD, P.O. Box 6123, Site Code 791A, Phoenix, Arizona 85005-6123, Attention: Developmental Home Licensing Unit.

R6-6-1004.03. Contents of a Complete Application Package - Initial License

An initial application package is complete when the Division has all of the following information:

1. From the license applicant, a completed application form as prescribed in R6-6-1001(A) which contains the following information:
  - a. Personally identifying information, as follows:
    - i. Name and gender,
    - ii. Date and place of birth,
    - iii. Social security number.

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- iv. Ethnicity and religious preference.
  - v. Current and previous address.
  - vi. Dates resided at previous address.
  - vii. Length of Arizona residency.
  - viii. Current marital status and marital history, and
  - ix. Any other names by which the license applicant has been known.
  - b. Personally identifying information on the license applicant's household members, as follows:
    - i. Name.
    - ii. Gender.
    - iii. Date of birth.
    - iv. Relationship to license applicant, and
    - v. Length of time living in the home.
  - c. Personally identifying information on the license applicant's children who do not live with the license applicant, including emancipated children, as follows:
    - i. Name;
    - ii. Current address;
    - iii. Date of birth; and
    - iv. Occupation or school, if currently attending.
  - d. Any current or prior licenses or certificates held by the license applicant to provide care to a child or adult, as follows:
    - i. Type of license or certificate;
    - ii. Date of each license and certificate;
    - iii. State in which each license or certificate was issued;
    - iv. Any license or certificate which was revoked, denied, voluntarily surrendered, or suspended, and the circumstances; and
    - v. Name of any other agency with which the license applicant is currently licensed or certified to provide services to children or adults.
  - e. A description of the license applicant's home, as follows:
    - i. The name of the school district in which the license applicant's home is located;
    - ii. Identification and description of any swimming pool, spa, fish pond, or other body of water; and
    - iii. Number of bedrooms.
  - f. Information about the license applicant, as follows:
    - i. Educational background;
    - ii. Employment history;
    - iii. Previous experience in providing room and board for any person;
    - iv. Any contact with Child Protective Services (CPS) or Adult Protective Services (APS) and the circumstances;
    - v. Any arrests and the circumstances;
    - vi. Any history of mental illness or treatment for a mental illness or emotional disorder including hospitalization for alcohol, drug, or mental health issues and the circumstances;
    - vii. If currently or previously employed by the Department of Economic Security or the Division, position, title, name of the supervisor, and name of the program;
    - viii. The reason for wanting to provide foster care;
    - ix. Gender, age, characteristics, and special needs of the individual the license applicant would prefer to take into the home;
    - x. Any experience caring for individuals who have special needs;
  - xi. Discipline techniques used or believed appropriate for rearing children; and
  - xii. Anticipated changes in the license applicant's family in the next 12 months.
  - g. Information about the license applicant's household members, as follows:
    - i. Any contact with CPS or APS by anyone currently or formerly residing with the license applicant and the circumstances;
    - ii. Any arrests and the circumstances;
    - iii. Any history of mental illness or treatment for a mental illness or emotional disorder including hospitalization for alcohol, drug, or mental health issues and the circumstances;
    - iv. If currently or previously employed by the Department of Economic Security or the Division, position, title, name of supervisor, and name of the program;
    - v. Any experience caring for individuals with special needs; and
    - vi. Discipline techniques used or believed appropriate for rearing children.
  - h. Reference information for the license applicant, as follows:
    - i. Three references who can attest to the license applicant's character and skill; and
    - ii. If the license applicant is working or has worked with children or adults with developmental disabilities, 1 employment reference;
    - i. List of any individuals who live on the property on which the license applicant's home is located but not in the license applicant's home.
2. From the license applicant, the following documents as listed on the application form:
- a. A completed declaration of criminal history for the license applicant and each adult household member on a Division form with the following information:
    - i. Name.
    - ii. Social security number.
    - iii. Date of birth.
    - iv. Address.
    - v. A declaration of whether the individual has committed any of the crimes listed in A.R.S. § 36-594(3) and R6-6-1018, and
    - vi. Dated signature.
  - b. Documentation showing that the license applicant and each adult household member have been fingerprinted;
  - c. Documentation showing that the license applicant has a current driver's license, and current vehicle liability insurance as prescribed in R6-6-1012(A);
  - d. A completed monthly budget on a Division form showing the license applicant's monthly income, and monthly expenses, and the circumstances for any declaration of bankruptcy;
  - e. A physician's statement for the license applicant and each adult household member as prescribed in R6-6-1001(L);
  - f. Documentation of current immunizations for each child living in the license applicant's home as prescribed in R6-6-1001(E)(5);
  - g. Documentation that the license applicant has completed training as prescribed in R6-6-1005(A).

3. From sources other than the applicant, the documents listed on the application form, as follows:
  - a. Three letters of reference for the license applicant as prescribed in R6-6-1001(G);
  - b. If the license applicant works with children or adults with developmental disabilities, 1 employment letter of reference as prescribed in R6-6-1001(H);
  - c. Documentation that the license applicant and each adult household member have had a criminal history check as prescribed in R6-6-1001(B);
  - d. Documentation showing that the license applicant's home has passed:
    - i. A fire inspection as prescribed in R6-6-1011(E), and
    - ii. A health and safety inspection as prescribed in R6-6-1011(D).
  - e. Documentation that vehicles used for transporting foster children have passed a Division safety inspection to meet the safety requirements set forth in R6-6-1012(B); and
  - f. Documentation that the CPS/APS Central Registry has been checked as prescribed in R6-6-1001(C).
- f. Any current or prior license or certificate held by the license applicant to provide care to a child or adult, as follows:
  - i. Type of license or certificate;
  - ii. Date of each license and certificate;
  - iii. State in which the license or certificate was issued;
  - iv. Any license or certificate which was revoked, denied, voluntarily surrendered, or suspended, and the circumstances; and
  - v. Name of any other agency with which the license applicant is currently licensed or certified to provide services to children or adults.
- g. List of any individuals who live on the property on which the license applicant's home is located, but not in the license applicant's home;
- h. List of the household members and their relationship to the applicant and each other;
- i. Any changes that should be made to the license conditions;
- j. Dated signature.

2. From the license applicant, the items listed in R6-6-1004.03(2)(c), (2)(d), (2)(f), and the following:
  - a. A completed declaration of criminal history for each new adult household member and, at 3-year intervals, a completed declaration for all adult household members;
  - b. Documentation showing that each new adult household member has been fingerprinted and, at 3-year intervals, that all adult household members have been fingerprinted;
  - c. A physician's statement every 3 years from the date of the initial license for the license applicant and all adult household members; and
  - d. Documentation that the license applicant has completed training as prescribed in R6-6-1005(B).
3. From sources other than the applicant, the documents listed in R6-6-1004.03(3)(d)(i), (3)(e), and (3)(f) and the following:
  - a. Documentation that each new adult household member has had a criminal history check and that all adult household members have had a criminal history check every 3 years, and
  - b. Documentation that the license applicant's home has passed a health and safety inspection every 3 years since the date of the initial license.

**R6-6-1004.04. Contents of a Complete Application Package - Renewal License**

A license renewal application package is complete when the Division has all the following information:

1. From the license applicant, a completed renewal application form as prescribed in R6-6-1001(A) which contains the following information:
  - a. Personally identifying information, as follows:
    - i. Name,
    - ii. Address, and
    - iii. Phone number.
  - b. Personally identifying information on the license applicant's household members, as follows:
    - i. Name,
    - ii. Gender,
    - iii. Age,
    - iv. Relationship to the license applicant, and
    - v. School or occupation.
  - c. Personally identifying information on the license applicant's children who do not live with the license applicant, including emancipated children, as follows:
    - i. Name;
    - ii. Age;
    - iii. Address; and
    - iv. Occupation or school, if currently attending.
  - d. Information about the license applicant, as follows:
    - i. Any arrest or investigation for a criminal offense, including charge, and arresting agency; and
    - ii. Any referral to or treatment for a psychiatric or psychological problem, including substance abuse, in the last year.
  - e. Information about the license applicant's household members, including:
    - i. Any arrest or investigation for a criminal offense, including charge, and arresting agency;
    - ii. Any referral to or treatment for a psychiatric or psychological problem, including substance abuse, in the last year.

**R6-6-1004.05. Contents of a Completed Request for an Amended License**

A request for an amended license is complete when the Division has the following:

1. A description of the change requested to the license, and
2. Documentation that the requested change complies with this Article.

**ARTICLE 11. ADULT DEVELOPMENTAL HOME LICENSE**

**R6-6-1104.01. Time-Frame for Granting or Denying a License**  
For the purpose of A.R.S. § 41-1073, the Division establishes the following licensing time-frames:

1. Administrative completeness review time frame:
  - a. For an initial license, 90 days;
  - b. For a renewal license, 30 days; and
  - c. For an amended license, 30 days.
2. Substantive review time-frame:

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- a. For an initial license, 30 days;
  - b. For a renewal license, 31 days; and
  - c. For an amended license, 10 days.
3. Overall time-frame:
- a. For an initial license, 120 days;
  - b. For a renewal license, 61 days; and
  - c. For an amended license, 40 days.

**R6-6-1104.02. Administrative Completeness and Substantive Review Process**

- A. The Division shall send the license applicant a written notice within the administrative completeness review time-frame indicating that the application package is either complete or incomplete.
- B. If the application package is incomplete, the Division shall list the missing information in the notice and ask the license applicant to supply the missing information within 60 days from the date of notice. If the license applicant fails to do so, the Division may close the file.
- C. A license applicant whose file has been closed and who later wishes to become licensed may reapply to the Division. The administrative completeness time-frame starts over when the Division receives the written request to reapply.
- D. When the application is complete, the Division shall complete a substantive review of the license applicant's qualifications. The Division shall:
  - 1. Review the application form and all required documents to ensure compliance with this Article,
  - 2. Complete a home study as prescribed in R6-6-1101(D), and
  - 3. Gather additional information needed to determine the license applicant's fitness to serve as an Adult Developmental Home service provider and ability to comply with Adult Developmental Home requirements, which may include:
    - a. Interviewing the license applicant;
    - b. Contacting references;
    - c. Verifying information provided in the application;
    - d. Visiting the license applicant's home; and
    - e. Requesting additional information, assessments, or tests as prescribed in R6-6-1101(F) and R6-6-1103(C).
- E. If a license is denied, the Division shall send a notice to the license applicant as prescribed in R6-6-1118(F) and A.R.S. § 41-1076.
- F. An applicant shall submit a license application package to DES/DDD, P.O. Box 6123, Site Code 791A, Phoenix, Arizona 85005-6123, Attention: Developmental Home Licensing Unit.

**R6-6-1104.03. Contents of a Complete Application Package - Initial License**

An initial application package is complete when the Division has all of the following information:

- 1. From the license applicant, a completed application form as prescribed in R6-6-1101(A) which contains the following information:
  - a. Personally identifying information, as follows:
    - i. Name and gender,
    - ii. Date and place of birth,
    - iii. Social security number,
    - iv. Ethnicity and religious preference,
    - v. Current and previous address,
    - vi. Dates resided at previous address,
    - vii. Length of Arizona residency,
    - viii. Current marital status and marital history, and

- ix. Any other names by which the license applicant has been known.
- b. Personally identifying information on the license applicant's household members, as follows:
  - i. Name,
  - ii. Gender,
  - iii. Date of birth,
  - iv. Relationship to license applicant, and
  - v. Length of time living in the home,
- c. Personally identifying information on the license applicant's children who do not live with the license applicant, including emancipated children, as follows:
  - i. Name;
  - ii. Current address;
  - iii. Date of birth; and
  - iv. Occupation or school, if currently attending.
- d. Any current or prior licenses or certificates held by the license applicant to provide care to a child or adult, as follows:
  - i. Type of license or certificate;
  - ii. Date of each license and certificate;
  - iii. State in which each license or certificate was issued;
  - iv. Any license or certificate which was revoked, denied, voluntarily surrendered, or suspended and the circumstances; and
  - v. Name of any other agency with which the license applicant is currently licensed or certified to provide services to children or adults.
- e. A description of the license applicant's home, as follows:
  - i. The name of the school district in which the license applicant's home is located;
  - ii. Identification and description of any swimming pool, spa, fish pond, or other body of water; and
  - iii. Number of bedrooms.
- f. Information about the license applicant, as follows:
  - i. Educational background;
  - ii. Employment history;
  - iii. Previous experience in providing room and board for any person;
  - iv. Any contact with CPS or APS and the circumstances;
  - v. Any arrest and the circumstances;
  - vi. Any history of mental illness or treatment for a mental illness or emotional disorder including hospitalization for alcohol, drug, or mental health issues and the circumstances;
  - vii. If currently or previously employed by the Department of Economic Security or the Division, position, title, name of the supervisor, and name of the program;
  - viii. The reason for wanting to provide care to an adult;
  - ix. Gender, age, characteristics, and special needs of the individual the license applicant would prefer to take into the home;
  - x. Any experience caring for individuals who have special needs;
  - xi. Discipline techniques used or believed appropriate; and
  - xii. Anticipated changes in the license applicant's family in the next 12 months.

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- g. Information about the license applicant's household member, as follows:
    - i. Any contact with CPS or APS by anyone currently or formerly residing with the license applicant and the circumstances;
    - ii. Any arrests and the circumstances;
    - iii. Any history of mental illness or treatment for a mental illness or emotional disorder including hospitalization for alcohol, drug, or mental health issues and the circumstances;
    - iv. If currently or previously employed by the Department of Economic Security or the Division, position, title, name of the supervisor, and name of the program;
    - v. Any experience caring for individuals with special needs; and
    - vi. Discipline techniques used or believed appropriate.
  - h. Reference information for the license applicant, as follows:
    - i. Three references who can attest to the license applicant's character and skill; and
    - ii. If the license applicant is working or has worked with children or adults with developmental disabilities, 1 employment reference;
    - i. List of any individuals who live on the property on which the license applicant's home is located, but not in the license applicant's home.
2. From the license applicant, the following documents listed on the application form:
- a. A completed declaration of criminal history for the license applicant and each adult household member on a Division form with the following information:
    - i. Name,
    - ii. Social security number,
    - iii. Date of birth,
    - iv. Address,
    - v. A declaration of whether the individual has committed any of the crimes listed in A.R.S. § 36-594(3) and R6-6-1118, and
    - vi. Dated signature.
  - b. Documentation showing that the license applicant and each adult household member have been fingerprinted;
  - c. Documentation showing that the license applicant has a current driver's license, and current vehicle liability insurance as prescribed in R6-6-1112(A);
  - d. A completed monthly budget on a Division form showing the license applicant's monthly income, and monthly expenses, and the circumstances for any declaration of bankruptcy;
  - e. A physician's statement for the license applicant and each adult household member as prescribed in R6-6-1101(L);
  - f. Documentation of current immunizations for each child living in the license applicant's home as prescribed in R6-6-1101(E)(5);
  - g. Documentation that the license applicant has completed training as prescribed in R6-6-1105(A).
3. From sources other than the applicant, the documents listed on the application form, as follows:
- a. Three letters of reference for the license applicant as prescribed in R6-6-1101(G);
  - b. If the license applicant works with children or adults with developmental disabilities, 1 employment letter of reference as prescribed in R6-6-1101(H);
  - c. Documentation that the license applicant and each adult household member have had a criminal history check as prescribed in R6-6-1101(B);
  - d. Documentation showing that the license applicant's home has passed:
    - i. A fire inspection as prescribed in R6-6-1111(E), and
    - ii. A health and safety inspection as prescribed in R6-6-1111(D).
  - e. Documentation that vehicles used for transporting individuals with developmental disabilities have passed a Division safety inspection to meet the safety requirements in R6-6-1112(B); and
  - f. Documentation that the CPS/APS Central Registry has been checked as prescribed in R6-6-1101(C).
- R6-6-1104.04. Contents of a Complete Application Package - Renewal License**  
A license renewal application package is complete when the Division has all the following information:
- 1. From the license applicant, a completed renewal application form as prescribed in R6-6-1101(A) which contains the following information:
    - a. Personally identifying information, as follows:
      - i. Name,
      - ii. Address, and
      - iii. Phone number.
    - b. Personally identifying information on the license applicant's household members, as follows:
      - i. Name,
      - ii. Gender,
      - iii. Age,
      - iv. Relationship to the license applicant, and
      - v. School or occupation.
    - c. Personally identifying information on the license applicant's children who do not live with the license applicant, including emancipated children, as follows:
      - i. Name;
      - ii. Age;
      - iii. Address; and
      - iv. Occupation or school, if currently attending.
    - d. Information about the license applicant, as follows:
      - i. Any arrest or investigation for a criminal offense, including charge, and arresting agency;
      - ii. Any referral to or treatment for a psychiatric or psychological problem, including substance abuse, in the last year.
    - e. Information about the license applicant's household member, including:
      - i. Any arrest or investigation for a criminal offense, including charge, and arresting agency;
      - ii. Any referral to or treatment for a psychiatric or psychological problem, including substance abuse, treatment in the last year.
    - f. Any current or prior license or certificate held by the license applicant to provide care to a child or adult, as follows:
      - i. Type of license or certificate;
      - ii. Date of each license and certificate;

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- iii. State in which the license or certificate was issued;
  - iv. Any license or certificate which was revoked, denied, voluntarily surrendered, or suspended and the circumstances; and
  - v. Name of any other agency with which the license applicant is currently licensed or certified to provide services to children or adults.
  - g. List of any individuals who live on the property on which the license applicant's home is located, but not in the license applicant's home;
  - h. List of the household members and their relationship to the applicant and to each other;
  - i. Any changes that should be made to the license conditions;
  - j. Dated signature.
2. From the license applicant, the items listed in R6-6-1104.03(2)(c),(2)(d), (2)(f), and the following:
- a. A completed declaration of criminal history for each new adult household member and, at 3-year intervals, a completed declaration for all adult household members;
  - b. Documentation showing that each new adult household member has been fingerprinted and, at 3-year intervals, that all adult household members have been fingerprinted;
  - c. A physician's statement every 3 years from the date of the initial license for the license applicant and all adult household members; and
  - d. Documentation that the license applicant has completed training as prescribed in R6-6-1105(B).
3. From sources other than the applicant, the documents listed in R6-6-1104.03(3)(d)(i), (3)(e), and (3)(f) and the following:
- a. Documentation that each new adult household member has had a criminal history check and that all adults household members have had a criminal history check every 3 years; and
  - b. Documentation that the license applicant's home has passed a health and safety inspection every 3 years since the date of the initial license.

**R6-6-1104.05. Contents of a Complete Request for an Amended License**

A request for an amended license is complete when the Division has the following:

- 1. A description of the change requested to the license, and
- 2. Documentation that the requested change complies with this Article.

**ARTICLE 15. STANDARDS FOR CERTIFICATION OF HOME AND COMMUNITY-BASED SERVICE (HCBS) PROVIDERS**

**R6-6-1504.01. Time-Frame for Granting or Denying an HCBS certificate**

For the purpose of A.R.S. § 41-1073, the Division establishes the following HCBS certificate time-frames:

- 1. Administrative completeness review time-frame:
  - a. For an initial certificate, 60 days;
  - b. For a renewal certificate, 25 days; and
  - c. For an amended certificate, 25 days.
- 2. Substantive review time-frame:
  - a. For an initial certificate, 60 days;
  - b. For a renewal certificate, 5 days; and
  - c. For an amended certificate, 5 days.

- 3. Overall time-frame:
  - a. For an initial certificate, 120 days;
  - b. For a renewal certificate, 30 days; and
  - c. For an amended certificate, 30 days.

**R6-6-1504.02. Administrative Completeness and Substantive Review Process**

- A. The Division shall send the applicant a written notice within the administrative completeness review time-frame indicating that the application package is either complete or incomplete.
- B. If the application package is incomplete, the Division shall list the missing information in the notice and ask the applicant to supply the missing information within 30 days from the date of notice. If the applicant fails to do so, the Division may close the file.
- C. An applicant whose file has been closed and who later wishes to become certified may reapply to the Division. The administrative completeness time-frame starts over when the Division receives the written request to reapply.
- D. When the application is complete, the Division shall complete a substantive review of the applicant's qualification. The Division shall:
  - 1. Review the application form and all required documents to ensure compliance with this Article,
  - 2. Conduct CPS/APS background checks, and
  - 3. Verify previous licensure or certification.
- E. If an HCBS certificate is denied, the Division shall send a notice to the applicant and include the following information:
  - 1. The reason for the denial with citation to supporting statutes or rules,
  - 2. The applicant's right to appeal the denial, and
  - 3. The time periods for appealing the denial.
- F. An applicant shall submit an HCBS certificate application package to DES/DDD, P.O. Box 6123, Site Code 791A, Phoenix, Arizona 85005-6123, Attention: HCBS Certification Unit.

**R6-6-1504.03. Contents of a Complete Application Package - Initial Certificate**

An initial application package is complete when the Division has all of the following information:

- 1. From the applicant, a completed application form as prescribed in R6-6-1504 (B); and
- 2. From the applicant, the following documents listed on the application form:
  - a. A completed AHCCCS provider participation agreement form as prescribed in R6-6-1503 which contains the following information:
    - i. The applicant's name, social security number or tax identification number, and business address;
    - ii. Terms of the agreement between the provider and AHCCCS; and
    - iii. Signature of the applicant,
  - b. A completed declaration of criminal history as prescribed in R6-6-1504(B)(6) on a Division form which contains the following information:
    - i. Name of the applicant,
    - ii. Social security number,
    - iii. Date of birth,
    - iv. Applicant address,
    - v. A declaration of whether or not the applicant has committed any of the crimes listed in R6-6-1514, and
    - vi. Dated signature.

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- c. Documentation showing that fingerprints have been taken as prescribed in R6-6-1506;
  - d. Documentation showing current CPR training as prescribed in R6-6-1520;
  - e. Documentation showing current First Aid training as prescribed in R6-6-1520;
  - f. Documentation showing Article 9 review as prescribed in R6-6-1520;
  - g. Documentation showing that the applicant has a current driver's license, vehicle registration, and liability insurance as prescribed in R6-6-1520(D);
  - h. Copies of any applicable professional license or certification as prescribed in R6-6-1504(C); and
  - i. AHCCCS provider registration form as prescribed in R6-6-1503 which contains the following information:
    - i. Name, social security number, and Federal Employer Identification (FEI) number of the applicant;
    - ii. Physical and mailing address of the applicant;
    - iii. Telephone number and telefacsimile number, if applicable for the applicant;
    - iv. Categories of service provided;
    - v. Changes from the prior year, if necessary;
    - vi. AHCCCS provider identification number;
    - vii. Districts and counties served;
    - viii. Place and date of birth; and
    - ix. Dated signature.
3. From sources other than the applicant, the documents listed on the application form as follows:
- a. Three letters of reference as prescribed in R6-6-1504(D), and
  - b. Documentation showing that the applicant's home or office has passed:
    - i. A fire inspection as prescribed in R6-6-1505, and
    - ii. A health and safety inspection as prescribed in R6-6-1505.

**R6-6-1504.04. Contents of a Complete Application Package - Renewal Certificate**

A renewal application is complete when the Division has all the following information:

- 1. From the applicant, the following items:
  - a. AHCCCS provider registration form;
  - b. Documentation of current CPR and First Aid training, current driver's license, and applicable professional licenses and certifications, if prior documentation has expired;
  - c. A completed declaration of criminal history every 3 years since the date of initial certification; and
  - d. Documentation that fingerprints have been taken at 3-year intervals.
- 2. From sources other than the applicant, documentation that the applicant's home or office has passed a fire inspection every 2 years since the date of initial certification.

**R6-6-1504.05. Contents of a Complete Request for an Amended Certificate**

A request for an amended HCBS certificate is complete when the Division has the following information:

- 1. AHCCCS provider registration form, and
- 2. Documentation to support the requested change.

**NOTICE OF FINAL RULEMAKING**

**TITLE 9. HEALTH SERVICES**

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

**PREAMBLE**

<b>1. <u>Sections Affected</u></b>	<b><u>Rulemaking Action</u></b>
R9-22-501	Amend
R9-22-502	Amend
R9-22-503	Amend
R9-22-504	Amend
R9-22-505	Amend
R9-22-506	Repeal
R9-22-507	Amend
R9-22-508	Amend
R9-22-509	Amend
R9-22-510	Amend
R9-22-511	Amend
R9-22-512	Amend
R9-22-513	Amend
R9-22-514	Amend
R9-22-515	Repeal
R9-22-518	Amend
R9-22-519	Repeal
R9-22-520	Amend
R9-22-521	Amend
R9-22-522	Amend
R9-22-523	Amend
R9-22-524	Amend

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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. § 36-2903.01  
Implementing statute: A.R.S. §§ 36-2903, 36-2906, 36-2907
3. **The effective date of the rules:**  
December 8, 1997
4. **A list of all previous notices appearing in the Register addressing the final rule:**  
Notice of Rulemaking Docket Opening: 3 A.A.R. 2310, August 22, 1997  
Notice of Proposed Rulemaking: 3 A.A.R. 2225, August 22, 1997
5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**  
Name: Cheri Tomlinson  
Address: Arizona Health Care Cost Containment System  
801 East Jefferson, MD4200  
Phoenix, Arizona 85034  
Telephone: (602) 417-4198  
Fax: (602) 256-6756
6. **An explanation of the rule, including the agency's reasons for initiating the rule:**  
Changes are made to 9 A.A.C. 22, Article 5, which pertains to general provisions and standards for contractors and providers. The changes are designed to:
  - Eliminate duplicative language,
  - Improve consistency between acute care and ALTCS rules whenever possible, and
  - Provide additional clarity and conciseness to existing language.
7. **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.
8. **The summary of the economic, small business, and consumer impact:**  
It is anticipated there will be a nominal to minimal economic impact upon a limited number of AHCCCS contractors and providers as a result of changes to R9-22-502 requiring contractors to comply with:
  - Provider-to-member ratio as specified in contract. Current rule specifies a provider-to-member ratio of 1 primary care physician (PCP) per 2,500 members. The current provider-to-member ratio in contract is 1 PCP to 1,800 adults or 1,200 children age 12 or younger. In addition, the contract requires that AHCCCS members do not comprise a majority of the PCPs panel of patients.
  - Appointment standards as specified in contract.  
Even though some contractors, providers, or both, may view this as a more significant change, the impact of the change is further moderated because contract language permits contractors to request the Administration to approve a variation to the standards. While it is anticipated that relatively few PCPs will be impacted by the change, the actual number of PCPs with provider-to-member ratios in excess of contract standards remains unclear because the agency has not regularly tracked provider-to-member ratios. Contractors are responsible for ensuring that their provider-to-member ratios are in accordance with contract. However, beginning in late 1997 AHCCCS will begin to monitor provider-to-member ratios on a quarterly basis based on the provider affiliation tape submitted by contractors. In addition, during annual operational and financial reviews, the Administration examines contractor compliance with contract requirements. Although the agency does not keep records, AHCCCS is confident that there are relatively few providers who will not be able to meet the new standards. In addition, for those providers who do not, the agency will permit exceptions to the rule if accessibility and quality standards can be met.

There are a number of other changes to the rules (as noted in the Economic, Small Business, and Consumer Impact Statement on file with this Agency and the Office of the Secretary of State) that are anticipated to have a nominal impact upon, and be of benefit to, the following entities;

- AHCCCS,
- AHCCCS contractors (including contractors that are governmental entities or private business entities),
- AHCCCS providers (including those providers that could be considered small or large businesses), and
- AHCCCS members.

Other entities considered, but which will not be directly impacted by the changes include:

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- Other governmental entities and political subdivisions; and
  - The general public, including taxpayers and private individuals.
9. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**  
The changes between the proposed rules and the final rules are minimal and include:
- Grammatical, verb tense, punctuation, and minor wording changes; and
  - Clarified in R9-22-522(B)(3) that the Administration only approves initial QM/UM plan and does not approve modifications to a QM/UM plan.
10. **A summary of the principal comments and the agency response to them:**  
The Administration received 1 comment regarding R9-22-522(B). The Administration clarified that we only approve an initial QM/UM plan.
11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**  
None.
12. **Incorporations by reference and their location in the rules:**  
1634 Agreement, October 1, 1982, incorporated at R9-22-512(F)(5).  
42 CFR 455, Subpart B, September 30, 1986, incorporated at R9-22-520(B)(4).
13. **Was this rule previously adopted as an emergency rule?**  
No.
14. **The full text of the rules follows:**

**TITLE 9. HEALTH SERVICES**

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

**ARTICLE 5. GENERAL PROVISIONS AND STANDARDS**

- R9-22-501. Pre-existing conditions Conditions
- R9-22-502. Availability and accessibility Accessibility of service Service
- R9-22-503. Reinsurance
- R9-22-504. Marketing; prohibition Prohibition against inducements; misrepresentation; discrimination; sanctions Inducements; Misrepresentations; Discrimination; Sanctions
- R9-22-505. Approval of advertisements Advertisements and marketing materials Marketing Materials
- R9-22-506. Provider registration Repealed
- R9-22-507. Member records Record and systems
- R9-22-508. Limitation of benefit coverage Benefit Coverage for illness Illness or injury Injury due to catastrophe Catastrophe
- R9-22-509. Transition and coordination Coordination of patient care Member Care
- R9-22-510. Transfer of members Members
- R9-22-511. Fraud or abuse Abuse
- R9-22-512. Release of Safeguarded Information by the Administration and Contractors
- R9-22-513. Discrimination prohibition Prohibition
- R9-22-514. Equal opportunity Opportunity
- R9-22-515. Filing notices and appeals Repealed
- R9-22-518. Information to enrolled members Enrolled Members
- R9-22-519. Periodic reports and information Repealed
- R9-22-520. Financial statements Statements, Periodic Reports and Information
- R9-22-521. Medical audits Program Compliance Audits
- R9-22-522. Contractor's Internal Utilization Control System Quality Management/Utilization Management (QM/UM) Requirements
- R9-22-523. Financial resources Resources

R9-22-524. Continuity of care Care

**ARTICLE 5. GENERAL PROVISIONS AND STANDARDS**

- R9-22-501 Pre-existing conditions Conditions**
- A. Except as otherwise provided in Article 3 of these rules, this Chapter, a contractor shall be responsible for providing the full scope of AHCCCS covered services to each enrolled member from the effective date of enrollment eligibility until the time of notification of termination, suspension, or transfer of such the member's enrollment. Liability shall This responsibility include includes providing treatment for all of an enrolled a member's pre-existing conditions.
- B. An AHCCCS A contractor or subcontractor shall not adopt or utilize use any procedure to identify individuals who have an existing or anticipated medical or psychiatric problems condition in order to discourage or exclude the individuals from enrolling in such the contractor's health plan or encourage the individuals to enroll in another health plan.

**R9-22-502 Availability and accessibility Accessibility of service Service**

~~Contractors shall provide available, accessible and adequate numbers of institutional facilities, service locations, service sites, professional, allied and paramedical personnel for the provision of covered services, including all emergency medical care on a 24 hours a day, seven days a week basis. The contractor shall have or provide the following as a minimum:~~

- ~~1. One full-time equivalent primary care physician per 2,500 patients. Practitioners, as defined in these Rules, shall be designated as 5 primary care physicians in determining equivalency requirements.~~
- ~~2. A designated emergency services facility, providing care on a 24 hours a day, seven days a week basis, accessible to members in each contracted service area. One or more physicians and one nurse shall be on call or on duty at such facility at all times.~~

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3. ~~An emergency services system employing at least one physician, registered nurse, physician's assistant or nurse practitioner, accessible to members by telephone 24 hours a day, seven days a week, for information in the event of an emergency, as defined by these rules, and to providers who need verification of patient membership and treatment authorization.~~
  4. ~~An emergency services call log containing: member's name, address, telephone number, date of call, time of call, nature of complaint or problem, and instructions given each member.~~
    - A. A contractor shall provide adequate numbers of available and accessible:
      1. Institutional facilities;
      2. Service locations;
      3. Service sites; and
      4. Professional, allied, and paramedical personnel for the provision of covered services, including all emergency medical services for 24 hours a day, 7 days a week.
    - B. A contractor shall minimally provide the following:
      1. A ratio of primary care providers to adults and children, as specified in contract;
      2. A designated emergency services facility, providing care 24 hours a day, 7 days a week, accessible to members in each contracted service area. One or more physicians and 1 or more nurses shall be on call or on duty at the facility at all times;
      3. An emergency services system employing at least 1 physician, registered nurse, physician's assistant, or nurse practitioner, accessible by telephone 24 hours a day, 7 days a week, to members who need information in an emergency, and to providers who need verification of patient membership and treatment authorization;
      4. An emergency services call log or database to track the following information:
        - a. Member's name,
        - b. Address and telephone number,
        - c. Date and time of call,
        - d. Nature of complaint or problem, and
        - e. Instructions given to member.
      5. A written procedure plan for the communication of communicating emergency services information to the a member's primary care physician provider, and other appropriate organizational units; units;
      6. An appointment system for each of its service locations. The appointment system shall assure that:
        - a. Members with acute or urgent problems shall be triaged and provided same-day service when necessary;
        - b. Time-specific appointments for routine medically necessary care from the primary care physician shall be available within three weeks of a member's request and on the same day for emergency care. Referral appointments to specialists must be the same day for emergency care, within three days for urgent care and within 30 days for routine care.
        - e. Waiting times for members with appointments shall not exceed 45 minutes except when the provider is unavailable due to an emergency.
      6. An appointment standard as specified in contract for the following:
        - a. Emergency appointments;
        - b. Urgent care appointments; and
        - c. Routine care appointments.
  7. ~~One primary care physician who an enrolled member may select or to whom the member may be assigned. This physician is responsible for supervising, coordinating and providing initial and primary care to patients; initiating referrals for specialty care, and maintaining continuity of patient care. Contractors whose organization does not ordinarily include primary care physicians shall enter into an affiliation or subcontract with organizations or individuals to provide such primary care; the contractor shall agree to provide services under the primary care physician's guidance and direction.~~
    7. Waiting times for members with appointments that do not exceed 45 minutes, except when the provider is unavailable due to an emergency.
- C. A contractor shall have an affiliation with or subcontract with an organization or individual to provide primary care services. The contractor shall agree to provide services under the primary care provider's guidance and direction.
    1. A primary care provider selected by or to whom an enrolled member is assigned shall be responsible for:
      - a. Supervising, coordinating, and providing initial and primary care to the member;
      - b. Initiating referrals for specialty care;
      - c. Maintaining continuity of member care; and
      - d. Maintaining an individual medical record for each assigned member.
    2. A Primary primary care physicians and provider or specialists specialist providing inpatient services to a members member must shall have staff privileges in a minimum of one 1 general acute care hospital under subcontract with the contracting health plan contractor, within the service area of the contractor.

**R9-22-503. Reinsurance**

- A. Contractor-acquired reinsurance. A contractor may obtain reinsurance for coverage of prepaid capitated members. A contractor shall not obtain reinsurance to reduce liability below 25% of the applicable deductible level during any AHCCCS contract year. This limitation shall does not apply to reinsurance obtained by a contractor to cover the cost of services provided by noncontracting providers and nonproviders to members under emergency circumstances.
- B. Administration reinsurance. For purposes of the Administration's reinsurance program, the insured entity shall be a prepaid plan with which the Administration contracts. Only costs incurred during the contract year in which a member is enrolled with a contractor qualify for reinsurance. Any movement of a member from membership with 1 contractor to membership with another contractor shall be cause for resetting the deductible level unless resetting is waived by the Administration.
  1. Costs qualifying for reinsurance shall have been incurred during the contract year or such part of that year in which the individual member is enrolled with the contractor. Any movement of a member from membership with one contractor to membership with another contractor shall be cause for the resetting of the deductible level
  2. The contractor shall notify the AHCCCS Administration when an individual member's incurred costs for inpatient, emergency and certain outpatient services, as prescribed in subsection (C), reach 60% of the applicable deductible level.
- C. Coinurance and deductibles for eligible members.
  1. Coinurance. As set forth stated in the contract, the Administration shall pay a percentage of costs in excess

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of the applicable deductible level incurred in the provision of, or payment paying for covered inpatient hospital emergency and certain outpatient services and when applicable, nursing facilities and acute medical and psychiatric services approved by the Director, pursuant to A.R.S. § 36-2906(D). These include dialysis services not covered by Title XVIII, total parenteral nutrition, and other ambulatory services.

2. Deductible. A contractor is responsible for payment of shall pay the deductible for members.
- D. Computation of the deductible level. The deductible level shall be calculated as determined by the costs charges are paid by the contractor, or the AHCCCS fee schedule, if the costs were are paid under a subcapitated arrangement.
- E. Costs Amounts in excess of the deductible level shall be paid based upon charges adjudicated or costs paid by the contractor or the AHCCCS fee schedule, whichever is less, minus the applicable coinsurance and third-party reimbursements unless the costs are paid under a subcapitated arrangement. In subcapitated cases, the Administration shall base reimbursement of reinsurance encounters on the calculated AHCCCS allowed amount minus Medicare/TPL payments and applicable quick pay discounts.
  1. The contractor shall provide maintain evidence that costs incurred have been adjudicated paid by the contractor prior to before submitting reinsurance claims encounters. This information is subject to AHCCCS Administration review.
  2. Third- First- and 3rd-party collections shall reduce be reflected by the contractor as reductions in the reinsurance claim encounters submitted on a dollar-for dollar-basis.
  3. Payments made by contractor-purchased reinsurance are not considered third 1st- and 3rd-party collections for the purpose of Administration reinsurance.
- F. Claims Encounter submission. A contractor shall be responsible for the preparation prepare, review, verification, verify, certification certify, and submission submit, of reinsurance claims encounters for consideration to the Administration.
  1. The contractor shall certify that the validity of the services listed were actually rendered, and that the services were medically necessary, and within the scope of AHCCCS benefits.
  2. The contractor shall submit reinsurance claims on the forms encounters in the format prescribed by the Administration.
  3. The contractor shall initiate and adjudicate all claims evaluate an encounter for probable third-1st and 3rd-party liability prior to before submitting a reinsurance claim the encounter for reinsurance consideration to the Administration, except for claims unless the encounter involving liability of involves underinsured or uninsured motorist liability insurance, third- 1st- and 3rd-party liability insurance, and or a tort-feasors feisor.
- G. Claims Encounter processing. The Administration shall be responsible for processing the Administration process reinsurance claims associated or related encounters submitted by the a contractor.
  1. The Administration shall accept for processing only those claims encounters which that are submitted directly by an AHCCCS contractor and which that comply with the conditions set forth in subsections (B), (C), (E), and (F).
  2. The Administration shall establish and maintain separate records of all reinsurance claims-submitted cases

established and reviewed and of all payments and case reviews made to the contractor as a result of such claims these cases.

3. Contractors shall be subject The Administration shall subject a contractor to utilization of services and other evaluative reviews by the Administration of care provided to a member which results that result in a reinsurance claim case.
- H. Payment of claims reinsurance cases. The Administration shall reimburse the a contractor for costs incurred in excess of the applicable deductible level calculated according to the provisions of subsection (E) and in accordance with A.A.C. R9-22-703(B)(2).
- I. The Administration may limit reinsurance reimbursement to reimbursement for a lower or alternative levels level of care when if the Director or his designee determines such that the less costly alternatives alternative could and should have been utilized used by a the contractor. A contractor whose claims reinsurance case are is reduced or denied shall be notified in writing by the Administration. Such The notification shall include the cause for reduction or denial and describe the applicable grievance and appeal process pursuant to available under Article 8 of these rules- this Chapter.
- J. The Administration may require or its contractors may arrange special contractual reinsurance terms that prescribe special reinsurance requirements for catastrophic cases. Catastrophic cases include, but are not limited to organ and bone marrow transplants (excluding kidney and cornea transplants which are covered under regular reinsurance), and hemophilic cases. The contractor shall notify the AHCCCS Administration when a member is identified for possible reimbursement of AHCCCS-approved catastrophic cases. The determination of whether a case or type of case is catastrophic shall be made by the Director based on the following criteria:
  1. Severity of medical condition, including prognosis; and
  2. Average cost or average length of hospitalization and medical care, or both, in Arizona for the type of case under consideration.
  3. Average cost of hospitalization and medical care in Arizona for the type of case under consideration.

**R9-22-504. Marketing; prohibition Prohibition against inducements; misrepresentation; discrimination; sanctions Inducements; Misrepresentations; Discrimination; Sanctions**

- A. Contractors and their A contractor or the contractor's marketing representatives representative shall neither not offer nor 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. Any marketing solicitation offering benefits, goods a benefit, good, or services service, in excess of those the covered services set forth in Article 2 of these rules shall be deemed inducements: an inducement.
- B. Marketing representatives A marketing representative shall not misrepresent themselves itself, the contracting health plan represented, or the AHCCCS program, through false advertising, false statements, or in any other manner in order to induce an eligible persons and members person or member of other another contracting entities entity to enroll in a given the represented health plan.
  1. Violations The Administration shall deem violations of this subsection shall to include, but not be limited to, false or misleading claims, inferences, or representations that:

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- a. An AHCCCS-eligible person or member will lose benefits under the AHCCCS program or any other health or welfare benefits to which he the eligible person or member is legally entitled, if such person the eligible person or member does not enroll in a given the represented contracting health plan;
  - b. Marketing representatives are employees of the state or representatives of the Administration, a county, or any health plan other than the health plan with whom they are employed, or by whom they are reimbursed; and
  - c. The represented health plan is recommended or endorsed as superior to its completion competition by any state or county agency, or any other organization, which has not unless the organization has certified its endorsement in writing to such the health plan and the Administration.
- C. Marketing representatives A marketing representative shall not engage in any marketing or other pre-enrollment practices practice that discriminate discriminates against an eligible person or a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental handicap disability, or health status.
- D. Contractors The Administration shall hold a contractor shall bear responsibility responsible for the performance of any marketing representative, subcontractor or agent, program, or process under its employ or direction and shall be make the contractor subject to the contract sanctions set forth in Sections R9-22-405 and R9-22-406 of these rules for any failure to comply with the specifications of Section R9-22-505 and this Section this Chapter.

**R9-22-505. Approval of advertisements Advertisements and marketing materials Marketing Materials**

- A. Contractor A contractor shall submit its proposed advertisements, marketing strategies, materials marketing materials, and paraphernalia shall be reviewed for review and approved approval by the Director Administration prior to distribution of before distributing the materials or implementation of implementing the activities.
- B. All A contractor shall submit all proposed marketing materials and strategies shall be submitted in writing to the Director Administration.
- C. The Director will Administration shall review and approve or disapprove all marketing materials and strategies for approval or disapproval. A notice of disapproval will be accompanied by The Administration shall include a statement of objections and recommendations in a notice of disapproval.
- D. To minimize the expense of revising advertising or other copy, material may be submitted in draft form subject to final approval and filing of a proof or final copy. To minimize the expense of revising advertising or other copy, a contractor may submit the marketing materials in draft form, subject to final approval and filing of a proof or final copy.
- E. Two copies of the proof or final approved copy of materials shall be submitted to and maintained by the Administration. A contractor shall provide 2 copies of the proof or final approved copy of marketing materials to the Administration.

**R9-22-506. Provider Registration Repealed**

In order to be reimbursed by the AHCCCS program, either by a contractor or directly by the Administration, individuals providing covered services shall be registered with the Administration.

**R9-22-507. Member records Record and systems**

~~Each contractor shall maintain a member service record that will contain encounter data, grievances, complaints and service information for each member. A contractor shall maintain a member service record that contains at least the following for each member:~~

1. Encounter data.
2. Grievances and appeals.
3. Any informal complaints, and
4. Service information.

**R9-22-508. Limitation of benefit coverage Benefit Coverage for illness Illness or injury Injury due to catastrophe Catastrophe**

The Director may limit the scope of health care benefits provided by a prepaid capitated contractor to exclude the care of illness or injury which that results from, or is greatly aggravated by, a catastrophic occurrence, including an act of war, ~~declared or undeclared, declared or undeclared war, and which that~~ occurs subsequent to after enrollment.

**R9-22-509. Transition and coordination Coordination of patient care Member Care**

- A. The Administration will shall coordinate and implement disenrollment and re-enrollment procedures when a member's change of residency requires a change in contractor.
- B. Each A contractor shall assist the Administration in the transition of members to and from other AHCCCS contractors. ~~Such assistance and coordination shall include, but not be limited to, the forwarding of medical and other records and the facilitation and scheduling of transitional, medically necessary appointments for care and services within 30 working days of the Administration's request. Cost of reproducing and forwarding medical charts and other materials shall be borne by the contractor with which the member was previously enrolled.~~
  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. A contractor's policies and procedures regarding transition of members are subject to review and approval by the Administration;
    - 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 transitioned 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 materials to the receiving contractor. The cost of reproducing and forwarding medical records and other materials shall be borne by the relinquishing contractor;
  4. Within the contract-specified timelines, the receiving contractor shall ensure that the member selects or is

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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 new services.

~~C. Each contractor shall assist in the coordination of medical services provided its members. Such assistance shall include the referral of members, for medically necessary services not covered by AHCCCS, to other community health agencies or county medical assistance programs when the member may be eligible for residual care services.~~

~~DC. Contractors are prohibited from utilizing A contractor shall not use a county or nonprovider health resource alternatives which diminish alternative that diminishes the contractor's contractual responsibility and or accountability for providing the full scope of AHCCCS-covered services. Referrals made to other health agencies by a contractor, primarily for the purpose of reducing the contractor's financial to reduce expenditures incurred by the contractor on behalf of its members, may result in the application of sanctions as specified in Article 4 of these rules. described in this Chapter.~~

~~ED. Contractors A contractor may transfer members a member from a noncontracting provider to a contracting provider's facility at the earliest time when such as soon as a transfer shall will not be harmful to the member's health as authorized by the member's primary care physician provider or the contractor's Medical Director. The A member's plan shall pay the cost of such transfer shall be the responsibility of the member's plan. transfer.~~

**R9-22-510. Transfer of members Members**

Contractors A contractor shall implement procedures to allow dissatisfied members a member to transfer from the primary care physician provider of record to another primary care physician provider within the same contracting organization. Criteria for a transfer shall include, but are not be limited to, identification of those problems between the member and the physician, resulting in serious deterioration of the physician-patient relationship, to:

1. Change in the member's health, requiring a different medical focus;
2. Change in the member's residency resulting in difficulty in obtaining services from the assigned primary care provider; or
3. Identification of those problems any problem between the member and the physician primary care provider, resulting in serious deterioration of the physician primary care provider - patient member relationship.

**R9-22-511. Fraud or abuse Abuse**

All contractors, providers, and nonproviders A contractor, provider, or nonprovider shall advise the Director or his designee immediately in writing immediately, in writing, of any cases case of suspected fraud or abuse.

**R9-22-512. Release of Safeguarded Information by the Administration and Contractors**

~~A. Information to be safeguarded concerning applicants, eligible persons or members of AHCCCS includes:-~~

1. ~~Names, addresses and Social Security numbers;~~
2. ~~Social and economic conditions or circumstances;~~
3. ~~Agency evaluation of personal information;~~
4. ~~Medical data and services, including diagnosis and past history of disease or disability;~~
5. ~~State Data Exchange (SDX) tapes from the U.S. Social Security Administration;~~
6. ~~Information system tapes from the Arizona Department of Economic Security.~~

~~B. Unrestricted information. The restrictions upon disclosure of information shall not apply to summary data, statistics, utilization data, and other information which do not identify an individual applicant, eligible person, or member.~~

~~C. The use or disclosure of information concerning an eligible person, applicant or member, shall be limited to:-~~

1. ~~The person concerned;~~
2. ~~Individuals authorized by the person concerned, and~~
3. ~~Persons or agencies for official purposes.~~

~~Safeguarded information may be released to these parties only under the conditions specified in subsections (D), (E), and (F) below:~~

~~D. Safeguarded information may be released to the applicant, eligible person, or member concerned only under the conditions herein specified:~~

1. ~~Eligibility case record. An applicant, eligible person or member may view the contents of his or her eligibility case record at any time, provided a county eligibility official or responsible caseworker is present during the examination of the eligibility record. An unemancipated minor may view the eligibility case record in which he or she is included with the written permission of a parent or person standing in a parental relationship.~~
2. ~~Medical record. The eligible person, member or authorized representative may view his or her medical record after written notification to the provider and at a reasonable time and place.~~

~~E. Release to individual(s) authorized by the individual concerned. Eligibility case records, medical records, and any other AHCCCS-related confidential and secured information of eligible persons or applicants may be released to individuals authorized by the eligible person or applicant only under the following conditions:-~~

1. ~~Authorization for release of information must be obtained from the client/applicant or designated representative.~~
2. ~~Authorization used for release must be a written document, separate from any other document, and must specify the following:~~
  - a. ~~Information or records, in whole or in part, which are authorized for release;~~
  - b. ~~To whom the release shall be made;~~
  - c. ~~The period of time for which the authorization is valid, if limited; or~~
  - d. ~~The dated signature of the adult and mentally competent client/applicant or designated legal representative. In the case of a minor client/applicant, signature of a parent, custodial relative or designated representative is required unless the minor is capable and sufficiently mature to understand the consequences of authorizing and not authorizing;~~

~~3. In the case where an appeal or grievance has been filed, the appellant, grievant, and/or the appellant's or grievant's designated representative shall be permitted to review, obtain, or copy any nonprivileged record necessary for the proper presentation of the case. The grievant or appellant also may authorize release of information deemed necessary to the contested issue, to the opposing party in the case.~~

~~F. Release to persons or agencies for official purposes.~~

1. ~~Official purposes are those purposes directly related to the administration of AHCCCS:~~
  - a. ~~Establishing eligibility;~~
  - b. ~~Determining the amount of medical assistance;~~

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- e. ~~Providing services for eligible persons and members;~~
- d. ~~Conducting or assisting an investigation, prosecution, or civil or criminal proceedings related to AHCCCS;~~
- e. ~~Performing evaluations and analyses of AHCCCS operations.~~
- 2. ~~Employees of the Administration. For official purposes, safeguarded information, case records and medical records information may be disclosed without the consent of an applicant, member or eligible person for purposes related to administration of the program and only to the extent required in performance of duties by the following persons:~~
  - a. ~~Employees of the Administration;~~
  - b. ~~Employees of the U.S. Social Security Administration;~~
  - c. ~~Employees of the Arizona Department of Economic Security;~~
  - d. ~~Employees of the U.S. Department of Health and Human Services;~~
  - e. ~~Employees of contractors and subcontractors;~~
  - f. ~~Employees of the state of Arizona Attorney General's Office;~~
  - g. ~~Employees of counties including Boards of Supervisors, AHCCCS eligibility offices, and the County Attorney.~~
- 3. ~~Law enforcement officials.~~
  - a. ~~Case record. The Administration may release, without an eligible person's or member's written or verbal consent, information to authorized officials for the purposes of an investigation, prosecution, or criminal or civil proceedings conducted by or on behalf of the Administration, the state of Arizona, or a federal agency in connection with the administration of AHCCCS.~~
  - b. ~~Medical record. The Administration may release safeguarded information contained in the member's medical record to law enforcement officials without the member's consent only in situations of suspected cases of fraud and abuse against the AHCCCS program.~~
- 4. ~~Review committees. For official purposes, safeguarded information, case records, and medical services information may be disclosed without the consent of the applicant, member, or eligible person to members, agents or employees of review committees in accordance with the provisions of A.R.S. § 36-2917.~~
- 5. ~~Compliance with the 1634 Agreement. In accordance with the 1634 Agreement between the state of Arizona and the U.S. Department of Health and Human Services, the recipient of any information or records disclosed or used pursuant to an official, routine request shall also be responsible for complying with the provisions of the 1634 Agreement.~~
- G. ~~Subcontractors shall not be required to obtain written approval from the member before transmitting member medical records to physicians:~~
  - 1. ~~Providing services to members under subcontract with the contractor;~~
  - 2. ~~Retained by the subcontractor to provide services that are infrequently used or are of an unusual nature;~~
  - 3. ~~Providing services under the prime contract.~~
- H. ~~Written consent shall be obtained before medical records of a former member may be transmitted to any physician.~~
- A. The Administration, contractors, providers, and noncontracting providers shall safeguard information concerning an applicant, eligible person, or member, which includes 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 services, including diagnosis and history of disease or disability;
  - 6. State Data Exchange (SDX) tapes from the U.S. Social Security Administration; and
  - 7. Information system tapes from the Arizona Department of Economic Security.
- B. The restriction upon disclosure of information does not apply to:
  - 1. Summary data;
  - 2. Statistics;
  - 3. Utilization data; and
  - 4. Other information that does not identify an applicant, eligible person, or member.
- C. The Administration, contractors, providers, and noncontracting providers shall use or disclose information concerning an eligible person, applicant, or member only under the conditions specified in subsection (D), (E), and (F) and only to:
  - 1. The person concerned,
  - 2. Individuals authorized by the person concerned, and
  - 3. Persons or agencies for official purposes.
- D. Safeguarded information shall be viewed by or released to only:
  - 1. An applicant;
  - 2. An eligible person;
  - 3. A member; or
  - 4. An unemancipated minor, with written permission of a parent, custodial relative, or designated representative, if:
    - a. An Administration employee or its authorized representative, county eligibility official, or responsible caseworker is present during the examination of the eligibility record; or
    - b. As outlined in subsection (E) after written notification to the provider, and at a reasonable time and place.
- E. An eligibility case record, medical record, and any other AHCCCS-related confidential and safeguarded information regarding an eligible person, member, applicant, or unemancipated minor shall be released to individuals authorized by the eligible person, member, applicant, or unemancipated minor only under the following conditions:
  - 1. Authorization for release of information is obtained from the eligible person, member, applicant, or designated representative;
  - 2. Authorization used for release is a written document, separate from any other document, that specifies the following information:
    - a. Information or records, in whole or in part, which are authorized for release;
    - b. To whom release is authorized;
    - c. The period of time for which the authorization is valid, if limited; and
    - d. A dated signature of the adult and mentally competent member, eligible person, applicant, or designated representative. If the eligible person, member, or applicant is a minor, the signature of a parent, custodial relative, or designated representa-

itive shall be required unless the minor is sufficiently mature to understand the consequences of granting or denying authorization. If the eligible person, member, or applicant is mentally incompetent, authorization shall be according to A.R.S. § 36-509;

3. If an appeal or grievance is filed, the eligible person, member, applicant, or designated representative shall be permitted to review and obtain or copy any nonprivileged record necessary for the proper presentation of the case.
- F. Release of safeguarded information to individuals or agencies for official purposes:
1. Official purposes directly related to the administration of the AHCCCS program are:
    - a. Establishing eligibility and post-eligibility treatment of income, as applicable;
    - b. Determining the amount of medical assistance;
    - c. Providing services for eligible persons and members;
    - d. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the AHCCCS program;
    - e. Performing evaluations and analyses of AHCCCS operations;
    - f. Filing liens on property as applicable;
    - g. Filing claims on estates, as applicable; and
    - h. Filing, negotiating, and settling medical liens and claims.
  2. For official purposes related to the administration of the AHCCCS program and only to the extent required in performance of duties, safeguarded information, including case records and medical records, may be disclosed to the following persons without the consent of the applicant, member, or eligible person:
    - a. Employees of the Administration;
    - b. Employees of the U.S. Social Security Administration;
    - c. Employees of the Arizona Department of Economic Security;
    - d. Employees of the Arizona Department of Health Services;
    - e. Employees of the U.S. Department of Health and Human Services;
    - f. Employees of contractors, program contractors, providers, and subcontractors;
    - g. Employees of the Arizona Attorney General's Office; or
    - h. Employees of counties including Boards of Supervisors, AHCCCS eligibility offices, and the County Attorney, as applicable.
  3. Law enforcement officials:
    - a. Information may be released to law enforcement officials without the applicant's, eligible person's, or member's written or verbal consent, for the purpose of an investigation, prosecution, or criminal or civil proceeding relating to the administration of the AHCCCS program.
    - b. Medical record. The Administration and contractors shall release safeguarded information contained in a member's medical record to law enforcement officials without the member's consent only if the member is suspected of fraud or abuse against the AHCCCS program.

c. A contractor shall release the medical record or information in the case record or other information developed in case management or utilization management operations without the member's written or verbal consent, for the purpose of an investigation, prosecution, or similar criminal proceeding not in connection with the Administration, only if the law enforcement official requesting the information has statutory authority to obtain the information.

4. The Administration may release safeguarded information including case records and medical records to a review committee in accordance with the provisions of A.R.S. § 36-2917, without the consent of the applicant, eligible person, or member.
  5. In accordance with the 1634 Agreement between the State of Arizona and the U.S. Department of Health and Human Services, a recipient of information or records disclosed or used for an official purpose shall comply with the 1634 Agreement, dated October 1, 1982, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
  6. Providers shall furnish requested records to the Administration and its contractors at no charge.
- G. The holder of a medical record of a former applicant, eligible person, or member shall obtain written consent from the former applicant, eligible person, or member before transmitting the medical record to a primary care provider.
- H. Subcontractors are not required to obtain written consent from an eligible person or member before transmitting the eligible person's or member's medical records to a physician who:
1. Provides a service to the eligible person or member under subcontract with the program contractor,
  2. Is retained by the subcontractor to provide services that are infrequently used or are of an unusual nature, and
  3. Provides a service under the contract.

**R9-22-513. Discrimination prohibition Prohibition**

- A. A contractor, provider, and nonprovider shall not discriminate against a member or eligible person an eligible person or member because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, or physical or mental handicap disability in accordance with Title VI of the U.S. Civil Rights Act of 1964, 42 USC, Section 2000d, and rules and regulations promulgated pursuant according thereto to, or as otherwise provided by law or regulation. For the purpose of providing covered service under contract pursuant according to A.R.S. Title 36, Chapter 29, discrimination includes, but is not limited to, the following if done on the grounds of the eligible person's or member's race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, national origin, or physical or mental handicap includes, but is not limited to, the following disability:
1. Denying or providing an eligible person or a member any covered service or availability of a facility;
  2. Providing to a an eligible person or member any covered service which that is different, or is provided in a different manner or at a different time from that provided to other AHCCCS members under contract, other public or private members/patients, or the public at large except where when medically necessary;

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3. Subjecting an eligible person or a member to segregation or separate treatment in any manner related to the receipt of any covered service; restricting a member in any way in ~~his or her~~ the enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and
  4. ~~The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, income status, AHCCCS membership, or physical or mental handicap of the participants to be served~~ Assigning to an eligible person or member times or places for the provision of services that are different from those assigned to other AHCCCS members under contract.
- B. All provisions set forth in the this Section shall not apply except that those to an eligible persons person defined as eligible pursuant according to A.R.S. § 36-2901 paragraph (4), subdivisions (d), (e), (f) and (g), are (4)(d) through (4)(g), who is not required by statute or these rules required to obtain their health care services at a county-owned and operated facility, if such the health care facility is awarded a contract as an AHCCCS provider. These persons A person eligible pursuant according to A.R.S. § 36-2901 paragraph (4), subdivision (b)(4)(b) shall have freedom of choice in selecting membership with an AHCCCS contractor in all instances in which more than one 1 choice of contractors contractor is available. However, such an eligible persons person shall become members a member of a county program and receive services in a county facility, if a county is the only AHCCCS contractor in such for the eligible persons person in the service areas: area.
- C. The A contractor shall take affirmative action to ensure that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental handicap disability, except where medically indicated.

**R9-22-514. Equal opportunity Opportunity**

The contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the contractor, state that it is an equal opportunity employer and will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice, to be provided by the Administration, advising the labor union or workers' representative of the contractor's commitment as an equal opportunity employer and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

A contractor shall, in all solicitations or advertisements for employees placed by, or, on behalf of the contractor;

1. Specify that it is an equal opportunity employer;
2. Send a notice provided by the Administration to each labor union representative or worker with a collective bargaining agreement, or other contract or understanding, stating that the contractor is an equal opportunity employer; and
3. Post copies of the notice in conspicuous places available to employees and applicants for employment.

**R9-22-515. Filing notices and appeals Repealed**

All notices and appeals or other statements shall be considered filed for the purpose of these rules when received in writing by the Administration.

**R9-22-518. Information to enrolled members Enrolled**

**Members**

A. Each contractor shall produce and distribute printed information materials to each enrolled member or family unit within ten 10 days of receipt of notification of enrollment from the Administration. The information materials shall be written in English and a ~~second language~~ all languages when used by 200 members or 5 percent, %, whichever is greater, of the enrolled population. are non-English speaking. Informational The informational materials shall include the following: must meet the requirements specified in the contractor's current contract.

1. A description of all available services and an explanation of any service limitations, exclusions from coverage or charges for services, when applicable;
  2. An explanation of the procedure for obtaining covered services, including a notice stating that AHCCCS shall only be liable for services authorized by a member's primary care physician;
  3. A list of the names, telephone numbers and service site addresses of primary care physicians available for selection by the member, and a description of the selection process, including a statement that informs members that they may request another primary care physician in the event that they are dissatisfied with their assignment;
  4. Locations, telephone numbers and procedures for obtaining emergency health services;
  5. Explanation of the procedure for obtaining emergency health services outside the contractor's service area;
  6. The causes for which a member shall lose enrollment;
  7. A description of the grievance procedures;
  8. Co-payment schedules along with a statement that services shall not be denied if a member is unable to pay a copayment;
  9. Information on the appropriate use of health services and of the maintenance of personal and family health;
  10. Information regarding emergency and medically necessary transportation offered by the contractor as well as the availability of public transportation; and;
  11. Other information deemed essential to use the program.
- B. Each A contractor shall provide its member a member with the name, address, and telephone number of their the member's primary care providers provider within ten 10 days from the date of their enrollment. This notice shall include information on how the members member may change primary care physicians providers, if dissatisfied with their assignment the primary care provider assigned.
- C. Notification of changes in services. Each A contractor shall revise and distribute to members a service guide insert describing any changes which change that the contractor proposes to make in services provided or in service locations. The insert shall be distributed to all affected members or family units at least 14 days prior to before a planned change. Notification shall be provided as soon as possible when unforeseen circumstances require an immediate change in services, sites or locations.
- D. All A contractor shall submit informational and educational materials prepared by the contractor shall be approved by the Director prior to distribution for approval by the Administration before distributing the materials to enrolled members and families.

**R9-22-519. Periodic reports and information Repealed**

Upon request by the Administration, each contractor shall furnish to the Administration information from its records relating to contract performance.

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**R9-22-520. Financial statements Statements, Periodic Reports and Information**

**A.** Upon request by the Administration, a contractor shall furnish to the Administration information from its records relating to contract performance.

**A.B.** Each A contractor shall provide the Administration with the following financial statement(s) following:

1. An annual certified financial report prepared by a certified public accountant to be submitted no later than 120 days after the close of the contractor's fiscal year. Such The certified public accountants who prepare the report shall be independent of the contractor, subcontracting entities, and their officers or directors, or and any affiliates.
2. Quarterly financial statements for the quarters ended December 31, March 31, June 30, and September 30. These quarterly reports shall be submitted to the Administration no later than 45 60 days after the end of the reporting period month.
2. Monthly claims aging analyses. Monthly claims reports shall be submitted to the Administration no later than 30 days after the end of the reporting period.
3. Monthly financial statements, if required by the Administration submitted no later than 60 days after the end of the reporting period.
4. Disclosures of information on ownership and control required by 42 CFR 455, Subpart B, September 30, 1986, incorporated by reference herein and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
5. Cost reporting, audits, and financial reporting as specified in contract or provider agreement.

**BC.** All financial statements shall identify separately all AHC-CCS-related transactions, including allocations of overhead and other shared expenses where applicable. The A contractor shall provide supplemental schedules describing all inter-entity transactions and eliminations to provide comparability necessary for the Administration to analyze use in analyzing the overall financial status of the entire health care delivery system.

**R9-22-521. Medical audits Program Compliance Audits**

**A.** Each health plan shall be medically audited by the The Administration shall conduct a program compliance audit of a contractor at least once every 12 months during the term of its contract with the contractor. Unless the Administration determines that advance notice will render a medical review program compliance audit less useful, a contractor will be notified approximately three 3 weeks in advance of the date of an on-site medical review program compliance audit. The Administration may conduct, without prior notice, inspections of contractor facilities or perform other elements of a medical review program compliance audit, either in conjunction with the medical audit program compliance audit or as part of an unannounced inspection program.

**B.** In pursuit of the review objectives, the A review team may perform any or all of the following procedures:

1. Conduct private interviews and group conferences with members, physicians, and other health professionals and members of its the contractor's administrative staff including, but not limited to, its the contractor's principal management persons;
2. Examination of Examine records, books, reports, and papers of the health plan contractor and any management company, and all providers or subcontractors pro-

viding health care and other services to the health plan. The examination may include, but not be limited to: the 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 such additional documentation deemed necessary by the Administration to properly review the quality of medical care.

**R9-22-522. Contractor's Internal Utilization Control System Quality Management/Utilization Management (OM/UM) Requirements**

**A.** Each contractor shall design a formal Quality Management System and shall implement the system effectively, efficiently and continuously. A written Quality Management Plan which shall include a Utilization Management Plan shall be submitted to and subject to approval by the Administration. The Plan shall be updated annually. The quality management system shall be designed and implemented with actions to promote the provision of quality health care services. It shall have as its primary goal the systematic improvement of health care and shall be concerned with structures, processes and outcomes, as they interrelate.

A contractor shall comply with Quality Management/Utilization Management (OM/UM) requirements specified in this Section and in contract. The contractor shall ensure compliance with OM/UM requirements that are accomplished through delegation or subcontract with another party.

**B.** The health professionals of the contractor shall have primary responsibility for the design and ongoing implementation of the Quality Management System. While the responsibility ordinarily shall be discharged by committees of health professionals who are employed by or provide services to the contractor, nothing contained in this Section shall relieve the contractor from the ultimate management responsibility.

A contractor shall:

1. Submit a written OM/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,
  - b. Identifying the numbers and costs of services provided,
  - c. Assessing and improving the quality and appropriateness of care and services,
  - d. Evaluating the outcome of care provided to members, and
  - e. Determining the steps and actions necessary to improve service delivery.
2. Submit the OM/UM plan on an annual basis within timelines specified in contract. If the OM/UM plan is changed during the year, the contractor shall submit the revised plan before implementation;
3. Receive approval from the Administration before implementing the initial OM/UM plan;
4. Ensure that a OM/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 OM/UM plan; and
  - b. Ensure and allocate qualified OM/UM personnel and sufficient resources to implement the contractor's OM/UM activities.

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5. Ensure that the OM/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 OM/UM data; and
  - i. Other activities necessary to improve the quality of care and the efficient, cost effective delivery and utilization of services.
- C. The contractor shall design and implement procedures for continuously reviewing the performance of health care personnel and the utilization of facilities, services and costs. An eligible person's or member's primary care provider shall maintain medical records that:
1. Are detailed and comprehensive and identify:
    - a. All medically necessary services provided to the member by the contractor and the subcontractors, and
    - b. All emergency services provided by nonproviders for an eligible person or member.
  2. Conform to professional medical standards and practices for documentation of medical diagnostic and treatment data;
  3. Facilitate follow-up treatment; and
  4. Permit professional medical review and medical audit processes.
- D. Medical records and systems:
1. The member medical record shall be maintained by the primary care provider and shall include a record of all medical services received by the member from the contractor and its providers, subcontracting and noncontracting.
  2. Medical records shall be maintained in a detailed and comprehensive manner which conforms to professional medical standards and practices, permits professional medical review and medical audit processes, and which facilitates a system for follow-up treatment.
  3. Medical records or copies of medical records of all members enrolled with a subcontractor, or for which a subcontractor has provided services, shall be forwarded to the contractor or its designee within 30 working days following termination of a contract between the subcontractor and the contractor.  
A subcontractor or its designee shall forward medical records or copies of medical records of all members assigned to the subcontractor or for whom the subcontractor has provided services, within 30 days following termination of a contract between the subcontractor and the contractor.
- E. The Administration shall monitor contractors and their providers to ensure compliance with Administration OM/UM requirements and adherence to the contractor OM/UM plan.
1. A contractor and its providers shall cooperate with the Administration in the performance of its OM/UM monitoring activities; and
  2. A contractor and its providers shall develop and implement mechanisms for correcting deficiencies identified through the Administration's OM/UM monitoring.
- F. Each contractor shall develop and implement a program of utilization control methods for hospitals that shall at a minimum include prior authorization of nonemergency hospital admissions, concurrent review of inpatient stays and retrospective review of hospital claims to ensure that covered hospital services are not used unnecessarily or unreasonably. The contractor's utilization control methods are subject to evaluation by the Administration to determine cost effectiveness and to measure if the utilization control methods are reducing, controlling, or eliminating unnecessary or unreasonable utilization. The contractor shall staff its program of utilization control activities consistent with requirements in its contract with the Administration. The contractor may subcontract with an organization or entity designed to conduct either prior authorization, concurrent review or retrospective review activities. Such a subcontract is subject to prior approval as required by R9-22-402.
- G. Pursuant to R9-22-519, each contractor shall submit to the Administration hospital inpatient and outpatient utilization information to facilitate evaluation of the cost effectiveness and health implications of the contractor's utilization control activities.
- H. In providing prior authorization of nonemergency inpatient admissions, the contractor may use criteria, guidelines or procedures approved by the Administration.
- I. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall not withhold access to medical records regarding members and shall in all other ways fully cooperate with the contractor or its designated representative in performance of the contractor's utilization control activities. Failure to cooperate may result in denial or nonpayment of claims.
- R9-22-523. Financial Resources Resources**
- A. The Director shall require a contractor or offeror shall demonstrate upon request to the Administration that it has adequate financial reserves, administrative abilities and soundness of program design to carry out its contractual obligations; has:
1. Adequate financial reserves,
  2. Administrative abilities, and
  3. Soundness of program design to carry out its contractual obligations.
- B. Contract provisions required by the Director shall include, but are not limited to, the maintenance of deposits, performance bonds, financial reserves or other financial security. As specified in A.R.S. § 36-2903, the Director requires that contract provisions include, but not be limited to:
1. Maintenance of deposits,
  2. Performance bonds,
  3. Financial reserves, or
  4. Other financial security.
- R9-22-524. Continuity of care Care**
- Each contractor shall establish and maintain a system to assure ensure continuity of care which shall, at a minimum, include:
1. Referral of members needing Referring members who need specialty health care services;
  2. Monitoring of members with chronic medical conditions;
  3. Providing hospital discharge planning and coordination including post-discharge care; and
  4. Monitoring the operation of the system through professional review activities.

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TITLE 9. HEALTH SERVICES

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

PREAMBLE

1. Sections Affected

R9-28-501	Amend
R9-28-502	Amend
R9-28-503	Amend
R9-28-504	Amend
R9-28-505	Amend
R9-28-508	Amend
R9-28-510	Amend
R9-28-511	Amend
R9-28-512	Amend
R9-28-513	Amend
R9-28-514	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

Implementing statute: A.R.S. §§ 36-409, 36-425, 36-2932, 36-2938, 36-2939, 36-2940, 36-2944, 36-2947, 36-2952
3. The effective date of the rules:

December 8, 1997
4. A list of all previous notices appearing in the Register addressing the final rule:

Notice of Rulemaking Docket Opening: 3 A.A.R. 1096, April 18, 1997

Notice of Proposed Rulemaking: 3 A.A.R. 2236, August 22, 1997
5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Cheri Tomlinson

Address: Arizona Health Care Cost Containment System  
801 East Jefferson, MD4200  
Phoenix, Arizona 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756
6. An explanation of the rule, including the agency's reasons for initiating the rule:

Changes are made to 9 A.A.C. 28, Article 5, pertaining to standards for ALTCS program contractors and ALTCS providers in order to implement recommendations made in the previous 5-year-rule review. The change are designed to:

  - Establish uniformity between ALTCS and acute rules by cross-referencing rules whenever possible and appropriate,
  - Clarify rule through minor wording and language modification to enhance the clarity and conciseness of the Article, and
  - Conform with federal regulations and state statute.
7. 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
8. The summary of the economic, small business, and consumer impact:

It is anticipated that the economic impact will be nominal because the changes are nonsubstantive and are intended to add clarity and conciseness to rule language and bring the rules into conformity with federal regulations and state statute.

Entities which may benefit from the changes include:

  - ALTCS contractors (including those contractors that are governmental entities or private business entities),
  - ALTCS members, and
  - The Administration.

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Other entities considered, but will not be directly affected include:

- The larger business community;
- Other governmental entities, political subdivisions, or both; and
- The general public, including taxpayers and private individuals.

9. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**

The changes between the proposed rules and the final rules are minimal and include:

- Minor wording, grammatical, and punctuation changes;
- Inserted "and group homes" after "settings" in R9-28-504(B)(1);
- Deleted "Arizona Department of Economic Security" and inserted "appropriate regulatory agency of the state" in R9-28-504(B)(1); and
- Deleted "Arizona Department of Health Services" and inserted "according to A.A.C., Title 9, Chapter 10" in R9-28-504(B)(2).

10. **A summary of the principal comments and the agency response to them:**

No comments were received from the public regarding this rulemaking package.

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

None

12. **Incorporations by reference and their location in the rules:**

- 42 CFR 442, September 28, 1995, and 42 CFR 483, September 29, 1995, incorporated at R9-28-503(A);
- 42 CFR 442, Subpart C, November 20, 1992, and 42 CFR 483, September 29, 1995, incorporated at R9-28-503(B);
- 42 CFR 482, September 9, 1996, and 42 CFR 456, Subpart C, September 29, 1978, incorporated at R9-28-505(B); and
- 42 CFR 456, Subparts C, D, and F, December 1, 1986, incorporated at R9-28-511(A).

13. **Was this rule previously adopted as an emergency rule?**

No.

14. **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**

Section

- R9-28-501. General provisions Provisions
- R9-28-502. Long-term care provider standards Care Provider Requirements
- R9-28-503. Licensure and Certification for Long-term Care Institutional Facilities
- R9-28-504. Standards of Participation, Licensure, and Certification for Noninstitutional Long-term Care HCBS Providers
- R9-28-505. Standards, licensure, and certification for providers of hospital and medical services Licensure and Certification for Providers of Hospital and Medical Services
- R9-28-508. Program contractor standards—submittal of comprehensive plan for delivery of services Contractor Standards - Submittal of Comprehensive Plan for Delivery of Services
- R9-28-510. Case Management
- R9-28-511. Quality Management Requirements Management/Utilization Management (QM/UM) Requirements
- R9-28-512. Financial reporting requirements Statements, Periodic Reports and Information
- R9-28-513. Program compliance audits Compliance Audits

R9-28-514. ~~Safeguarding and release of confidential information~~ Release of Safeguarded Information by the Administration and Contractors

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

**R9-28-501. General provisions Provisions**

- A. ~~ALTCS eligible and enrolled members shall receive covered services as set forth in Article 2 of this Chapter. The provision of these services shall be coordinated by program contractors. In counties where there is no program contractor, the Administration shall provide ALTCS covered services to eligible persons. The Department of Economic Security, in its role as a program contractor, shall provide services to ALTCS members with developmental disabilities, as defined in A.R.S. § 36-551.~~

An eligible person or member may receive the covered services specified in Article 2 of this Chapter. A program contractor shall provide and coordinate services for a member enrolled with the program contractor. The Administration shall provide and coordinate ALTCS-covered services to an eligible person or member in counties where there is no program contractor. The Department of Economic Security, in its role as a program contractor, shall provide and coordinate

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services to an eligible person or member with developmental disabilities, as defined in A.R.S. § 36-551.

- B. ~~In order to~~ To participate in the ALTCS program, either through a program contractor or directly through the Administration, providers a provider of ALTCS-covered services shall be registered with the Administration.
- C. ~~Program contractors shall meet standards relating to the provision and coordination of long-term care services as set forth in this Article.~~

**R9-28-502. Long-term care provider standards Care Provider Requirements**

- A. ~~ALTCS providers~~ A provider shall obtain any necessary authorization from the program contractor or the Administration for services provided to an ALTCS-eligible persons person or enrolled members member.
- B. ~~ALTCS providers~~ A provider shall maintain and make available to a program ~~contractors contractor~~ and to the Administration, financial, and medical records for ~~a period of not less than five 5 years from the date of final payment, or for records relating to costs and expenses to which the Administration has taken exception, 5 years after the date of final disposition or resolution of the exception, service delivery.~~ Such The records shall meet the uniform accounting standards as prescribed specified by the Administration, and accepted practices for maintenance of medical records, including detailed specification of all patient services delivered, the rationale for delivery, and the service date.
- C. ~~ALTCS providers~~ A provider shall not submit a claim, demand, or otherwise collect payment from ~~a member or eligible person~~ an eligible person or member for ALTCS-covered services paid to the provider by the Administration or program contractor. Providers A provider shall not bill, or attempt to collect payment, directly or through a collection agency, from a person claiming to be ALTCS eligible without 1st receiving verification from the Administration that the person was ineligible for ALTCS on the date of service, or that services provided were not ALTCS-covered services.
- D. ~~ALTCS providers shall provide cost reporting, audits, and financial reporting as specified in contract or provider agreement.~~
- E. ~~ALTCS providers shall cooperate with a program contractors and ALTCS utilization review and quality assurance programs and comply with the utilization control and review procedures specified in 42 CFR 456, incorporated by reference herein and on file with the Office of the Secretary of State.~~

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

- A. ~~ALTCS nursing facilities shall be Medicare and Medicaid certified and meet the requirements set forth in 42 CFR 405, Subpart K, and Part 442, incorporated by reference herein and on file with the Office of the Secretary of State, and the Arizona Department of Health Services rules for licensure.~~ Nursing facilities that provide services to an eligible person or member shall be Medicare and Medicaid certified and meet the requirements in 42 CFR 442, September 28, 1995, and 42 CFR 483, September 29, 1995, incorporated by reference and on file with the Administration and the Office of the Secretary of State, and meet the Arizona Department of Health Services' rules for licensure. This incorporation by reference contains no future editions or amendments.
- B. ~~An ICF-MR shall be Medicaid certified and meet the requirements set forth in 42 CFR 442, Subparts C, E and G and Part~~

~~483, incorporated by reference herein and on file with the Office of the Secretary of State, and A.R.S. § 36-2939(A)(3). An ICF-MR shall be Medicaid certified and meet the requirements in A.R.S. § 36-2939(B)(1) and 42 CFR 442 Subpart C, November 20, 1992, and 42 CFR 483, September 29, 1995, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.~~

- C. All ALTCS long-term care institutional facilities nursing facilities and ICF-MRs that provide services to an eligible person or member shall be registered as providers with the Administration. To be ~~a registered provider of long-term care institutional services, registered, the institution~~ a provider shall meet the licensure and certification requirements of subsections (A) or (B) of this Section, and have ~~an executed a~~ current provider agreement with a program contractor.

**R9-28-504. Standards of Participation, Licensure, and Certification for Noninstitutional Long-term Care HCBS Providers**

- A. All noninstitutional long-term care providers shall be registered with the Administration; ~~and meet the requirements of the Arizona Department of Health Services' rules for licensure, if applicable. Alternate residential facilities shall meet the requirements of 45 CFR 1397, incorporated by reference herein and on file with the Office of the Secretary of State, in the provision of home and community-based services to ALTCS members and, in the case of group homes for the developmentally disabled, be licensed by the Arizona Department of Economic Security, and in the case of adult foster care be licensed by the county or the Arizona Department of Health Services.~~
- B. ~~Home health services. To be a registered provider of home health services, including home health aide services, a home health agency shall be Medicare certified and licensed pursuant to A.A.C. Title 9, Chapter 10, Article 11.~~ Additional qualifications:
  1. Community residential settings and group homes for an individual with developmental disabilities shall be licensed by the appropriate regulatory agency of the state according to 6 A.A.C. 6;
  2. Adult foster care homes shall be certified or licensed according to 9 A.A.C. 10;
  3. Home health services agencies shall be Medicare certified and licensed according to 9 A.A.C. 10;
  4. An individual providing homemaker services shall meet the requirements specified in contract;
  5. An individual providing personal care services shall meet the requirements specified in contract;
  6. An adult day health provider shall be licensed according to 9 A.A.C. 10;
  7. A therapy provider shall meet the requirements stated below:
    - a. A physical therapy provider shall meet the requirements in 4 A.A.C. 24;
    - b. A speech therapy provider shall be certified by the American Speech, Language, and Hearing Association;
    - c. An occupational therapy provider shall meet the requirements in 4 A.A.C. 43; and
    - d. A respiratory therapy provider shall meet the requirements in 4 A.A.C. 45;
  8. A respite provider shall meet the requirements specified in contract;
  9. A hospice provider shall be Medicare certified and licensed according to 9 A.A.C. 10;

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10. A provider of home delivered meal service shall comply with hygiene requirements in 9 A.A.C. 8;
  11. A provider of non-emergency transportation shall be licensed by the Arizona Department of Transportation, Motor Vehicle Division;
  12. A provider of emergency transportation shall meet the licensure requirements in 9 A.A.C. 13;
  13. A day care provider for the developmentally disabled shall meet the licensure requirements in 6 A.A.C. 6;
  14. A habilitation provider shall meet the requirements in A.A.C. R6-6-1523 or the therapy requirements in this Section;
  15. Another service provider approved by the director shall meet the requirements specified in a program contractor's contract with the Administration;
  16. A behavioral health provider shall have all applicable state licenses or certifications, and meet the service specifications in A.A.C. R9-22-1205;
  17. An adult care home shall meet the requirements in 9 A.A.C. 10; and
  18. A supportive residential living center shall meet the requirements in 9 A.A.C. 10.
- C.** Homemaker. To be a registered provider of homemaker services, the individual shall meet the ALTCS homemaker service specifications dated January 1987, incorporated by reference herein, and on file with the Office of the Secretary of State; copies are also available at the central office of the AHCCCS Administration. The rule does not include any later amendments or editions of the incorporated service specifications.
- D.** Personal care. To be a registered provider of personal care services, the individual shall meet the ALTCS personal care service specifications set forth in contract.
- E.** Adult day health. To be a registered provider of adult day health services, the provider shall have all applicable state licenses.
- F.** Physical, speech, respiratory and occupational therapy.
1. To be a registered provider of physical therapy services, the individual shall be licensed to practice physical therapy pursuant to A.R.S. § 32-2001 et seq.
  2. To be a registered provider of speech therapy, the individual shall meet the requirements set forth in A.A.C. Title 9, Chapter 10, Article 11.
  3. To be a registered provider of occupational therapy, the individual shall meet the requirements set forth in A.A.C. Title 9, Chapter 10, Article 11.
  4. To be a registered provider of respiratory therapy, the individual shall meet the requirements set forth in A.A.C. Title 9, Chapter 10, Article 11.
- G.** Respite services. To be a registered provider of noninstitutional respite services, the provider shall meet the requirements of subsection (B) or (D) or the respite standards for sitter services set forth in contract.
- H.** Hospice services. To be a registered provider, the hospice facility shall be Medicare certified and shall have all applicable state licenses.
- I.** Home delivered meals services. To be registered with the Administration, providers of these services shall comply with hygiene requirements set forth in A.A.C. Title 9, Chapter 8, Article 1, and the ALTCS home delivered meals service specifications dated January 1987, incorporated by reference herein and on file with the Office of the Secretary of State; copies are also available at the central office of the AHCCCS Administration. The rule does not include any later amendments or editions of the incorporated service specifications.
- J.** Transportation services. To be registered with the Administration, providers of nonemergency transportation services shall be licensed by the Arizona Department of Transportation, Motor Vehicle Division. Providers of emergency transportation shall meet the licensure requirements set forth in A.A.C. Title 9, Chapter 13, Article 10.
- K.** Developmentally disabled day care. To be a registered provider of developmentally disabled day care services, the provider shall be licensed by the Arizona Department of Economic Security.
- L.** Habilitation. To be a registered provider of habilitation services the provider must meet the ALTCS service specifications for habilitation providers, dated September 1992, incorporated by reference herein and on file with the Office of the Secretary of State.
- M.** Attendant care services. To be a registered provider of attendant care services, the individual shall meet the ALTCS Attendant Care service specifications.
- R9-28-505. Standards, licensure, and certification for providers of hospital and medical services Licensure and Certification for Providers of Hospital and Medical Services**
- A. ALTCS providers A provider of hospital and medical care services shall be registered with the Administration.
  - B. Providers of hospital services shall be licensed by the Arizona Department of Health Services, and shall meet requirements set forth in 42 CFR 482, and Part 456, Subpart C, incorporated by reference herein and on file with the Office of the Secretary of State  
With the exception of an Indian Health Service (IHS) hospital and a Veterans Administration hospital, which must be Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited, a provider of hospital services shall be licensed by the Arizona Department of Health Services, be JCAHO accredited, and meet the requirements in 42 CFR 482, September 9, 1996, and 42 CFR 456(C), September 29, 1978, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation contains no future editions or amendments.
- R9-28-508. Program contractor standards—submittal of comprehensive plan for delivery of services Contractor Standards - Submittal of Comprehensive Plan for Delivery of Services**
- A. Program contractors shall annually submit a comprehensive plan for delivery of services under the ALTCS program. The comprehensive service delivery plan shall set forth the methods and procedures to be used by the program contractor in complying with the standards defined in this Article and for the provision of services to ALTCS enrolled members.
  - B. In addition to the elements required by contract, the comprehensive service delivery plan shall contain those elements listed below:
    1. The program contractor's procedures for selection of providers of ALTCS services and specification of the method and amount of payment. The plan shall demonstrate that the program contractor has selected or will select cost effective providers and that the amount of reimbursement is tied to the quality of care provided.
    2. The program contractor's plan for case management, including a discussion of procedures the contractor intends to follow in order to place members, monitor placement, and provide member's involvement in the placement decision.A program contractor shall annually submit a comprehensive plan for delivery of services under the ALTCS program as

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specified in the RFP during bid years or the RFP amendment during renewal years. The program contractor shall ensure that the comprehensive service delivery plan describes the methods and procedures to be used by the program contractor in complying with the standards defined in this Article, and in providing services to an eligible person or member.

**R9-28-510. Case Management**

- A. Each eligible member of ALTCS shall be assigned a case manager to coordinate, monitor and reassess the need for and provision of long-term care services.
- B. The case manager shall be responsible for the duties listed below:
1. The case manager shall assure placement of the member in appropriate long-term care services within 30 days of notification of enrollment.
  2. The case manager shall complete the case management plan when the member is enrolled in ALTCS, and shall reevaluate and update as necessary that plan upon transfer of the member to another facility, to a hospital, when there is a change in the member's in-home service package or when there is a change in the member's level of care. The case management plan shall specify the services to be received by the member, the units and frequency of those services, the provider of service and the effective time period. The case management plan shall serve as authorization for services for individuals who continue to be financially and medically eligible for services.
  3. The case manager shall coordinate with the primary care physician in determining the necessary services for the member, including hospital and medical services.
  4. The case manager shall allow for the member's participation in preparation of the case management plan.
  5. The case manager shall assist the member to maintain or progress toward the highest level of functioning.
  6. The case manager shall monitor receipt of services by the member.
  7. When ALTCS services are no longer necessary, the case manager shall initiate transfer to AHCCCS or other available programs, where appropriate.
  8. The case manager shall not include home and community-based services in the case management plan if the services exceed 80% of the institutional cost without submittal of justification.
  9. The case manager shall not include hospitalization and other services in excess of \$265 per day in the case management plan for a ventilator dependent individual unless the Administration determines after utilization review that the care is medically indicated and provided at the lowest appropriate level.
  10. A program contractor shall only provide payment or reimbursement for ALTCS services provided according to the case management plan.
  11. The case manager shall perform additional monitoring of members with rehabilitation potential, or members whose condition is fragile, or is unstable, and members whose case management plan is marginally cost effective, or whose use of medical and hospital services is unusual.
  12. To ensure a smooth transition and continuity of care, the case manager shall assist the member in transfer of facilities or providers, and transfer of records.
  13. The case manager shall update the case management plan at least every 90 days for eligible persons receiving home and community-based services, every 180 days

for eligible persons in nursing facilities, and every 30 days for ventilator dependent eligible persons.

- C. Program contractors shall submit the initial case management plan and subsequent updates to the Administration within 5 working days of preparation or revision of such plan.
- A. Each eligible person and member shall be assigned a case manager to:
1. Identify.
  2. Plan.
  3. Coordinate.
  4. Monitor, and
  5. Reassess the need for and provision of long-term care services.
- B. The case manager shall:
1. Ensure that appropriate ALTCS placement and services are provided for an eligible person or member within 30 days of notification of enrollment;
  2. Complete a case management plan when an eligible person or member is enrolled in ALTCS. The case manager shall re-evaluate and revise the plan when the eligible person or member:
    - a. Transfers to another facility.
    - b. Transfers to a hospital.
    - c. Has a change in the in-home service package, or
    - d. Has a change in the level of care.
  3. Specify the services to be received by an eligible person or member, including the:
    - a. Duration.
    - b. Scope of services.
    - c. Units of service.
    - d. Frequency of service delivery.
    - e. Provider of services, and
    - f. Effective time period.
  4. Authorize services for an eligible person or member who continues to be financially and medically eligible for services;
  5. Coordinate with a primary care provider in determining the necessary services for an eligible person or member, including hospital and medical services;
  6. Ensure that an eligible person or member participates in the preparation of the eligible person's or member's case management plan;
  7. Assist an eligible person or member to maintain or progress toward the highest level of functioning;
  8. Monitor receipt of services by an eligible person or member;
  9. Initiate a transfer to AHCCCS or other programs, where appropriate, when ALTCS HCBS services are no longer necessary;
  10. Submit written justification to the case manager's supervisor to include HCBS in the case management plan, if the services exceed 80% of the institutional cost;
  11. Ensure that records are transferred when an eligible person or member is transferred from a facility or provider to a new facility or provider;
  12. Perform additional monitoring of an eligible person or member with rehabilitation potential, whose condition is fragile or unstable, whose case management plan is marginally cost effective, or whose use of medical and hospital services is unusual;
  13. Revise a case management plan for an eligible person or member according to the terms of the contract; and
  14. Arrange behavioral health services if necessary and, if the case manager does not meet the definition of a behavioral health professional according to A.A.C. R9-

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22-1201, have initial and quarterly consultation and collaboration with a behavioral health professional to review the treatment plan.

- C. A program contractor shall submit the initial case management plan and all revisions to the Administration within 14 days of initially preparing or revising the plan.

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

A. Program contractors shall be responsible for submitting to the Administration a quality management plan, which incorporates the utilization requirements specified in this Section. Program contractors shall review the plan annually, update it as needed, and submit the updates to the Administration. Program contractors or providers of ICF-MR facilities shall follow utilization review and control requirements set forth in 42 CFR 456.401(b)(1), October 1, 1978, incorporated by reference herein and on file with the Office of the Secretary of State.

B. Program contractors shall perform, or delegate to institutional providers the performance of, utilization review and control requirements. Such utilization review and control requirements shall include:

1. Formation of a utilization review committee;
2. Completion of medical care evaluation studies for hospitals and mental hospitals;
3. Submission of utilization review quarterly showing reports to the Administration;
4. Maintenance and updating the plan of care for each member;
5. Certification and recertification of the need for hospice services;
6. Certification of an eligible person's need for care and recertification of the eligible person's need for care. For ICF-MR, this shall take place annually after initial certification.

C. Program contractors shall monitor compliance with physician certification and recertification of terminal illness for individuals receiving hospice services.

D. Program contractors shall monitor compliance with the home health agency plan of care. The plan shall be reviewed by a physician every 60 days.

E. Program contractors shall maintain Utilization Review Committees which meet the requirements set forth in 42 CFR 456.405-456.407, October 1, 1978, incorporated by reference herein and on file with the Office of the Secretary of State.

F. The program contractor shall also maintain a quality management process for both institutional and noninstitutional members. This process shall examine patterns of care, document and correct patterns which are of insufficient quality or cost-effectiveness, and monitor provider compliance with utilization review and control requirements. This process shall also include the review of case manager functions and providers of care, as well as overall performance of the delivery system.

G. Program contractors shall implement utilization control functions specified in R9-22-522(F) through (I).

H. The Administration shall be responsible for utilization review, utilization control, and quality management functions, including:

1. Inspection of care by the Administration;
2. Monitoring program contractors and providers to ensure compliance with quality management plans and standards set forth in this Article;

3. Conducting utilization review for members who receive services on a fee-for-service basis;

4. Conducting post payment review.

I. Program contractors shall cooperate with the Administration in the performance of functions set forth in subsection (H).

J. Program contractors shall develop and maintain a mechanism for correction of utilization or quality of care deficiencies.

A. A program contractor shall:

1. Comply with all requirements specified in A.A.C. R9-22-522; and

2. Submit quarterly utilization control reports within time lines specified in contract and in accordance with 42 CFR 456 Subparts C, D, and F, December 1, 1986, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. In addition to OM/UM monitoring activities specified in A.A.C. R9-22-522, the Administration shall conduct inspections of care at ICF-MR facilities, psychiatric hospitals, inpatient psychiatric facilities for individuals less than age 21 (behavioral health residential treatment centers), and institutions for mental disease (IMDs) where members reside while receiving treatment.

**R9-28-512. Financial reporting requirements-Statements, Periodic Reports and Information**

A. Upon request of the Administration, each program contractor shall furnish information from its records relating to contract performance:

B. Financial statements:

1. Each program contractor shall provide the Administration with the following financial statements:

a. An annual certified financial report prepared by a certified public accountant to be submitted not later than 120 days after the close of the program contractor's fiscal year. Such certified public accountants shall be independent of the program contractor, subcontracting entities, and their officers or directors, and any affiliates.

b. Quarterly financial statements for the quarters ending December 31, March 31, June 30, and September 30. These quarterly reports shall be submitted to the Administration not later than 45 days after the end of the reporting period.

2. All statements shall identify separately all ALTCS related transactions, including allocations of overhead and other shared expenses where applicable. The program contractor shall provide supplemental schedules describing all inter-entity transactions and eliminations to provide comparability necessary for the Administration to analyze the overall financial status of the entire delivery system.

The Administration and its contractors shall meet the requirements specified in A.A.C. R9-22-520.

**R9-28-513. Program compliance audits Compliance Audits**

A. Each program contractor shall be audited by the Administration at least once every 12 months. Unless the Administration determines that advance notice will render a review less useful, a program contractor shall be notified approximately three weeks in advance of the date of an on-site review. The Administration shall conduct, without prior notice, inspections of program contractor facilities or perform other elements of a review, either in conjunction with another audit or as part of an unannounced inspection program.

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**B.** In pursuit of the review objectives, the review team may perform any or all of the procedures listed below:

1. Conduct private interviews and group conferences with members, physicians and other health professionals, and members of the program contractor's administrative staff including, but not limited to, its principal management persons.
2. Examine records, books, reports and papers of the program contractor and any management company, and all providers or noncontracting providers of health care and other services to the program contractor. The examination shall include:
  - a. The minutes of staff meetings;
  - b. Peer review and quality of care review records;
  - c. Duty rosters of medical personnel;
  - d. Appointment records;
  - e. Written procedures for the internal operation of the program contractor;
  - f. Contracts and correspondence with members and with providers of health care services and other services to the program contractor; and
  - g. Such additional documentation deemed necessary by the Administration to properly review the quality of care.

The Administration and its contractors shall meet the requirements specified in A.A.C. R9-22-521 for an ALTCS eligible person or member.

**R9-28-514. Safeguarding and release of confidential information**  
Release of Safeguarded Information by the Administration and Contractors

**A:** Information to be safeguarded concerning ALTCS applicants, eligible persons or members includes the information listed below:

1. Names, addresses, and Social Security numbers;
2. Social and economic conditions or circumstances;
3. Agency evaluation of personal information;
4. Medical data and services, including diagnosis and past history of disease or disability;
5. State Data Exchange (SDX) tapes from the U.S. Social Security Administration; and
6. Information system tapes from the Arizona Department of Economic Security.

**B:** Unrestricted information. The restrictions upon disclosure of information shall not apply to summary data, statistics, utilization data, and other information which do not identify an individual applicant, eligible person, or member.

**C:** The use or disclosure of information concerning an eligible person, applicant or member, shall be limited to the person concerned, or individuals authorized by the person concerned, and persons or agencies for official purposes. Safeguarded information may be released to these parties only under the conditions specified in subsections (D), (E) and (F) of this Section.

**D:** Safeguarded information may be released to the applicant, eligible person, or member only under the conditions specified below:

1. Eligibility case record. An applicant, eligible person or member may view the contents of his or her eligibility case record at any time, provided an Administration official, or its authorized representative is present during the examination of the eligibility record. An unemancipated minor may view the eligibility case record in which he is included with the written permission of a parent or person standing in a parental relationship.

2. Medical record. The eligible person, member or authorized representative may view his or her medical record after written notification to the provider and at a reasonable time and place.

**E.** Release to individuals authorized by the person concerned. Eligibility case records, records, medical records, and any other ALTCS related confidential and secured information regarding categorically eligible or eligible person, a member or applicants may be released to individuals authorized by the client or applicant only under the conditions listed below:

1. Authorization for release of information shall be obtained from the member, applicant or designated representative;
2. Authorization used for release shall be a written document, separate from any other document, and shall specify the information listed below:
  - a. Information or records, in whole or in part, which are authorized for release;
  - b. To whom the release shall be made;
  - c. The period of time for which the authorization is valid, if limited;
  - d. The dated signature of the adult and mentally competent member, applicant or designated representative. In the case of a minor member or applicant, the signature of a parent, custodial relative or designated representative is required unless the minor is capable and sufficiently mature to understand the consequences of the authorization and of not giving authorization

3. In the case where a complaint, appeal, or grievance has been filed, the member, applicant or his designated representative shall be permitted to review, obtain, or copy any record necessary for the proper presentation of the case.

**F.** Release to persons or agencies for official purposes:

1. For this purpose those official purposes which are directly related to the administration of ALTCS are:
  - a. Establishing eligibility and post-eligibility treatment of income;
  - b. Determining the amount of medical assistance;
  - c. Providing services for eligible persons and members;
  - d. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to ALTCS;
  - e. Performing evaluations and analyses of ALTCS operations;
  - f. Filing liens on property;
  - g. Filing claims on estates.
2. Employees of the Administration. For official purposes, safeguarded information, case records and medical records information may be disclosed to the persons listed below without the consent of an applicant, member or eligible person for purposes related to administration of the program and only to the extent required in performance of duties:
  - a. Employees of the Administration, and its contractors;
  - b. Employees of the U.S. Social Security Administration;
  - c. Employees of the Arizona Department of Economic Security;
  - d. Employees of the Arizona Department of Health Services;

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- e. ~~Employees of the U.S. Department of Health and Human Services;~~
- f. ~~Employees of program contractors and providers;~~
- g. ~~Employees of the Arizona Attorney General's Office.~~
- 3. **Law enforcement officials:**
  - a. ~~Case record. The Administration and or contractor may release, with out an eligible person's or member's written or verbal consent, information to authorized officials for the purposes of an investigation, prosecution, or criminal or civil proceedings conducted by or on behalf of the Administration, the State of Arizona, or a Federal agency in connection with the administration of ALTCS.~~
  - b. ~~Medical record. The Administration may release safeguarded information contained in the member's medical record to law enforcement officials without the member's consent in cases of suspected fraud or abuse against the ALTCS program.~~
- 4. ~~Review committees. For official purposes, safeguarded information, case records, and medical services information may be disclosed without the consent of the applicant, member, or eligible person to members,~~
  - ~~agents or employees of review committees in accordance with the provisions of A.R.S. § 36-2917.~~
  - 5. ~~Compliance with the 1634 Agreement. In accordance with the 1634 Agreement between the State of Arizona and the U.S. Department of Health and Human Services, the recipient of any information or records disclosed or used pursuant to an official purpose shall also be responsible for complying with the provisions of the 1634 Agreement, dated October 1982, incorporated by reference herein, and on file with the Office of the Secretary of State.~~
    - G. ~~Written consent shall be obtained before medical records of a former member may be transmitted to any physician.~~
    - H. ~~Providers shall not be required to obtain written approval from the member before transmitting member medical records to physicians who:~~
      - 1. ~~Provide services to members under subcontract with the program contractor;~~
      - 2. ~~Are retained by the provider to provide services that are infrequently used or are of an unusual nature;~~
      - 3. ~~Provide services under the prime contract.~~

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

**NOTICE OF FINAL RULEMAKING**

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

PREAMBLE

- |  |   |
|--|---|
| <b>1. <u>Sections Affected</u></b><br>R20-5-601<br>R20-5-602 | <b><u>Rulemaking Action</u></b><br>Amend<br>Amend |
|--|---|
- 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. § 23-405(4)  
Implementing statute: A.R.S. § 23-410
- 3. The effective date of the rule:**  
December 12, 1997
- 4. A list of all previous notices appearing in the Register addressing the final rule:**  
Notice of Rulemaking Docket Opening: 3 A.A.R. 979, April 4, 1997  
Notice of Proposed Rulemaking: 3 A.A.R. 1088, April 18, 1997
- 5. The name and address of agency personnel with whom persons may communicate regarding the rule:**  
Name: Cathy Neville, Assistant Director  
Address: Industrial Commission of Arizona  
Division of Occupational Safety and Health  
800 West Washington Street, Suite 203  
Phoenix, Arizona 85007  
Telephone: (602) 542-1695  
Fax: (602) 542-1614
- 6. An explanation of the rule, including the agency's reason for initiating the rule:**  
R20-5-601 requires change to incorporate an amendment pertaining to occupational exposure to 1,3-butadiene of the construction standards as published in 61 FR 56746-56856, November 4, 1996; amendments for corrections and partial stay to the safety standards for scaffolds used in the construction industry as published in 61 FR 59831-59832, November 25, 1996; and amendments to the occupational exposure to methylene chloride standards as published in 62 FR 1491-1619, January 10, 1997.

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R20-5-602 requires change to incorporate an amendment pertaining to occupational exposure to 1,3-butadiene of the general industry standards as published in 61 FR 56746-56856, November 4, 1996; and amendments to the occupational exposure to methylene chloride standard as published in 62 FR 1494-1619, January 10, 1997.

Under its approved state program enforcing the Occupational Safety and Health Act, the state must adopt standards that are at least as effective as those adopted by the U.S. Department of Labor. Therefore, the Industrial Commission updates its occupational safety and health standards by adopting by reference the most current and applicable federal occupational safety and health standards for the construction and general industry.

7. 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
8. The summary of the economic, small business, and consumer impact:  
The Federal Occupational Safety and Health Administration has determined that these amendments will have minimal to modest impact for most affected industry groups and has determined the amendments to be economically feasible. Cost and benefit analysis of these amendments is available for inspection, review, and copying at the Industrial Commission of Arizona, Division of Occupational Safety and Health, 800 West Washington Street, Phoenix, Arizona 85007.
9. A Description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):  
None
10. A summary of the principal comments and the agency response to them:  
No comments, either oral or written, were submitted.
11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:  
Not applicable
12. Incorporations by reference and their location in the rules:  
29 CFR 1926, *Federal Occupational Safety and Health Standards for the Construction Industry*, with amendments as of January 10, 1997. This incorporation by reference will appear in R20-5-601.  
29 CFR 1910, *Federal Occupational Safety and Health Standards for General Industry*, with amendments as of January 10, 1997. This incorporation by reference will appear in R20-5-602.
13. Was this rule previously adopted as an emergency rule?  
No
14. The full text of the rules follows:

TITLE 20. COMMERCE, BANKING, AND INSURANCE  
CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

ARTICLE 6. OCCUPATIONAL SAFETY AND HEALTH  
CONSTRUCTION STANDARDS

Section

- R20-5-601. The Federal Occupational Safety and Health Standards for Construction, 29 CFR 1926
- R20-5-602. The Federal Occupational Safety and Health Standards for General Industry, 29 CFR 1910

ARTICLE 6. OCCUPATIONAL SAFETY AND HEALTH  
CONSTRUCTION STANDARDS

R20-5-601. The Federal Occupational Safety and Health Standards for Construction, 29 CFR 1926  
Each employer shall comply with the standards enumerated in the *Federal Occupational Safety and Health Standards for Construction*, as published in 29 CFR 1926, with amendments as of January 10, 1997 ~~August 30, 1996~~, incorporated by reference and on file with the Office of the Secretary of State. Copies of these referenced ~~materials~~ material are available for review at the Industrial Commission of Arizona and may be obtained from the United States Government Printing Office, Superintendent of Documents, Washington, D.C. 20402. These standards shall apply to all conditions and practices related to construction activity by all employers, both public and private, in the state of Arizona.

This incorporation by reference does not include amendments or editions to 29 CFR 1926 published after January 10, 1997 ~~August 30, 1996~~.

R20-5-602. The Federal Occupational Safety and Health Standards for General Industry, 29 CFR 1910

- A. Each employer shall comply with the standards in Subparts C through Z inclusive of the federal Occupational Safety and Health Standards for General Industry, as published in 29 CFR 1910, with amendments as of January 10, 1997 ~~August 23, 1996~~, incorporated by reference and on file with the Office of the Secretary of State. Copies of these reference materials are available for review at the Industrial Commission of Arizona and may be obtained ~~from~~ ~~from~~ the United States Government Printing Office, Superintendent of Documents, Washington, D.C. 20402. These standards shall apply to all conditions and practices related to general industry activity by all employers, both public and private, in the state of Arizona. This incorporation by reference does not include amendments or editions to 29 CFR 1910 published after January 10, 1997 ~~August 23, 1996~~.
- B. No change.
- C. No change.
- D. No change.