



*Arizona Administrative Register*  
**Notices of Exempt Rulemaking**

---

R9-31-405.	New Section
R9-31-406.	New Section
R9-31-407.	New Section
R9-31-501.	New Section
R9-31-502.	New Section
R9-31-503.	New Section
R9-31-504.	New Section
R9-31-505.	New Section
R9-31-506.	Reserved
R9-31-507.	New Section
R9-31-508.	New Section
R9-31-509.	New Section
R9-31-510.	New Section
R9-31-511.	New Section
R9-31-512.	New Section
R9-31-513.	New Section
R9-31-514.	New Section
R9-31-515.	Reserved
R9-31-516.	Reserved
R9-31-517.	Reserved
R9-31-518.	New Section
R9-31-519.	Reserved
R9-31-520.	New Section
R9-31-521.	New Section
R9-31-522.	New Section
R9-31-523.	New Section
R9-31-524.	New Section
R9-31-525.	Reserved
R9-31-526.	Reserved
R9-31-527.	Reserved
R9-31-528.	Reserved
R9-31-529.	Reserved
R9-31-601.	New Section
R9-31-701.	New Section
R9-31-702.	New Section
R9-31-703.	New Section
R9-31-704.	New Section
R9-31-705.	New Section
R9-31-706.	Reserved
R9-31-707.	New Section
R9-31-708.	Reserved
R9-31-709.	New Section
R9-31-710.	Reserved
R9-31-711.	New Section
R9-31-712.	Reserved
R9-31-713.	New Section
R9-31-714.	Reserved
R9-31-715.	New Section
R9-31-716.	New Section
R9-31-717.	New Section
R9-31-801.	New Section
R9-31-802.	New Section
R9-31-803.	New Section
R9-31-804.	New Section
R9-31-901.	New Section
R9-31-1001.	New Section
R9-31-1002.	New Section
R9-31-1101.	New Section
R9-31-1102.	New Section
R9-31-1103.	New Section
R9-31-1104.	New Section
R9-31-1201.	New Section
R9-31-1202.	New Section
R9-31-1203.	New Section
R9-31-1204.	New Section

*Arizona Administrative Register*  
**Notices of Exempt Rulemaking**

---

R9-31-1205.	New Section
R9-31-1206.	New Section
R9-31-1207.	New Section
R9-31-1301.	New Section
R9-31-1302.	New Section
R9-31-1303.	New Section
R9-31-1304.	New Section
R9-31-1305.	New Section
R9-31-1306.	New Section
R9-31-1307.	New Section
R9-31-1308.	New Section
R9-31-1309.	New Section
R9-31-1401.	Reserved
R9-31-1501.	Reserved
R9-31-1601.	New Section
R9-31-1602.	New Section
R9-31-1603.	New Section
R9-31-1604.	New Section
R9-31-1605.	New Section
R9-31-1606.	New Section
R9-31-1607.	New Section
R9-31-1608.	New Section
R9-31-1609.	New Section
R9-31-1610.	New Section
R9-31-1611.	New Section
R9-31-1612.	New Section
R9-31-1613.	New Section
R9-31-1614.	New Section
R9-31-1615.	New Section
R9-31-1616.	New Section
R9-31-1617.	New Section
R9-31-1618.	New Section
R9-31-1619.	New Section
R9-31-1620.	New Section
R9-31-1621.	New Section
R9-31-1622.	New Section
R9-31-1623.	New Section
R9-31-1624.	New Section
R9-31-1625.	New Section

2. **The specific authority for the rulemaking, including both the authorizing statute (general and the statutes the rules are implementing (specific):**

Authorizing statute: Laws 1998, Ch. 4, 4th Special Session.

Implementing statute: Laws 1998, Ch. 4, 4th Special Session.

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

October 23, 1998

4. **A list of all previous notices appearing in the Register addressing the exempt rule:**

Notice of Rulemaking Docket Opening: 4 A.A.R. 1974, July 24, 1998.

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name: Cheri Tomlinson, Federal & State Policy Administrator

Address: 801 East Jefferson  
Mail Drop 4200  
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, including the statutory citation to the exemption from the regular rulemaking procedures:**

The federal government, through passage of the Balanced Budget Act, increased funding to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children. Based on this law, the Arizona Legislature passed Laws 1998, Ch. 4, 4th Special Session, giving AHCCCS the authority to establish the Children's Health Insurance Program (CHIP). This program will commence on November 1, 1998. Arizona's CHIP will provide health insurance to Arizona

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

children under the age of 19, whose family income level is at or below 150% of the federal poverty level.

Laws 1998, Ch. 4, § 11 exempts AHCCCS from the normal rulemaking process.

7. **A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material.**

None

8. **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.

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

There will be a minimal impact on AHCCCS due to the administrative expense of developing and implementing a new program. Examples of such increased administrative expenses include: (1) designing a new computer system for the CHIP program; (2) hiring 59 eligibility people to screen applications; and (3) creating an extensive outreach program. These costs, as well as all other costs of the program, are funded 75% by federal dollars and 25% by state tobacco tax dollars.

There will be a minimal impact to the Arizona Department of Health Services (ADHS) because ADHS is responsible for providing health care services to CHIP members who choose qualifying health centers to be their providers. ADHS will need to expand its existing monitoring activities to an increased population.

There will be a minimal impact to the Department of Economic Security (DES) because DES will be partnering with AHCCCS to screen applications for potential Title XIX eligibility.

The following entities will benefit from the program:

- AHCCCS health plans because they will have an increase in membership.
- AHCCCS health plan providers because they will have an increase in their number of patients.
- Arizona children, who are currently without health insurance, may be eligible for the program and will have access to health care services. Moreover, some children may be deemed eligible for Title XIX coverage through the screening process which would also be a mechanism for providing health coverage to more uninsured children.

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

Not applicable.

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

The Administration received comments from 11 entities. Their comments and the Administration's response is detailed below:

**Rule Citation:** R9-31-112

**Comment:** There was a clarification in the rules made for the definition of certified nurse practitioner. A certified nurse practitioner means a registered nurse practitioner as certified by the Arizona Board of Nursing according to A.R.S. Title 32, Chapter 15.

**Response:** The Administration added the term "practitioner".

**Rule Citation:** R9-31-112

**Comment:** The definition is unclear. What is meant by "...disorders in Administration standards"? Which Administration standards are being referred to?

**Response:** The Administration corrected the typographical error in the rule language to clarify the definition.

**Rule Citation:** R9-31-113

**Comment:** The definition of action and date of action fails to include denial of service. Insert this in the definition. It is important that KidsCare members and their doctors have the right to appeal denial of a medically necessary service.

**Alternative Language:** "Action" means a termination, suspension, reduction or denial of a covered service with the date on which the termination, suspension or reduction becomes effective.

**Response:** "Action" and "Denial" are 2 separate definitions used in this Article because:

1. "Action" is when a member may continue to receive the service during a grievance process; and
2. When you appeal a "Denial" for services a party may request an expedited hearing. However, the member does not continue to receive a service.

*Arizona Administrative Register*  
**Notices of Exempt Rulemaking**

---

**Rule Citation:** R9-31-205

**Comment:** Delete subsection C paragraph 2. As currently worded, the Section would disallow coverage for any physical examination that may also be used by another public/private agency that is assisting the child. This exception is over broad. For example, a medically necessary physical examination done may be used not only for diagnosis or treatment of the child, but Social Security may review the report to determine whether the child meets its disability criteria; or Girl Scout's may utilize the report to determine the child's appropriateness for camp. It appears the Administration's concern is that physical examinations done solely for other agencies not be covered. However, it is unnecessary to include a separate Section to address this concern because an exam done merely for another agency would not meet "medically necessary" criteria and therefore would not be covered.

**Response:** Due to the state statute the Administration is required to offer the benefits package of the least expensive health benefits coverage plan available to state employees (Intergroup).

**Rule Citation:** R9-31-213(D)

**Comment:** Alternative Language: "Members with special health care needs will be referred to the Children's Rehabilitative Services program" or "Members with special health care needs may be referred to the Children's Rehabilitative Services program"

At a minimum, members with special health care needs who have medical conditions likely to qualify for coverage under the Children's Rehabilitative Services (CRS) program, and their primary care providers, shall be notified of the potential availability of the CRS delivery system and provided written information on the CRS application process."

**Response:** The Administration is not able to make this say "shall" as requested because our state KidsCare legislation says "may".

This information is provided in contract. The language is as follows:

The program for CRS-covered conditions is administered by the Arizona Department of Health Services (ADHS) for children who meet CRS eligibility criteria. The Contractor is responsible for referring children to the CRS program who are potentially eligible for these services. Eligibility criteria and the referral process are described in the CRS Policy and Procedures Manual available in the Bidder's Library (Division of Business and Finance-AHCCCS). The Contractor is also responsible for providing primary medical care, including emergency services and initial care of newborn infants, for members who are also CRS eligible, and to require the member's Primary Care Provider (PCP) to coordinate their care with the CRS program. All services provided must be included in the member's medical record maintained by the PCP.

**Rule Citation:** R9-31-216

**Comment:** We assume that alcoholic beverages was a mistake and that it will be deleted.

**Response:** The Administration agrees with the correction. This will be removed from the KidsCare rules.

**Rule Citation:** R9-31-302

**Comment:** Include in the Section that the notice shall be personally delivered or mailed by regular mail. The date of notice shall be the date of personal delivery to the individual or postmark date, if mailed.

**Response:** Change "send" to "mail" in this Section.

The Date of Notice will be the date used for decision making purposes in order to be consistent with Title XIX.

**Rule Citation:** R9-31-303

**Comment:** Premium Sharing Program (PSP) - If a child is on PSP, is the child eligible for KidsCare?

**Response:** Children on PSP will not be converted to KidsCare unless they choose to go bare for 6 months.

**Rule Citation:** R9-31-303

**Comment:** If a PSP member fails to pay the premiums and loses coverage will that person have to go bare for 6 months before being able to qualify for KidsCare?

**Response:** Yes.

*Arizona Administrative Register*  
**Notices of Exempt Rulemaking**

---

**Rule Citation:** R9-31-303

**Comment:** What if the person loses PSP for some other reason. Will that person have to go bare for 6 months? An example of this would be losing coverage because the member moves to a county where the PSP is not operational.

**Response:** No. The member will not have to go bare for 6 months.

**Rule Citation:** R9-31-303

**Comment:** There is a need to develop a specific subsection which clarifies that recipients of Indian Health Services will not be adversely impacted by this 6 month "bare" requirement. Indian Health Services is not a health insurance program. It is a treaty obligation of the federal government. Litigation has also clarified that IHS is the payor of last resort.

**Response:** The Administration added IHS to the list of categories which do not have to go bare for 6 months.

As specified in 42 U.S.C. § 1397bb, Native Americans may be covered under KidsCare without having to go bare.

**Rule Citation:** R9-31-303

**Comment:** "Is not eligible for Title XIX or other federally operated or financed health care insurance program, except the Indian Health Service as specified in A.R.S. § 36-2983."

Following "Indian Health Service" insert "and tribal PL. 93-638 health care provider" in order to maintain consistency throughout the document.

**Response:** The Administration will make this change.

**Rule Citation:** R9-31-303(M)

**Comment:** "Has not been covered by health insurance during the previous 6 months unless that health insurance was discontinued due to the involuntary loss of employment as specified in A.R.S. § 36-2983. The 6 months of ineligibility due to previous coverage shall not apply to (See List 1-7)."

The prior health insurance coverage exception rule should also apply to members who receive services at Indian Health Service and tribal health facilities.

**Response:** The Administration added IHS to the list of categories which do not have to go bare for 6 months.  
As specified in 42 U.S.C. § 1397bb, Native Americans may be covered under KidsCare without having to go bare.

**Rule Citation:** R9-31-303(M)

**Comment:** Alternative Language: "...previous and/or existing coverage under Children's Rehabilitative Services" be added to the list of exceptions. This will help clarify in writing that CRS enrollment will not stand in the way of a child's eligibility for KidsCare.

**Response:** The Administration agreed to clarify this and state that a member does not have to go bare if enrolled with CRS.

**Rule Citation:** R9-31-304

**Comment:** Delete lines 29-32. These subparagraphs presume that a household member who is out of the home for 30 days or less for employment, military service, or education is providing financial support from their income to the household. Out-of-home family member's income if contributed to the household would be included under current rules. If a family member is absent and not providing any support, even though he or she may have income, the applicant household should not be penalized.

Alternative: Delete R9-31-304(C)(3).

**Response:** The Administration will continue to count income because the individuals are still considered residents.

*Arizona Administrative Register*  
**Notices of Exempt Rulemaking**

---

**Rule Citation:** R9-31-304

**Comment:** Under the proposed disregard of income Section, AHCCCS has allowed income tax refunds to be excluded. Yet, the KidsCare application requires the family to report the Earned Income Tax Credit (EITC). EITC is disregarded when determining eligibility for TANF and Food Stamps. The same principle should apply here.

**Response:** The Administration does disregard EITCs, however, the Administration asks for the EITC information on the application so the Administration knows the proper amount to disregard.

**Rule Citation:** R9-31-304

**Comment:** When a family applies for the Medically Needy/Medically Indigent Program (MN/MI) and the family has a member enrolled in KidsCare, for the purpose of MN/MI household count, is the KidsCare member included?

**Response:** Yes.

**Rule Citation:** R9-31-306

**Comment:** Provisions should be inserted that would allow the family to move their child from 1 health contractor to another or to a health center. Children eligible for IHS have the flexibility to move among providers outside the annual enrollment period.

**Response:** The Administration will allow members to change enrollment choice during annual enrollment except for IHS members. The reason for this is to be consistent with Title XIX.

**Rule Citation:** R9-31-307

**Comment:** Provides that there is a 1 time 12 month period of continuous coverage and then a variety of exceptions are enumerated. Provisions to allow for redetermination should be included.

**Response:** The Administration will not do a re-determination during the 12 month guarantee period. The member is guaranteed 1, 12 month period unless 1 of the circumstances enumerated in the rule occurs. If for some reason a member believes the member has been terminated in error, the member may reapply.

**Rule Citation:** R9-31-308

**Comment:** There may be situations where the family cannot comply with the request for verification in the allowed time. Suggest that the line be rephrased to state "...within 10 days unless good cause can be demonstrated, the Administration may discontinue ..."

**Response:** If an applicant cannot provide verification information, the application must be denied. However, an applicant can always appeal a denial and argue that there was good cause which should override this conclusion. In such an event, it is best to review each case on a case-by-case basis to determine the unique circumstances which may constitute good cause.

**Rule Citation:** R9-31-705(B)

**Comment:** The timeline for providers to issue a remit on denied or reduced claims needs to be changed from 30 to 60 days as per R9-22-705 in the Acute Care Rules.

**Response:** Due to the Balanced Budget Act of 1997 (federal law) the Administration was required to update R9-31-705, as well as R9-22-705, to state that contractors must provide a written notice for a claim that is denied or reduced within the time period specified by the contract between a contractor and a subcontracting entity. In the absence of a contract, the contractor must issue 90% of its written notices for claims that are denied or reduced within 30 days and 99% of its written notices within 90 days.

**Rule Citation:** R9-31-711

**Comment:** In some hospitals, the Emergency Room is adjacent to or the same as an Urgent Care Center. If a person were to use the Urgent Care Center would a \$5.00 copayment be charged?

**Response:** In instances where there is 1 location to serve a dual purpose, the service will be declared "urgent care" and there will not be a copayment.

*Arizona Administrative Register*  
**Notices of Exempt Rulemaking**

---

**Rule Citation:** R9-31-1202

**Comment:** Is a Residential Treatment Center (RTC) stay the same as an acute inpatient stay?

**Response:** Residential Treatment Centers and acute hospital stays are both considered to be inpatient stays and count toward the service limitations.

**Rule Citation:** 9 A.A.C. 31, Article 13

**Comment:** The provisions of R9-31-1301 through R9-31-1309 are key to the handling of the grievance and appeal process. We suggest that these provisions be moved to Article 8.

**Response:** The provisions of R9-31-1301 through R9-31-1309 deal with a slightly different subject matter (i.e. when a service is reduced, suspended or terminated). This is an alternative process to the standard grievance and appeals process. Merging the Sections would create confusion.

Moreover, the alternative expedited hearing process is a separate Article under every other AHCCCS rule package.

**Rule Citation:** 9 A.A.C. 31, Article 16

**Comment:** The language fails to include specific reference to Urban Indian Programs when identifying which entities may provide and/or be reimbursed for services under the AHCCCS administered KidsCare Program.

Insert the language, Indian Health Service, Tribal Facility or Urban Indian Program (I/T/U) as consistent with the intent of Congress, and existing consultation language, to replace the incomplete reference to providers as currently written.

**Response:** The statute only allows IHS and Tribal Facilities to be reimbursed for services. Urban Indian Centers are not 638 Tribal Facilities unless they meet requirements of a Tribal organization.

**Rule Citation:** R9-31-1602(E)(2)

**Comment:** The signature of the member is obtained in advance of service provision indicating that the services have been explained to the member and that the member accepts responsibility for payment.

This Section is potentially problematic and presents a significant change in current practice under Contract Health Service and Title XIX-Medicaid when patients have to be referred outside of IHS. There needs to be further examination of the provision since its assumptions conflict with the current Indian health care delivery structure. It states that the signature of a member would be required when the member request services not available at an IHS or tribal facility to indicate that the member accepts responsibility for payment.

**Response:** This is an option for a member if the service is not covered. It is not mandatory. It does not prohibit the member from getting services through IHS contract health.

**Rule Citation:** R9-31-1608(C)(2)

**Comment:** Exemption to prescriptions in excess of a 30 days supply or a 100 unit dose.

It is suggested that AHCCCS consult with IHS and tribal facilities regarding an appropriate modification to extend prescriptions for chronic diseases and contraception. In the proposed rules, prescriptions can be extended to a 100-day supply or a 100 unit dose, whichever is more, when members live in areas not readily accessible to a pharmacy.

**Response:** The rules do allow for an exemption to prescriptions in excess of a 30 days supply or a 100 unit dose in the following circumstances:

1) The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is more;

2) The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply; or

3) The member lives in an area not readily accessible to a pharmacy and the prescription is limited to 100-days or 100-unit dose, whichever is more.

**Rule Citation:** R9-31-1618

**Comment:** Can IHS bill health plans when they provide services to a health plan member?

*Arizona Administrative Register*  
**Notices of Exempt Rulemaking**

**Response:** No. Title XXI funds will not be used for persons enrolled with a health plan who elect to receive services from IHS or a Tribal Facility.

**Rule Citation:** R9-31-1623

**Comment:** NACHC requests that the copayment required of KidsCare participants be waived. Not only are the policies of copayment inconsistent with current methods of service delivery through health care facilities, the expense of collection, documentation and reporting will far exceed any amounts collected from participants.

**Response:** The state CHIP statute requires copayments. Upon guidance from HCFA, the copayments which may be charged are very minimal.

In order to comply with the state statute, the Administration will charge a \$5 copayment for non-emergency use of the emergency room. With regard to Native Americans, AHCCCS has specifically asked the Health Care Financing Administration for guidance.

**Rule Citation:** R9-31-1623(B)

**Comment:** The AHCCCS Administration has received comment from ITCA that tribes and IHS will be prohibited from participating in the cost sharing and copayment provisions under KidsCare. 25 U.S.C. Section 1681 states, "the Indian Health Service shall neither bill nor charge those Indians who may have the economic means to pay unless and until such time as Congress has agreed upon a specific policy to do so and has directed the Indian Health Service to implement such a policy."

**Response:** The state CHIP statute requires copayments. Upon guidance from HCFA, the copayments which may be charged are very minimal.

In order to comply with the state statute, the Administration will charge a \$5 copayment for non-emergency use of the emergency room. With regard to Native Americans, AHCCCS has specifically asked HCFA for guidance.

**Rule Citation:** A.R.S. § 36-2984

**Comment:** Can health plans subcontract with commercial health plans for parent/guardian coverage?

**Response:** Plans cannot subcontract with other plans to provide family coverage. If the rates are excessively high, they can refer applicants to other insurance providers with a more affordable product.

**Rule Citation:** A.R.S. § 36-2989(A)

**Comment:** Will the Administration cover "traditional medicine men" for Native American populations?

**Response:** The Administration is not able to cover "traditional medicine men". This is because the state statute requires the Administration to offer the same benefits package as the least expensive health benefits coverage plan available to state employees (Intergroup).

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

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

- 42 CFR 438.114 as of September 29, 1998, incorporated in R9-31-210.
- 42 CFR 435.910 as of May 29, 1986, incorporated in R9-31-303.
- 42 CFR 435.920 as of May 29, 1986, incorporated in R9-31-303.
- 20 CFR 416 Appendix K as of April 1, 1997, incorporated in R9-31-304.
- 42 U.S.C. 1396b(m) as of August 5, 1997, incorporated in R9-31-401.
- 42 U.S.C. 1396u-2 as of August 5, 1997, incorporated in R9-31-401.
- 42 CFR 434.6 as of December 30, 1983, incorporated in R9-31-402.
- 42 CFR 447.50 through 447.58 as of December 19, 1990, incorporated in R9-31-402.
- 42 U.S.C. 1397 as of August 5, 1997, incorporated in R9-31-501.
- 42 CFR 455, Subpart B as of September 30, 1986, incorporated in R9-31-520.
- 42 U.S.C. 1396u-2 as of August 5, 1997, incorporated in R9-31-705.
- 42 CFR 433.154 as of May 12, 1980, incorporated in R9-31-1001.

14. **Was this rule previously adopted as an emergency rule?**  
No.

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

*Arizona Administrative Register*  
**Notices of Exempt Rulemaking**

**TITLE 9. HEALTH SERVICES**

**CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)  
CHILDREN'S HEALTH INSURANCE PROGRAM**

**ARTICLE 1. DEFINITIONS**

Section

- R9-31-101. Location of Definitions
- R9-31-102. Scope of Services Related Definitions
- R9-31-103. Eligibility and Enrollment Related Definitions
- R9-31-104. Reserved
- R9-31-105. General Provisions and Standards
- R9-31-106. Request for Proposal (RFP) Related Definitions
- R9-31-107. Standards for Payments Related Definitions
- R9-31-108. Grievance and Appeals Related Definitions
- R9-31-109. Reserved
- R9-31-110. 1st- and 3rd- Party Liability and Recoveries Related Definitions
- R9-31-111. Reserved
- R9-31-112. Covered Behavioral Health Services Related Definitions
- R9-31-113. Members' Rights and Responsibilities Related Definitions
- R9-31-114. Reserved
- R9-31-115. Reserved
- R9-31-116. Services for Native Americans Related Definitions

**ARTICLE 2. SCOPE OF SERVICES**

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

**ARTICLE 3. ELIGIBILITY AND ENROLLMENT**

- R9-31-301. General Requirements
- R9-31-302. Applications
- R9-31-303. Eligibility Criteria
- R9-31-304. Income Eligibility
- R9-31-305. Verification
- R9-31-306. Enrollment
- R9-31-307. Guaranteed Enrollment
- R9-31-308. Changes and Redeterminations
- R9-31-309. Newborn Eligibility
- R9-31-310. Notice Requirements

**ARTICLE 4. CONTRACTS**

- R9-31-401. General Provisions
- R9-31-402. Administration's Contracts with Contractors
- R9-31-403. Subcontracts

- R9-31-404. Contract Amendments; Mergers; Reorganizations
- R9-31-405. Suspension, Denial, Modification, or Termination of Contract
- R9-31-406. Contract; Sanction; Performance; and Solvency
- R9-31-407. Contract or Protest, Appeal

**ARTICLE 5. GENERAL PROVISIONS AND STANDARDS**

- R9-31-501. General Provisions
- R9-31-502. Availability and Accessibility of Service
- R9-31-503. Reinsurance
- R9-31-504. Marketing; Prohibition against Inducements; Misrepresentations; Discrimination; Sanctions
- R9-31-505. Approval of Advertisements and Marketing Materials
- R9-31-506. Reserved
- R9-31-507. Member Record
- R9-31-508. Limitation of Benefit Coverage for Illness or Injury due to Catastrophe
- R9-31-509. Transition and Coordination of Member Care
- R9-31-510. Transfer of Members
- R9-31-511. Fraud or Abuse
- R9-31-512. Release of Safeguarded Information by the Administration and Contractors
- R9-31-513. Discrimination Prohibition
- R9-31-514. Equal Opportunity
- R9-31-515. Reserved
- R9-31-516. Reserved
- R9-31-517. Reserved
- R9-31-518. Information to Enrolled Members
- R9-31-519. Reserved
- R9-31-520. Financial Statements, Periodic Reports and Information
- R9-31-521. Program Compliance Audits
- R9-31-522. Quality Management/Utilization Management (QM/UM) Requirements
- R9-31-523. Financial Resources
- R9-31-524. Continuity of Care
- R9-31-525. Reserved
- R9-31-526. Reserved
- R9-31-527. Reserved
- R9-31-528. Reserved
- R9-31-529. Reserved

**ARTICLE 6. REQUEST FOR PROPOSAL (RFP)**

- R9-31-601. General Provisions for RFP

**ARTICLE 7. STANDARDS FOR PAYMENTS**

- R9-31-701. General; Scope of the Administration's Liability; and Payment to a Contractor
- R9-31-702. Prohibitions Against Charges to Members
- R9-31-703. Claims
- R9-31-704. Transfer of Payments
- R9-31-705. Payments by Contractors
- R9-31-706. Reserved
- R9-31-707. Payments for Newborns
- R9-31-708. Reserved
- R9-31-709. Contractor's Liability to Hospitals for the Provision of Emergency and Subsequent Care
- R9-31-710. Reserved
- R9-31-711. Copayments

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

- R9-31-712. Reserved  
R9-31-713. Payments Made on Behalf of a Contractor: Recovery of Indebtedness  
R9-31-714. Reserved  
R9-31-715. Hospital Rate Negotiations  
R9-31-716. Specialty Contracts  
R9-31-717. Hospital Claims Review

**ARTICLE 8. GRIEVANCE AND APPEAL PROCESS**

- R9-31-801. General Provisions For All Grievances and Appeals  
R9-31-802. Eligibility Appeals and Hearing Requests For an Applicant and a Member  
R9-31-803. Grievances  
R9-31-804. Grievance and Appeal Process For Behavioral Health

**ARTICLE 9. QUALITY CONTROL**

- R9-31-901. General Provisions

**ARTICLE 10. 1ST- AND 3RD-PARTY LIABILITY AND RECOVERIES**

- R9-31-1001. 1st- and 3rd-Party Liability and Coordination of Benefits  
R9-31-1002. 1st- and 3rd-Party Liability Monitoring and Compliance

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

- R9-31-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims  
R9-31-1102. Determinations Regarding the Amount of the Penalty and Assessment  
R9-31-1103. Notice of Proposed Determination and Rights of Parties  
R9-31-1104. Issues and Burden of Proof

**ARTICLE 12. COVERED BEHAVIORAL HEALTH SERVICES**

- R9-31-1201. General Requirements  
R9-31-1202. Inpatient Behavioral Health Services  
R9-31-1203. Partial Care  
R9-31-1204. Outpatient Services  
R9-31-1205. Behavioral Health Emergency and Crisis Stabilization Services  
R9-31-1206. Other Behavioral Health Services  
R9-31-1207. Transportation Services

**ARTICLE 13. MEMBERS' RIGHTS AND RESPONSIBILITIES**

- R9-31-1301. General Provisions  
R9-31-1302. Denial of a Request for a Service  
R9-31-1303. Reduction, Suspension, or Termination of a Service  
R9-31-1304. Content of Notice  
R9-31-1305. Exceptions from an Advance Notice  
R9-31-1306. Notice in a Case of Probable Fraud  
R9-31-1307. Expedited Hearing Process  
R9-31-1308. Maintenance of Records  
R9-31-1309. Member Handbook

**ARTICLE 14. RESERVED**

**ARTICLE 15. RESERVED**

**ARTICLE 16. SERVICES FOR NATIVE AMERICANS**

- R9-31-1601. General Requirements  
R9-31-1602. General Requirements for Scope of Services  
R9-31-1603. Inpatient General Hospital Services  
R9-31-1604. Physician and Primary Care Physician and Practitioner Services  
R9-31-1605. Organ and Tissue Transplantation Services  
R9-31-1606. Dental Services  
R9-31-1607. Laboratory, Radiology, and Medical Imaging Services  
R9-31-1608. Pharmaceutical Services  
R9-31-1609. Emergency Services  
R9-31-1610. Transportation Services  
R9-31-1611. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices  
R9-31-1612. Health Risk Assessment and Screening Services  
R9-31-1613. Other Medical Professional Services  
R9-31-1614. Nursing Facility Services  
R9-31-1615. Eligibility and Enrollment  
R9-31-1616. Standards for Payments  
R9-31-1617. Prior Authorization  
R9-31-1618. Claims  
R9-31-1619. Hospital Claims Review  
R9-31-1620. Prohibitions Against Charges to Members  
R9-31-1621. Transfer of Payments  
R9-31-1622. The Administration's Liability to Hospitals for the Provision of Emergency and Subsequent Care  
R9-31-1623. Copayments  
R9-31-1624. Specialty Contracts  
R9-31-1625. Behavioral Health Services

**ARTICLE 1. DEFINITIONS**

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

- A.** For purposes of this Article the term member shall be substituted for the term eligible person.  
**B.** Location of definitions. Definitions applicable to Chapter 31 are found in the following.

Definition	Section or Citation
1. "1st party liability"	R9-22-110
2. "3rd party"	R9-22-110
3. "3rd party liability"	R9-22-110
4. "Accommodation"	R9-22-107
5. "Action"	R9-31-113
6. "Acute mental health services"	R9-22-112
7. "Administration"	R9-31-101
8. "Aggregate"	R9-22-107
9. "AHCCCS"	R9-31-101
10. "AHCCCS hearing officer"	R9-22-108
11. "Ambulance"	R9-22-102
12. "Ancillary department"	R9-22-107
13. "Appeal"	R9-22-108
14. "Appellant"	R9-31-108
15. "Applicant"	R9-31-101
16. "Application"	R9-31-101
17. "ADHS"	R9-31-112
18. "Behavioral health professional"	R9-31-112
19. "Behavioral health services"	R9-31-112
20. "Behavioral health technician"	R9-31-112
21. "Billed charges"	R9-22-107
22. "Capital costs"	R9-22-107
23. "Case management"	R9-31-112

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

24. "Certified nurse practitioner"	R9-31-102	88. "Operating costs"	R9-22-107
25. "Certified psychiatric nurse practitioner"	R9-31-112	89. "Outlier"	R9-31-107
26. "Child"	42 U.S.C. 1397jj	90. "Outpatient hospital service"	R9-22-107
27. "Clean claim"	A.R.S. § 36-2904	91. "Ownership change"	R9-22-107
28. "CMDP"	R9-31-103	92. "Peer group"	R9-22-107
29. "Continuous stay"	R9-22-101	93. "Pharmaceutical service"	R9-22-102
30. "Contract"	R9-22-101	94. "Physical therapy"	R9-22-102
31. "Contractor"	R9-31-101	95. "Physician"	A.R.S. § 36-2981
32. "Contract year"	R9-31-101	96. "Post stabilization services"	42 CFR 438.114
33. "Copayment"	R9-22-107	97. "Practitioner"	R9-22-102
34. "Cost avoidance"	R9-31-110	98. "Pre-existing condition"	R9-31-105
35. "Cost-to-charge ratio"	R9-22-107	99. "Prepaid capitated"	A.R.S. § 36-2981
36. "Covered charges"	R9-31-107	100. "Prescription"	R9-22-102
37. "Covered services"	R9-22-102	101. "Primary care physician"	A.R.S. § 36-2981
38. "CPT"	R9-22-107	102. "Primary care practitioner"	A.R.S. § 36-2981
39. "CRS"	R9-31-103	103. "Primary care provider"	R9-22-102
40. "Date of action"	R9-31-113	104. "Primary care provider services"	R9-22-102
41. "Day"	R9-22-101	105. "Prior authorization"	R9-22-102
42. "Denial"	R9-31-113	105. "Private duty nursing services"	R9-22-102
43. "Dentures"	R9-22-102	107. "Program"	A.R.S. § 36-2981
44. "DES"	R9-31-103	108. "Proposal"	R9-31-106
45. "Determination"	R9-31-103	109. "Prospective rates"	R9-22-107
46. "Diagnostic services"	R9-22-102	110. "Prudent layperson standard"	42 U.S.C. 1396u-2
47. "Director"	A.R.S. § 36-2981	111. "PSP"	R9-31-103
48. "DME"	R9-22-102	112. "Psychiatrist"	R9-31-112
49. "DRI inflation factor"	R9-22-107	113. "Psychologist"	R9-31-112
50. "EAC"	A.R.S. § 36-2905.03(B)	114. "Qualified alien"	P.L. 104-193
51. "ELIC"	A.R.S. § 36-2905.03(C) and (D)	115. "Qualifying Health Center"	A.R.S. § 36-2981
52. "Emergency medical condition"	42 U.S.C. 1396(v)	116. "Qualifying plan"	A.R.S. § 36-2981
53. "Emergency medical services"	R9-22-102	117. "Quality management"	R9-22-105
54. "Encounter"	R9-22-107	118. "Radiology services"	R9-22-102
55. "Enrollment"	R9-31-103	119. "Rebasing"	R9-22-107
56. "Facility"	R9-22-101	120. "Redetermination"	R9-31-103
57. "Factor"	R9-22-101	121. "Referral"	R9-22-101
58. "FPL"	A.R.S. § 36-2981	122. "RBHA"	R9-31-112
59. "Grievance"	R9-22-108	123. "Rehabilitation services"	R9-22-102
60. "Group Health Plan"	42 U.S.C. 1397jj	124. "Reinsurance"	R9-22-107
61. "GSA"	R9-22-101	125. "Request for hearing"	R9-31-108
62. "Guardian"	R9-22-103	126. "RFP"	R9-31-106
63. "Health plan"	A.R.S. § 36-2981	127. "Respiratory therapy"	R9-22-102
64. "Hearing aid"	R9-22-102	128. "Respondent"	R9-31-108
65. "Home health services"	R9-22-102	129. "Scope of services"	R9-22-102
66. "Hospital"	R9-22-101	130. "SDAD"	R9-22-107
67. "Household income"	R9-31-103	131. "SMP"	A.R.S. § 36-550
68. "ICU"	R9-22-107	132. "Service location"	R9-22-101
69. "IGA"	R9-31-116	133. "Service site"	R9-22-101
70. "IHS"	R9-31-116	134. "Specialist"	R9-22-102
71. "IHS or Tribal Facility Provider"	R9-31-116	135. "Speech therapy"	R9-22-102
72. "Inmate of a public institution"	42 CFR 435.1009	136. "Spouse"	R9-31-103
73. "Inpatient hospital services"	R9-31-101	137. "SSI-MAO"	R9-31-103
74. "License or licensure"	R9-22-101	138. "Sterilization"	R9-22-102
75. "Medical record"	R9-22-101	139. "Subcontract"	R9-22-101
76. "Medical review"	R9-31-107	140. "Substance abuse"	R9-31-112
77. "Medical services"	R9-22-101	141. "TRBHA"	R9-31-116
78. "Medical supplies"	R9-22-102	142. "Tier"	R9-22-107
79. "Medically necessary"	R9-22-101	143. "Tiered per diem"	R9-31-107
80. "Member"	A.R.S. § 36-2981	144. "Title XIX"	42 U.S.C. 1396
81. "MI/MN"	A.R.S. § 36-2901(4)(a) and (c)	145. "Title XXI"	42 U.S.C. 1397jj
82. "New hospital"	R9-22-107	146. "Treatment"	R9-31-112
83. "NE"	42 U.S.C. 1396r(a)	147. "Tribal facility"	A.R.S. § 36-2981
84. "NICU"	R9-22-107	148. "Utilization management"	R9-22-105
85. "Noncontracting provider"	A.R.S. § 36-2981		
86. "Occupational therapy"	R9-22-102		
87. "Offeror"	R9-31-106		

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

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

1. "Administration" means the Arizona Health Care Cost Containment System, its agents, employees and designated representatives.
2. "AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.
3. "Applicant" means a person who submits, or on whose behalf is submitted, a written, signed, and dated application for Title XXI benefits which has not been completed or denied.
4. "Application" means an official request for Title XXI benefits made in accordance with Article 3.
5. "Contractor" means a health plan that contracts with the Administration for the provision of hospitalization and medical care to members according to the provisions of this Article or a qualifying plan.
6. "Contract year" means the date beginning on October 1 and continuing until September 30 of the following year.
7. "Inpatient hospital services" means medically necessary services that require an inpatient stay in an acute hospital. Inpatient hospital services are provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.

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

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning: "Certified nurse practitioner" means a registered nurse practitioner as certified by the Arizona Board of Nursing according to A.R.S. Title 32, Chapter 15.

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

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

1. "CMDP" means Children's Medical and Dental Program.
2. "CRS" means Children's Rehabilitative Services.
3. "DES" means the Department of Economic Security.
4. "Determination" means the process by which an applicant is approved or denied for coverage.
5. "Enrollment" means the process by which a person is determined eligible for and enrolled in the program.
6. "Household income" means the total gross amount of all money received by or directly deposited into a financial account of a member of the household income group as defined in R9-31-309.
7. "PSP" means Premium Sharing Project, which is a 3-year pilot program established according to A.R.S. § 36-2923.
8. "Redetermination" means the periodic review of a member's continued Title XXI eligibility.
9. "Spouse" means the husband or wife of a Title XXI applicant or household member, who has entered into a contract of marriage, recognized as valid by Arizona.
10. "SSI-MAO" means Supplemental Security Income-Medical Assistance Only.

**R9-31-104. Reserved**

**R9-31-105. General Provisions and Standards**

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning: "Pre-existing condition" means an illness or injury that

is diagnosed or treated within a 6-month period preceding the effective date of coverage.

**R9-31-106. Request for Proposal (RFP) Related Definitions**  
Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

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

**R9-31-107. Standards for Payments Related Definitions**

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

1. "Covered charges" means billed charges that represent medically necessary, reasonable, and customary items of expense for Title XXI covered services that meet medical review criteria of the Administration or contractor.
2. "Medical review" means a review involving clinical judgment of a claim or a request for a service before or after it is paid or rendered to ensure that services provided to a member are medically necessary and covered services and that required authorizations are obtained by the provider. The criteria for medical review are established by the contractor based on medical practice standards that are updated periodically to reflect changes in medical care.
3. "Outlier" means a hospital claim or encounter in which the Title XXI inpatient hospital days of care have operating costs per day that meet the criteria described in A.A.C. R9-22-712.
4. "Tiered per diem" means a payment structure in which payment is made on a per-day basis depending upon the tier into which the Title XXI inpatient hospital day of care is assigned.

**R9-31-108. Grievance and Appeal Related Definitions**

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

1. "Appellant" means an individual filing any grievance or appeal under this Article.
2. "Request for hearing" means an appeal of an adverse eligibility action; an appeal filed after an informal decision has been rendered on a grievance by the Administration; an appeal of a grievance decision rendered by a contractor; or an appeal filed because a contractor has failed to render a timely grievance decision.
3. "Respondent" means the party responsible for the action being grieved or appealed. In Title XXI eligibility appeals, the Administration is the respondent. In most member grievances, the contractor generally is the respondent.

**R9-31-109. Reserved**

**R9-31-110. 1st- and 3rd-Party Liability and Recoveries**

*Arizona Administrative Register*  
**Notices of Exempt Rulemaking**

**Related Definitions**

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning: "Cost avoidance" means avoiding payment of claims when 1st- or 3rd-party payment sources are available.

**R9-31-111. Reserved**

**R9-31-112. Covered Behavioral Health Services Related Definitions**

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

1. "ADHS" means the Arizona Department of Health Services which is the department mandated to serve the public health needs of all Arizona residents.
2. "Behavioral health professional" means a psychiatrist, psychologist, social worker, counselor, certified nurse practitioner, registered nurse, or physician's assistant who meets appropriate licensure requirements or certification requirements.
3. "Behavioral health services" means those Title XXI covered and medically necessary treatment services for behavioral health or substance abuse disorders as specified in this Chapter.
4. "Behavioral health technician" means an individual with
  - a. Bachelor's degree in a behavioral health-related field;
  - b. Bachelor's degree in any field, plus 1 year of experience in a behavioral health service delivery;
  - c. A high school diploma or GED and a combination of behavioral health education and experience totaling 4 years. Behavioral health technicians shall be supervised by a behavioral health professional or a clinical supervisor.
5. "Case management" means a supportive service to enhance treatment compliance and effectiveness. Case management services may be telephonic, may vary in frequency and intensity based on member need, and are ordered by or provided by or under the clinical supervision of the assigned behavioral health professional.
6. "Certified psychiatric nurse practitioner" means a registered nurse certified by the Arizona Board of Nursing in A.R.S. Title 32, Chapter 15 as having a specialty in psychiatric care. Only a certified psychiatric nurse practitioner with a psychiatric and mental health certification may bill for covered behavioral health services.
7. "Psychiatrist" means a psychiatrist who is professionally licensed according to A.R.S. Title 32, Chapter 13 or Chapter 17, Board certified or Board eligible under the standards of the American Board of Psychiatry and Neurology or the Osteopathic Board of Neurology and Psychiatry.
8. "Psychologist" means a person who is licensed by the Arizona Board of Psychologist Examiners according to A.R.S. Title 32, Chapter 19.1.
9. "RBHA" means the Regional Behavioral Health Authority which is an organization under contract with ADHS to coordinate the delivery of behavioral health services in a geographically specific service area of the state.
10. "Substance abuse" means the chronic, habitual or compulsive use of any chemical matter which, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use,

may cause psychological or physiological dependence and/or impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse.

11. "Treatment" means the range of behavioral health care received by a member that is consistent with the therapeutic goals outlined in the individual service plan.

**R9-31-113. Members' Rights and Responsibilities Related Definitions**

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

1. "Action" means a termination, suspension, or reduction of a covered service for the purposes of 9 A.A.C. 31, Article 13 only.
2. "Date of action" means the intended date on which a termination, suspension, or reduction becomes effective for the purposes of 9 A.A.C. 31, Article 13 only.
3. "Denial" means the decision not to authorize a requested service for the purposes of 9 A.A.C. 31, Article 13 only.

**R9-31-114. Reserved**

**R9-31-115. Reserved**

**R9-31-116. Services for Native Americans Related Definitions**

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

1. "IGA" means Intergovernmental Agreement.
2. "IHS" means Indian Health Service.
3. "IHS or Tribal Facility Provider" means a person who is authorized by the IHS or Tribal Facility and registered as an AHCCCS provider to provide covered services to members. The IHS or Tribal Facility by authorizing the person to provide covered services, shall certify that the person meets all applicable federal and state requirements.
4. "TRBHA" means the Tribal Regional Behavioral Health Authority. Tribal governments, through an IGA with ADHS may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to a Native American member residing on reservation.

**ARTICLE 2. SCOPE OF SERVICES**

**R9-31-201. General Requirements**

- A. The Administration shall administer the program specified in A.R.S. § 36-2982.
- B. The Director has full operational authority to adopt rules or to use the appropriate rules adopted as specified in A.R.S. § 36-2986.
- C. Behavioral health services shall be provided as specified in 9 A.A.C. 31, Article 12.
- D. In addition to requirements and limitations specified in this Chapter, the following general requirements apply:
  1. As specified in A.R.S. § 36-2989, covered services provided to a member shall be medically necessary and provided by, or under the direction of, a primary care provider or a dentist; specialist services shall be provided under referral from, and in consultation with, the primary care provider.
    - a. The role or responsibility of a primary care provider, as defined in these rules, shall not be diminished by the primary care provider delegating the

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

- provision of primary care for a member to a practitioner, and
- b. The contractor may waive the referral requirements;
  - 2. Services shall be rendered in accordance with state and federal laws and regulations, the Arizona Administrative Code and AHCCCS contractual requirements;
  - 3. Experimental services as determined by the director, or services provided primarily for the purpose of research, shall not be covered;
  - 4. Services or items, if furnished gratuitously, are not covered and payment shall be denied;
  - 5. Personal care items are not covered and payment shall be denied;
  - 6. Services shall not be covered if provided to:
    - a. An inmate of a public institution;
    - b. A person who is a resident of an institution for the treatment of tuberculosis, or
    - c. A person who is in an institution for the treatment of mental diseases at the time of application.
- E. Services shall be provided by AHCCCS registered personnel or facilities, that meet state and federal requirements, and are appropriately licensed or certified to provide the services.
- F. Payment for services or items requiring prior authorization may be denied if prior authorization by the contractor is not obtained. Emergency services do not require prior authorization.
- 1. Services for unrelated conditions, requiring additional diagnostic and treatment procedures, require additional prior authorization.
  - 2. In addition to the requirements of 9 A.A.C. 31, Article 7, written documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.
- G. As specified in A.R.S. § 36-2989, covered services rendered to a member shall be provided within the service area of the member's primary contractor except when:
- 1. A primary care provider refers a member out of the contractor's area for medical specialty care;
  - 2. A covered service that is medically necessary for a member is not available within the contractor's service area;
  - 3. A net savings in service delivery costs can be documented without requiring undue travel time or hardship for a member or the member's family;
  - 4. A member is placed in a nursing facility located out of the contractor's service area, and
  - 5. The service is otherwise authorized by the contractor based on medical practice patterns, and cost or scope of service considerations.
- H. When a member is traveling or temporarily residing out of the service area of the member's contractor, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.
- I. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in these rules and in contract.
- J. If a member requests the provision of a service that is not covered by a contractor or not authorized by a contractor, the service may be rendered to a member by an AHCCCS-registered service provider under the following conditions:
- 1. A document that lists the requested services and the itemized cost of each is prepared by the contractor and provided to the member; and
- 2. The signature of the member is obtained in advance of service provision indicating that the services have been explained to the member and that the member accepts responsibility for payment.
- K. If a member is referred out of a contractor's service area to receive an authorized medically necessary service for an extended period of time, a contractor shall also provide all other medically necessary covered services for a member during that time.
- L. The restrictions, limitations, and exclusions in this Article shall not apply to contractors when electing to provide non-covered services.
- 1. The costs associated with providing any noncovered service to a member shall not be included in development or negotiation of capitation.
  - 2. Noncovered services shall be paid from administrative revenue or other contractor funds, unrelated to Title XXI services.
- R9-31-202. Reserved**
- R9-31-203. Reserved**
- R9-31-204. Inpatient General Hospital Services**  
Inpatient services provided in a general hospital shall be covered by contractors or noncontracting providers and shall include:
- 1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
    - a. Maternity care;
    - b. Neonatal intensive care (NICU);
    - c. Intensive care (ICU);
    - d. Surgery;
    - e. Nursery;
    - f. Routine care, and
    - g. Behavioral health (psychiatric) care as specified in A.R.S. § 36-2989 and 9 A.A.C. 31, Article 12.
  - 2. Ancillary services as specified by the Director and included in contract:
    - a. Labor, delivery and recovery rooms, and birthing centers;
    - b. Surgery and recovery rooms;
    - c. Laboratory services;
    - d. Radiological and medical imaging services;
    - e. Anesthesiology services;
    - f. Rehabilitation services;
    - g. Pharmaceutical services and prescribed drugs;
    - h. Respiratory therapy;
    - i. Blood and blood derivatives;
    - j. Central supply items, appliances, and equipment not ordinarily furnished to all patients and which are customarily reimbursed as ancillary services;
    - k. Maternity services; and
    - l. Nursery and related services.
- R9-31-205. Physician and Primary Care Physician and Practitioner Services**
- A. Primary care provider services shall be furnished by a physician or practitioner and shall be covered for members when rendered within the provider's scope of practice under A.R.S. § 36-2981. Primary care provider services may be provided in an inpatient or outpatient setting and shall include at a minimum:
- 1. Periodic health examinations and assessments;
  - 2. Evaluations and diagnostic workups;
  - 3. Medically necessary treatment;
  - 4. Prescriptions for medications and medically necessary supplies and equipment.

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

5. Referrals to specialists or other health care professionals when medically necessary as specified in A.R.S. § 36-2989.
6. Patient education.
7. Home visits when determined medically necessary.
8. Covered immunizations, and
9. Covered preventive health services.
- B. As specified in A.R.S. § 36-2989, a 2nd opinion procedure may be required to determine coverage for surgeries. Under this procedure, documentation must be provided by at least 2 physicians as to the need for the proposed surgery.
- C. The following limitations and exclusions apply to physician and practitioner services and primary care provider services:
  1. Specialty care and other services provided to a member upon referral from a primary care provider shall be limited to the services or conditions for which the referral is made, or for which authorization is given, unless referral is waived by the contractor.
  2. If a physical examination is performed with the primary intent to accomplish 1 or more of the objectives listed in subsection (A), it shall be covered by the member's contractor except if there is an additional or alternative objective to satisfy the demands of an outside public or private agency. Alternative objectives may include physical examinations and resulting documentation for:
    - a. Qualification for insurance.
    - b. Pre-employment physical evaluation.
    - c. Qualification for sports or physical exercise activities.
    - d. Pilot's examination (FAA).
    - e. Disability certification for establishing any kind of periodic payments.
    - f. Evaluation for establishing 3rd party liabilities, or
    - g. Physical ability to perform functions that have no relationship to primary objectives listed in subsection (A) of this Section.
  4. The following services shall be excluded from Title XXI coverage:
    - a. Infertility services, reversal of surgically induced infertility (sterilization), and sex change operations;
    - b. Abortion counseling services;
    - c. Abortions, unless authorized under federal law;
    - d. Services or items furnished solely for cosmetic purposes; and
    - e. Hysterectomies, unless determined to be medically necessary.

**R9-31-206. Organ and Tissue Transplantation Services**

The following organ and tissue transplantation services shall be covered for a member as specified in A.R.S. § 36-2989 if prior authorized and coordinated with a member's contractor:

1. Kidney transplantation;
2. Simultaneous Kidney/Pancreas transplant;
3. Cornea transplantation;
4. Heart transplantation;
5. Liver transplantation;
6. Autologous and allogeneic bone marrow transplantation;
7. Lung transplantation;
8. Heart-lung transplantation;
9. Other organ transplantation if the transplantation is required by federal law and if other statutory criteria are met; and
10. Immunosuppressant medications, chemotherapy, and other related services.

**R9-31-207. Dental Services**

Medically necessary dental services shall be provided for children under age 19 as specified in A.R.S. § 36-2989.

**R9-31-208. Laboratory, Radiology, and Medical Imaging Services**

As specified in A.R.S. § 36-2989, laboratory, radiology, and medical imaging services shall be covered services if:

1. Prescribed for members by a primary care provider or a dentist, or if prescribed by a physician or practitioner upon referral from the primary care provider or dentist, unless referral is waived by the contractor;
2. Provided in hospitals, clinics, physician offices, or other health care facilities by licensed health care providers; and
3. Provided by a provider that meets all applicable state and federal license and certification requirements and provides only services that are within the scope of practice stated in the provider's license or certification.

**R9-31-209. Pharmaceutical Services**

A. Pharmaceutical services may be provided by an inpatient or outpatient provider including hospitals, clinics, or appropriately licensed health care facilities and pharmacies.

B. The contractor shall make pharmaceutical services available during customary business hours and shall be located within reasonable travel distance of a member's residence.

C. As specified in A.R.S. § 36-2989, pharmaceutical services shall be covered if prescribed for a member by the member's primary care provider or dentist, or if prescribed by a specialist upon referral from the primary care provider, unless referral is waived by the contractor or its designee.

D. The following limitations shall apply to pharmaceutical services:

1. A medication personally dispensed by a physician or dentist is not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
2. A prescription in excess of a 30 day supply or a 100-unit dose is not covered unless:
  - a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is more.
  - b. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.
  - c. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 days or 100-unit dose, whichever is more.
3. A nonprescription medication is not covered unless an appropriate alternative over the counter medication is available and less costly than a prescription medication.
4. excess of the number specified, or if an initial prescription or refill as dispensed after 1 year from the original prescribed order.
5. Approval by the authorized prescriber is required for all changes in, or additions to, an original prescription. The date of a prescription change is to be clearly indicated and initialed by the dispensing pharmacist.

E. A contractor shall monitor and take necessary actions to ensure that a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

maintain physical well-being, is provided sufficient services to eliminate any gap in the required pharmaceutical regimen.

**R9-31-210. Emergency Medical Services**

- A.** Emergency medical services shall be provided based on the prudent layperson standard to a member by licensed providers registered with AHCCCS to provide services as specified in A.R.S. § 36-2989.
- B.** The provider of emergency services shall verify eligibility and enrollment status through the Administration to determine the need for notification to a contractor or a RBHA for a member and to determine the party responsible for payment of services rendered.
- C.** Access to an emergency room and emergency medical services shall be available 24 hours per day, 7 days per week in each contractor's service area. The use of examining or treatment rooms shall be available when required by a physician or practitioner for the provision of emergency services.
- D.** Consultation provided by a psychiatrist or psychologist shall be covered as an emergency service, so long as it meets the requirements of 9.A.A.C. 31, Article 12.
- E.** Emergency services do not require prior authorization but providers shall comply with the following notification requirements:
- 1.** Providers, nonproviders, and noncontracting providers furnishing emergency services to a member shall notify the member's contractor within 12 hours of the time the member presents for services;
  - 2.** If a member's medical condition is determined not to be an emergency medical condition, as defined in Article 1 of this Chapter, the provider shall notify the member's contractor before initiation of treatment and follow the prior authorization requirements and protocol of the contractor regarding treatment of the member's non-emergent condition. Failure to provide timely notice or comply with prior authorization requirements of the contractor constitutes cause for denial of payment.
- F.** A provider, a nonprovider, and a noncontracting provider shall request authorization from a contractor for post stabilization services. A contractor shall pay for the post stabilization services if:
- 1.** The service is pre-approved by a contractor, or
  - 2.** A contractor does not respond to an authorization request within the time-frame specified in 42 CFR 438.114, as of September 29, 1998, which is 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.

**R9-31-211. Transportation Services**

- A.** Emergency ambulance services.
- 1.** As specified in A.R.S. § 36-2989, emergency ambulance transportation services shall be a covered service for a member. Payment shall be limited to the cost of transporting the member in a ground or air ambulance:
    - a.** To the nearest appropriate provider or medical facility capable of meeting the member's medical needs; and
    - b.** When no other means of transportation is both appropriate and available.
  - 2.** A ground or air ambulance transport that originates in response to a 911 call or other emergency response system shall be reimbursed by the member's contractor if the medical condition at the time of transport justified a medically necessary ambulance transport. No prior

authorization is required for reimbursement of these transports.

- 3.** Determination of whether transport is medically necessary shall be based upon the medical condition of the member at the time of transport.
  - 4.** A ground or air ambulance provider furnishing transport in response to a 911 call or other emergency response system shall notify the member's contractor within 10 working days from the date of transport. Failure to notify the contractor may constitute cause for denial of claims.
- B.** Air ambulance services shall be covered only if:
- 1.** The air ambulance transport is initiated upon the request of an emergency response unit, a law enforcement official, a hospital or clinic medical staff member, a physician, or a practitioner;
  - 2.** The point of pickup is inaccessible by ground ambulance, or great distances, or other obstacles are involved in getting emergency services to the member or transporting the member to the nearest hospital or other provider with appropriate facilities; and
  - 3.** The medical condition of the member requires timely ambulance service and ground ambulance service will not suffice.
- C.** Medically necessary patient transfers provided by an emergency air or ground transportation provider may be covered when a member receiving inpatient services requires transport to another level of care or requires round trip transport to another facility to obtain necessary specialized diagnostic treatment services if:
- 1.** A member's condition is such that the use of any other method of transportation would be harmful to a member's health, and
  - 2.** Services are not available in the facility where a member is a patient.
- D.** Meals, lodging and escort services.
- 1.** Expenses for meals and lodging for a member while en route to, or returning from, an approved and prior authorized health care service site out of a member's service area or county of residence shall be a Title XXI covered service.
  - 2.** Expenses of an escort, who may be a family household member accompanying a member out of a member's service area shall be covered if the services of the escort are ordered in writing by a member's primary care provider, attending physician or practitioner.
- E.** Limitations.
- 1.** Expenses shall be allowed only when a member requires a covered service that is not available in the service area;
  - 2.** If a member is admitted to an inpatient facility, expenses for the escort shall be covered only when accompanying a member en route to, and returning from, the inpatient facility; and
  - 3.** A salary for an escort shall be covered if an escort is not a part of a member's family household.
- F.** Non-emergency transportation services are not covered as specified in A.R.S. § 36-2989.

**R9-31-212. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices**

- A.** As specified in A.R.S. § 36-2989, medical supplies, durable equipment, and orthotic and prosthetic devices shall be covered services if:
- 1.** Prescribed for a member by the member's primary care provider or if prescribed by a physician or practitioner

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

- upon referral from the primary care provider unless referral is waived by the contractor, or
2. Provided in compliance with requirements of this Chapter.
- B.** Medical supplies include consumable items covered under Medicare that are provided to a member and that are not reusable.
- C.** Medical equipment includes any durable item, appliance, or piece of equipment that is designed for a medical purpose, is generally reusable by others, and is purchased or rented for a member.
- D.** Prosthetic and orthotic devices include only those items that are essential for the habilitation or rehabilitation of a member.
- E.** The following limitations apply:
1. If medical equipment can not be obtained from alternative resources at no cost, the medical equipment shall be furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the equipment shall not exceed the cost of the equipment if purchased.
  2. Reasonable repair or adjustment of purchased medical equipment shall be covered if necessary to make the equipment serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.
  3. Changes in, or additions to, an original order for medical equipment shall be approved by the member's primary care provider or authorized prescriber, or prior authorized by the contractor for members, and shall be indicated clearly and initialed by the vendor. No change or addition to the original order for medical equipment shall be made after a claim for services has been submitted to a member's contractor, without prior written notification of the change or addition.
  4. Rental fees shall terminate:
    - a. No later than the end of the month in which the primary care provider or authorized prescriber certifies that the member no longer needs the medical equipment;
    - b. When the member is no longer eligible for Title XXI services; or
    - c. When the member is no longer enrolled with a contractor, with the exception of transitions of care as specified by the Director.
  5. Personal incidentals including items for personal cleanliness, body hygiene, and grooming shall not be covered unless needed to treat a medical condition and provided in accordance with a prescription.
  6. First aid supplies shall not be covered unless they are provided in accordance with a prescription.
- F.** Liability and ownership.
1. Purchased durable medical equipment provided to a member but which is no longer needed may be disposed of in accordance with each contractor's policy.
  2. If customized durable medical equipment is purchased by the contractor for a member, the equipment will remain with the member during times of transition, or upon loss of eligibility.
    - a. For purposes of this Section, customized durable medical equipment refers to equipment that has been altered or built to specifications unique to a member's medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.

- b. Customized equipment obtained fraudulently by a member shall be returned for disposal to the member's contractor.

**R9-31-213. Health Risk Assessment and Screening Services**

- A.** As specified in A.R.S. § 36-2989, the following services shall be covered for a member less than 19 years of age:
1. Screening services, including:
    - a. Comprehensive health, behavioral health and developmental histories;
    - b. Comprehensive unclothed physical examination;
    - c. Appropriate immunizations according to age and health history; and
    - d. Health education, including anticipatory guidance.
  2. Vision services as specified in A.R.S. § 36-2989 including:
    - a. Treatment for medical conditions of the eye,
    - b. 1 eye examination per contract year, and
    - c. Provision of 1 pair of prescriptive lenses per contract year.
  3. Hearing services, including:
    - a. Diagnosis and treatment for defects in hearing;
    - b. Testing to determine hearing impairment; and
    - c. Provision of hearing aids.
- B.** All providers of services shall meet the following standards:
1. Provide services by or under the direction of, the member's primary care provider or dentist.
  2. Perform tests and examinations in accordance with the AHCCCS Administration Periodicity Schedule.
    - a. Refer members as necessary for dental diagnosis and treatment, and necessary specialty care.
    - b. Refer members as necessary for behavioral health evaluation and treatment services as specified in 9 A.A.C. 31, Article 12.
- C.** Contractors shall meet the following additional conditions for members:
1. Provide information to members and their parents or guardians concerning services;
  2. Notify members and their parents or guardians regarding the initiation of screening and subsequent appointments according to the AHCCCS Administration Periodicity Schedule; and
- D.** Members with special health care needs may be referred to the Children's Rehabilitative Service program.

**R9-31-214. Reserved**

**R9-31-215. Other Medical Professional Services**

- A.** The following medical professional services provided to a member by a contractor shall be covered services when provided in an inpatient, outpatient, or office setting within limitations specified below:
1. Dialysis;
  2. Family planning services as specified in A.R.S. § 36-2989 including medications, supplies, devices, and surgical procedures provided to delay or prevent pregnancy. Family planning services are limited to:
    - a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
    - b. Natural family planning education or referral;
  3. Certified nurse midwife services provided by a certified nurse practitioner in midwifery;
  4. Podiatry services when ordered by a member's primary care provider as specified in A.R.S. § 36-2989;

5. Respiratory therapy;
6. Ambulatory and outpatient surgery facilities services;
7. Home health services in A.R.S. § 36-2989;
8. Private or special duty nursing services when medically necessary and prior authorized;
9. Rehabilitation services including physical therapy, occupational therapy, audiology and speech therapy within limitations in this Article;
10. Total parenteral nutrition services;
11. Chemotherapy; and
12. Hospice.

**B. The following shall be excluded as Title XXI covered services:**

1. Abortion counseling.
2. Services or items furnished solely for cosmetic purposes.
3. Chiropractic services, and
4. Licensed midwife service for prenatal care and home births.

**R9-31-216. Nursing Facility Services**

**A. Nursing facility services including room and board shall be covered for a maximum of 90 days per contract year if the medical condition of a member is such that, if nursing facility services are not provided, hospitalization of the individual would result.**

**B. Except as otherwise provided in 9 A.A.C. 28, the following services shall be excluded for purpose of separate billing if provided in a nursing facility:**

1. Nursing services including but not limited to:
  - a. Administration of medication,
  - b. Tube feedings,
  - c. Personal care services (assistance with bathing and grooming),
  - d. Routine testing of vital signs, and
  - e. Maintenance of catheters.
2. Basic patient care equipment and sickroom supplies, including, but not limited to:
  - a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over the counter remedies;
  - b. Bathing and grooming supplies;
  - c. Identification devices;
  - d. Skin lotions;
  - e. Medication cups;
  - f. Alcohol wipes, cotton balls, and cotton rolls;
  - g. Rubber gloves (non sterile);
  - h. Laxatives;
  - i. Beds and accessories;
  - j. Thermometers;
  - k. Ice bags;
  - l. Rubber sheeting;
  - m. Passive restraints;
  - n. Glycerin swabs;
  - o. Facial tissue;
  - p. Enemas;
  - q. Heating pads; and
  - r. Diapers.
3. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating;
4. Any services that are included in a nursing facility's room and board charge or services that are required of the nursing facility to meet federal mandates, state licensure standards, or county certification requirements;

5. Administrative physician visits made solely for the purpose of meeting state licensure standards or county certification requirements;
6. Physical therapy; and
7. Assistive devices and durable medical equipment.

**ARTICLE 3. ELIGIBILITY AND ENROLLMENT**

**R9-31-301. General Requirements**

**A. Administration.** The Administration shall administer the program as specified in A.R.S. § 36-2982.

**B. Operational authority.** The Director has full operational authority to adopt rules or to use the appropriate rules for the development and management of an eligibility and enrollment system as specified in A.R.S. § 36-2986.

**C. Expenditure limit and enrollment.**

1. Title XXI will accept enrollees subject to the availability of funds. If the Director determines that monies may be insufficient for the program, the Administration shall stop processing applications for the program as specified in A.R.S. § 36-2985.
2. After the Administration has verified that funding is sufficient, it will resume processing applications as specified in A.R.S. § 36-2985.
3. The Administration shall immediately stop processing all applications and shall provide 30 days advance notice to a member that the program will terminate on the 1st day of the following month after notice is served, if the federal government:
  - a. Eliminates federal funding for the program, or
  - b. Significantly reduces the federal funding below the estimated federal expenditures according to A.R.S. § 36-2985.

**R9-31-302. Applications**

**A. Availability.** The Administration shall make available Title XXI applications. Any person may request a Title XXI application.

**B. Submission of Applications.** An application shall be completed and submitted to the Administration:

1. In person,
2. By mail,
3. By fax, or
4. By other form approved by the Administration.

**C. Date of application.** The date of application is the date the Administration receives an application which:

1. Is signed by a person making an application,
2. Includes the name of the person for whom assistance is requested, and
3. Includes the address and telephone number of the person submitting the application.

**D. Completed application.**

1. The Administration shall consider an application complete when:
  - a. All questions are answered,
  - b. An enrollment choice is included, and
  - c. All necessary verification is provided by an applicant or an applicant's representative.
2. When the application is incomplete, the Administration shall:
  - a. Contact an applicant or an applicant's representative by telephone to obtain the missing information required for an eligibility determination; or
  - b. Mail a pending notice to an applicant or an applicant's representative, allowing 10 days from the date of the notice to provide the required information listed on the pending notice.

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

- E. Eligibility determination processing time.**
1. Except when there is an emergency beyond the Administration's control, the Administration shall not delay the eligibility determination beyond 30 days from the date of application when information and verification necessary to make the determination has been provided and obtained.
  2. An applicant shall provide the Administration with all requested verification within 10 days from the notice date of the written request for the information. If an applicant fails to provide the requested information and fails to request an extension of the 10 day period, the Administration may deny eligibility.
- F. Waiting list.** If the Administration stops processing an application because the monies are insufficient as specified in R9-31-301(C)(1), the Administration shall place an applicant on a waiting list and notify the applicant. When increased funding becomes available, the Administration shall contact an applicant on the waiting list and ask the applicant to submit a new application if the original application is more than 60 days old. Spaces will be filled as a completed application is received and approved.

**R9-31-303. Eligibility Criteria**

Eligibility. To be eligible for the program, a person shall meet all the following eligibility requirements:

- A. Age.** Is under 19 years of age. A child's coverage will continue through the month in which a child turns age 19 if the child is otherwise eligible;
- B. Citizenship.** Is a United States citizen or a qualified alien as specified in A.R.S. § 36-2983;
- C. Residency.** Is a resident of the state of Arizona as specified in A.R.S. § 36-2983. An Arizona resident is a person who currently lives in Arizona and intends to remain in Arizona indefinitely;
- D. Income.** Meets the income requirements in R9-31-304;
- E. Cost sharing.** Pays the cost sharing premium amount when premiums are required as specified in A.R.S. § 36-2982;
- F. Social security number.** Provides a social security number or applies for one within 30 days after an applicant submits a Title XXI application as specified in A.R.S. § 36-2983. The Administration shall not deny eligibility for Title XXI if an applicant does not provide or apply for a social security number unless the sole reason the child is ineligible for Title XIX is for failure to comply with social security number requirements specified in 42 CFR 435.910 and 42 CFR 435.920 as of May 29, 1986, which is 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;
- G. Assignment.** Assigns rights to any 1st- or 3rd-party coverage of medical care as specified in 9 A.A.C. 31, Article 10;
- H. Other federal program.** Is not eligible for Title XIX or other federally operated or financed health care insurance program, except the Indian Health Service or a Tribal Facility as specified in A.R.S. § 36-2983;
- I. Inmate of a public institution.** Is not an inmate of a public institution, as specified in A.R.S. § 36-2983;
- J. Patient in an institution for mental disease.** Is not a patient in an institution for mental disease at the time of application, or at the time of redetermination, as specified in A.R.S. § 36-2983;
- K. Other health coverage.** Is not covered under:
  1. An employer's group health insurance plan,
  2. Family or individual health insurance, or
  3. Other health insurance;

- L. State health benefits.** Is not a member of a family that is eligible for health benefits coverage under a state health benefit plan based on an applicant, a member, or a parent's employment with a public agency in the state of Arizona;
- M. Prior health insurance coverage.** Has not been covered by health insurance during the previous 6 months unless that health insurance was discontinued due to the involuntary loss of employment as specified in A.R.S. § 36-2983. The 6 months of ineligibility due to previous insurance coverage shall not apply to:
  1. A newborn as defined in R9-31-309,
  2. A Title XIX member as specified in 9 A.A.C. 22, Article 1,
  3. An MI/MN member as specified in 9 A.A.C. 22, Article 1,
  4. An EAC member as specified in 9 A.A.C. 22, Article 1,
  5. An ELIC member as specified in 9 A.A.C. 22, Article 1,
  6. A state funded SSI-MAO non-qualified alien as specified in A.R.S. § 36-2903.03,
  7. A Title XXI member,
  8. A CRS member, or
  9. A Native American member receiving services from IHS or a Tribal Facility.

**R9-31-304. Income Eligibility**

- A. Income standard.** The combined gross income of the household income group members as specified in subsection (C) of this Section shall not exceed the percentage of the appropriate FPL for the Title XXI household income group size as specified in A.R.S. § 36-2981 for the state fiscal year.
- B. Countable income.** The Administration shall count all income received during a month by the household income group members as specified in subsection (C) of this Section except income which is specified in subsections (D) and (E) of this Section.
- C. Title XXI household income group.**
  1. For this Section:
    - a. "Child" means a person under 19 years of age or an unborn child.
    - b. "Parent" means a biological, adoptive or step parent.
  2. The following related persons, when residing together, constitute a Title XXI household income group:
    - a. A married couple and children of either 1 or both;
    - b. An unmarried couple with a common child and other children of either 1 or both;
    - c. A married couple when 1 or both are under age 19 with no children;
    - d. A single parent and the single parent's children;
    - e. A child who does not live with a parent; and
    - f. The following persons, when living with a child:
      - i. A spouse of the child;
      - ii. A child of the spouse child;
      - iii. A child of the child; and
      - iv. The other parent of a child of the child.
  3. A person who is absent from a household shall be included in the child's household income group if absent:
    - a. For 30 days or less,
    - b. For the purpose of seeking employment or to maintain a job,
    - c. For serving in the military,
    - d. For an educational purpose and the child's parent claims the child as a dependent on the parent's income tax return.

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

**D. Income disregards. When determining gross income of the household, the Administration shall disregard the following:**

1. Income specified in 20 CFR Part 416 Appendix K as of April 1, 1997, which is incorporated by reference herein and on file with the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments;
2. Income paid according to federal law that prohibits the use of the income when determining eligibility for public benefits;
3. Money received by a member as the result of the conversion of an asset;
4. Income tax refunds; and
5. For a self-employed household member, the Administration shall count only the net income of that self-employment, after deducting the expenses of producing that income, but not income taxes or capital investments.

**E. Regular infrequent income. Income that is received regularly but less often than monthly shall be pro-rated over the number of months between payments with only the pro-rated monthly amount.**

**R9-31-305. Verification**

Verification. An applicant or a member shall provide the Administration with verification or authorize the release of verification to the Administration of all information necessary to complete the determination of eligibility.

**R9-31-306. Enrollment**

**A. Selection choices.**

1. Except as provided in subsections (A)(3), (4), and (5) of this Section, at the time of application, an applicant shall select from the following enrollment choices:
  - a. A contractor which includes a health plan or a qualifying plan as defined in A.R.S. § 36-2981.
  - b. A qualifying health center as specified in A.R.S. § 36-2907.06, or
  - c. The IHS as specified in A.R.S. § 36-2982. If a member is enrolled with the IHS, a member may elect to receive covered services from a participating 638 tribal facility.
2. Except as provided in subsections (A)(3), (4), and (5) of this Section, coverage shall not begin until a Title XXI enrollment choice is made.
3. The Administration shall enroll a member with CMDP when a member is a foster care child according to A.R.S. § 8-512.
4. When a Title XIX member becomes ineligible for Title XIX and DES determines a child eligible for Title XXI with no break in coverage,
  - a. The Title XXI child shall remain enrolled with the Title XIX contractor; and
  - b. The Administration shall send the Title XXI member a notice explaining the member's right to choose as specified in subsection (A)(1) of this Section.
5. When a person applies for Title XIX through DES and DES determines a child ineligible for Title XIX but eligible for Title XXI, the Administration shall enroll the child for Title XXI as follows:
  - a. If a Title XIX health plan pre-enrollment choice is pending at the time the Administration receives the Title XXI approval from DES, the Administration may:

- i. Enroll a child with the Title XIX health plan, and
- ii. Notify the member of the member's enrollment and provide the member an opportunity to select an enrollment choice as specified in subsection (A)(1) of this Section.

- b. If there is no pending Title XIX choice at the time the Administration receives the Title XXI approval from DES, the Administration shall pend the Title XXI decision and obtain a choice from the member as specified in subsection (A)(1) of this Section.

**B. Effective date of initial enrollment.**

1. For eligibility determinations completed by the 25th day of the month, enrollment shall begin on the 1st day of the month following the determination of eligibility.
2. For eligibility determination completed after the 25th day of the month, enrollment shall begin on the 1st day of the 2nd month following the determination of eligibility.

**C. Enrollment changes.**

1. If a member moves from 1 GSA to another GSA during the period of enrollment, enrollment changes will occur as follows:

- a. If a member's current enrollment choice is available in a member's new GSA, a member will remain enrolled with the member's current enrollment choice.

- b. If a member's current enrollment choice is not available in the new GSA, a member shall:

- i. Remain enrolled with the current enrollment choice. The current enrollment choice may limit services to emergency services outside the GSA as specified in R9-31-201.

- ii. Select from the enrollment choices provided in R9-31-306(A)(1) that are available in the new GSA. Once a new choice is made, a member shall be enrolled with the new choice effective with the date the Administration processes a member's enrollment choice. Covered services shall be available on the date of the enrollment change.

2. A member may change a member's enrollment choice:
  - a. During a member's annual enrollment choice period.

- b. At any time from:

- i. IHS to a contractor as specified in subsection (A)(1) of this Section;

- ii. A contractor to IHS,

- iii. IHS to a qualifying health center as specified in subsection (A)(1) of this Section,

- iv. A qualifying health center to IHS,

- v. A qualifying health center to a contractor.

- c. When a member is no longer a foster care child as specified in subsection (A)(3) of this Section.

3. Except for subsection (C)(2)(c) of this Section, the effective date of the new enrollment choice is the date the Administration processes the enrollment choice. The effective date of the enrollment change from CMDP to a Title XXI choice as specified in subsection (A)(1) of this Section, shall be the first of the following month.

**E. Annual enrollment choice period. A member shall have the opportunity to change enrollment within at least 12 months from the date of initial enrollment and then 12 months following the last time a member made an enrollment choice or had the opportunity to make an enrollment choice.**

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

**F.** Health Insurance Portability and Accountability Act of 1996. As specified in A.R.S. § 36-2982, a Title XXI member who has been disenrolled shall be allowed to use enrollment in the Title XXI program as creditable coverage as defined in A.R.S. § 36-2984.

**R9-31-307. Guaranteed Enrollment**

**A.** Guaranteed Enrollment. A child who has been determined eligible for Title XXI will be guaranteed a 1 time 12 month period of continuous coverage unless a child:

1. Attains age 19.
2. Is no longer a resident of the state.
3. Is an inmate of a public institution.
4. Is enrolled with Title XIX.
5. Is determined to have been ineligible at the time of approval.
6. Obtains private or group health coverage.
7. Is adopted and the new household does not meet the qualifications of this program.
8. Does not pay cost sharing premium amount when premiums are required as specified in A.R.S. § 36-2982.
9. Is a patient in an institution for mental diseases.
10. Voluntarily withdraws from the program, or
11. Whereabouts is unknown.

**B.** The 12 month guaranteed period will begin with the month an applicant is initially enrolled.

**R9-31-308. Changes and Redeterminations**

**A.** Reporting Changes. A member or a member's parent or guardian shall report the following changes to the Administration:

1. Any change in income that will begin or continue into the following month.
2. Any change of address.
3. The addition or departure of a household member.
4. Any health coverage under private or group health insurance.
5. Employment of a member or a parent with a state agency, and
6. Incarceration of a member.

**B.** Verification. If required verification is needed and requested as a result of a change specified in subsection (A) of this Section to determine the impact on eligibility and is not received within 10 days, the Administration may discontinue eligibility for a member unless a member is within the guaranteed eligibility period as specified in R9-31-307.

**C.** Redeterminations. If no change is reported, the Administration shall initiate redetermination no later than the end of the 12th month after the effective date of eligibility, or the completion of the most recent redetermination application, whichever is later.

**D.** Termination. If the Administration determines that a child no longer meets the eligibility criteria, or a child, a parent, or a guardian fails to respond or cooperate with the redetermination of eligibility, coverage will be terminated.

**R9-31-309. Newborn Eligibility**

**A.** Eligibility. A child born to a Title XXI member, is eligible for 12 months of coverage without filing an application under Title XXI provided:

1. The child continues to live with its mother during the 12 month period; and
2. One of the events as specified in R9-31-307(A) does not occur.

**B.** Deemed Coverage. A newborn's deemed newborn coverage shall begin effective with a newborn's date of birth and end

with the last day of the month in which a newborn turns age 1. Deemed newborn status does not preclude a child from applying for Title XIX and being approved.

**C.** Enrollment choice for a newborn. A newborn shall be enrolled with a mother's enrollment choice as specified in contract.

**D.** Notification of enrollment. The Administration shall notify a mother of a newborn's enrollment and provide a mother an opportunity to select an enrollment choice as specified in R9-31-306(A)(1).

**R9-31-310. Notice Requirements**

**A.** Applications. Upon completion of a determination of eligibility or ineligibility for any child in the household, the Administration shall issue a written notice to an individual who initiated the application. This notice shall include a statement of the intended action, an explanation of a person's hearing rights as specified in 9 A.A.C. 31, Article 8 and:

1. If approved, the notice shall contain the name and effective date of eligibility for each approved applicant;
2. If denied, the notice shall contain:
  - a. The name of each ineligible applicant.
  - b. The effective date of the denial.
  - c. The reasons for ineligibility including appropriate income calculations and income standard when the reason for the denial is based on excess income.
  - d. The legal authority supporting the reason for ineligibility, and
  - e. Where the references are physically located for review.

**B.** Terminations.

1. When the Administration proposes a termination of Title XXI eligibility, the Administration shall provide a member with:
  - a. Advance notice at least 10 days before the effective date of the adverse action except as provided in subsection (B)(1)(b) of this Section; or
  - b. Adequate notice no later than the date of adverse action when a member:
    - i. Voluntarily withdraws and indicates an understanding of the results of the action.
    - ii. Becomes an inmate of a public institution as specified in R9-31-303(I).
    - iii. Dies and the Administration has verification of the death.
    - iv. Has whereabouts that are unknown and the Administration's loss of contact is confirmed by returned mail from the post office with no forwarding address, or
    - v. Is approved for Title XIX.
2. In addition to the requirements listed in subsection (A)(2) of this Section, the termination notice shall include an explanation of a member's right to continued Title XXI coverage pending appeal as provided in 9 A.A.C. 31, Article 8.

**ARTICLE 4. CONTRACTS**

**R9-31-401. General Provisions**

**A.** Administration and contract authority. The Administration shall administer the program as specified in A.R.S. § 36 - 2982.

**B.** Rule authority. The Director has full operational authority to use the appropriate rules adopted for contract administration and oversight of contractors as specified in A.R.S. § 36-2986.

**C.** For purposes of this Chapter, as specified in A.R.S. § 36-2981, contractor includes the following:

*Arizona Administrative Register*  
**Notices of Exempt Rulemaking**

1. A health plan as specified in A.R.S. § 36-2981; or
  2. A qualifying plan as specified in A.R.S. § 36-2981 and that provides services to members as specified in A.R.S. § 36-2989.
  - D. Exemption from procurement process. The Administration is exempt from the procurement code as specified in A.R.S. §§ 36-2988 and 41-2501.
  - E. Contractor's financial responsibility. The Administration shall specify in contract when a person who has been determined eligible will be enrolled with a contractor and the date on which the contractor will be financially responsible for health and medical services to the person as specified in A.R.S. § 36-2987.
  - F. Contract. A contract may be canceled or rejected in whole or in part as specified in contract if it is deemed by the Director to be in the best interest of the state. The reasons for cancellation or rejection shall be made part of the contract file.
  - G. Damages or claims. Offerors shall have no right to damages or basis for any claims against the state, its employees, or agents, arising out of any action by the Administration according to the provisions of subsection (F) of this Section.
  - H. Ownership interest. A contractor shall not knowingly have a director, officer, partner, or person with ownership of more than 5% of the contractor's equity who has been debarred or suspended by any federal agency, as specified in 42 U.S.C. 1396u-2, as of August 5, 1997, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future additions or amendments.
  - I. Certification. The Administration shall certify a contractor as a risk-bearing entity as specified in 42 U.S.C. 1396b(m), as of August 5, 1997, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future additions or amendments.
- R9-31-402. Administration's Contracts with Contractors**
- A. Contracts with the Administration. The Administration shall use contractors that have a contract with the Administration to provide services to members who qualify for the program as specified in A.R.S. § 36-2988.
  - B. Conditions when the Administration is a contractor. The Director may require contract terms allowing the Administration to operate a contractor directly under circumstances specified in the contract according to A.R.S. § 36-2986.
  - C. Expansion or contraction of services or services areas. The Director may negotiate with any successful bidder for the expansion or contraction of services or service areas, after contracts have been awarded as specified in A.R.S. § 36-2988.
  - D. Amending contracts. The Administration has full authority to amend existing contracts awarded in compliance with A.R.S. § 36-2988.
  - E. Content of contract. Each contract between the Administration and a contractor shall be in writing and contain at least the following information:
    1. The method and amount of compensation or other consideration to be received by the contractor.
    2. The name and address of the contractor.
    3. The population to be covered by the contractor.
    4. The amount, duration, and scope of medical services to be provided, or for which compensation will be paid for Title XXI coverage.
    5. The term of the contract, including the beginning and ending dates, as well as methods of extension, renegotiation, and termination.
  6. A provision that the Director may evaluate, through inspection or other means, the quality, appropriateness, or timeliness of services performed under the contract.
  7. A description of the eligibility requirements for a Title XXI member, medical and cost record-keeping systems, and a provision that the Director may audit and inspect any of the contractor's records that pertain to services performed and determinations of amounts payable under the contract. These records shall be maintained by the contractor for 5 years from the date of final payment or, for records relating to costs and 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.
  8. A provision that contractors maintain all forms, records, and statistical information required by the Director for purposes of audit and program management. This material, including files, correspondence, and related information pertaining to services rendered or claims for payments shall be subject to inspection and copying by the Administration or by the Department of Health and Human Services during normal business hours at the place of business of the person or organization maintaining the records.
  9. A provision that the contractor safeguard information.
  10. Any activities to be performed by the contractor affecting members that are related to 3rd-party liability requirements prescribed in A.R.S. § 36-2986.
  11. Functions that may be subcontracted, including a provision that any subcontract meets the requirements of 42 CFR 434.6, as of December 30, 1983, which is 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.
  12. A provision that the contractor arrange for the collection of any required copayment by the provider.
  13. A provision that the contractor will not bill or attempt to collect from a Title XXI member for any covered service except as authorized by statute or these rules.
  14. A provision that the contract will not be assigned or transferred without the prior approval of the Director.
  15. Procedures for enrollment or re-enrollment of a covered population.
  16. Procedures and criteria for terminating the contract.
  17. A provision that any cost sharing requirements imposed for services furnished to members are in accordance with A.R.S. § 36-2982, and 42 CFR 447.50 through 447.58, as of December 19, 1990, which are 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.
  18. Procedures for terminating enrollment and choice of health professional.
  19. A provision that specifies the rates are actuarially sound.
  20. A provision that a contractor provide for an internal grievance procedure that:
    - a. Is approved in writing by the Administration;
    - b. Provides for prompt resolution; and
    - c. Ensures the participation of individuals with authority to require corrective action.
  21. A provision that the contractor maintain an internal quality management system consistent with A.R.S. §

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

36-2986 and Title XXI rule and policy as specified in R9-31-522.

22. A provision that the contractor submit marketing plans, procedures, and materials to the Administration for approval before implementation.
23. A statement that all representations made by contractors, or authorized representatives are truthful and complete to the best of their knowledge.
24. A provision that the contractor is responsible for all:
  - a. Tax obligations;
  - b. Worker's Compensation Insurance; and
  - c. All other applicable insurance coverage, for itself and its employees, and that the Administration has no responsibility or liability for any of the taxes or insurance coverage.
25. A provision that the contractor agrees to comply with all applicable statutes and rules.

**R9-31-403. Subcontracts**

- A. Approval. A contractor entering into a subcontract to provide services to a Title XXI member must meet the requirements specified in the contract. Any amendment to a subcontract shall be subject to review and approval by the Director. No subcontract alters the legal responsibility of a contractor to the Administration to ensure that all activities under the contract are carried out.
- B. Subcontracts. Each subcontract shall be in writing and include a:
  1. Provision that the subcontract is to be governed by, and construed in accordance with all laws, rules, and contractual obligations of the contractor.
  2. Provision to notify the Administration in the event the subcontract is amended or terminated.
  3. Provision that assignment or delegation of the subcontract is voidable, unless prior written approval is obtained from the Administration.
  4. Provision to hold harmless the state, the Director, the Administration, and a Title XXI member in the event the contractor cannot or will not pay for covered services performed by the subcontractor.
  5. Provision that the subcontract and subcontract amendments are subject to review and approval by the Director as established in these rules and that a subcontract or subcontract amendment may be terminated, rescinded, or canceled by the Director for a violation of these rules.
  6. Provision to hold harmless and indemnify the state, the Director, the Administration, or a Title XXI member against claims, liabilities, judgments, costs and expenses with respect to third parties, which may accrue against the state, the Director, the Administration, or a Title XXI member, through the negligence of the subcontractor.
  7. Provision that a Title XXI member is not to be held liable for payment to a provider in the event of contractor's bankruptcy; and
  8. Provision that the requirements contained in R9-31-402(E)(1) through (E)(10) and (E) (13), (14), (16), (20), (23), (24), (25) apply but substitute the term "subcontractor" wherever the term "contractor" is used.
- C. Waiver. A contractor may submit a written request to the Administration requesting a waiver of the requirement that the contractor subcontract with a hospital in the contractor's service area. The request shall state the reasons a waiver is believed to be necessary and shall state all efforts the contractor has made to secure a subcontract. For good cause shown, the Administration may waive the hospital subcontract

requirement. The Administration shall consider the following criteria in deciding whether to waive the hospital subcontract requirement:

1. The number of hospitals in the service area.
2. The extent to which the contractor's primary care physicians have staff privileges at noncontracting hospitals in the service area.
3. The size and population of, and the demographic distribution within, the service area.
4. Patterns of medical practice and care within the service area.
5. Whether the contractor has diligently attempted to negotiate a hospital subcontract in the service area.
6. Whether the contractor has any subcontracts in adjoining service areas with hospitals that are reasonably accessible to the contractor's members in the service area.
7. Whether the contractor's members can reasonably be expected to receive all covered services in the absence of a hospital subcontract.

**R9-31-404. Contract Amendments; Mergers; Reorganizations**

Any merger, reorganization, or change in ownership of a contractor shall require that the contractor submit the contract between the Administration and the contractor for amendment and prior approval by the Director. Additionally, any merger, reorganization, or change in ownership of a subcontractor that is related to or affiliated with the contractor shall constitute a contract amendment which requires the prior approval of the Director. To be effective, contract amendments shall be in writing and executed by the Director.

**R9-31-405. Suspension, Denial, Modification, or Termination of Contract**

- A. General. The Director may suspend, deny, refuse or fail to renew, or terminate a contract or subcontract for good cause as specified in contract.
- B. Modification and termination of the contract without cause. The Administration and contractor by mutual consent may modify or terminate the contract at any time without cause. Additionally, the Administration may terminate or suspend the contract in whole or in part without cause effective 30 days after mailing written notice of termination or suspension by certified mail, return receipt requested to the contractor.
- C. Notification.
  1. The Director shall provide the contractor written notice of intent to:
    - a. Suspend;
    - b. Deny;
    - c. Fail to renew; or
    - d. Terminate a contract or related subcontract.
  2. The Administration shall provide a notice to an affected principal, an enrolled member and an other interested party, and shall include:
    - a. The effective date; and
    - b. Reason for the action.
  3. The Administration shall immediately stop processing all applications and shall provide 30 days advance notice to a contractor that the program will terminate on the 1st day of the following month after notice is served, if the federal government:
    - a. Eliminates federal funding for the program; or
    - b. Significantly reduces the federal funding below the estimated federal expenditures according to A.R.S. § 36-2985.

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

**D. Records.**

1. All medical, financial, and other records shall be retained by a terminated contractor in accordance with state laws and rules. Medical records or copies of medical records may be required to be submitted to the Director, or designee, within 10 working days of the effective date of contract termination.
2. All contract records shall be retained for a period of 5 years and disposed of as specified in A.R.S. § 36-2986.

**R9-31-406. Contract; Sanction; Performance; and Solvency**

- A.** The Director may impose a sanction upon a contractor that violates any provision of the rules as specified in contract.
- B.** Adequate performance. The Director shall require contract terms that are necessary to ensure adequate performance by the contractor as specified in A.R.S. § 36-2986 and 9 A.A.C. 31, Article 5.
- C.** Solvency. The Director shall establish solvency requirements in contract as specified in A.R.S. § 36-2986 and 9 A.A.C. 31, Article 5.

**R9-31-407. Contract or Protest, Appeal**

The contractor shall file a grievance as specified in A.A.C. R9-22-804.

**ARTICLE 5. GENERAL PROVISIONS AND STANDARDS**

**R9-31-501. General Provisions**

- A.** As specified in A.R.S. § 36-2986, the Director has full operational authority to adopt rules or to use the appropriate rules adopted for this Article.
- B.** Pre-existing Conditions. Eligibility for the program may not be denied based on a child having a pre-existing medical condition as specified in 42 U.S.C. 1397, August 5, 1997, 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.
  1. Except as otherwise provided in Article 3 of this Chapter, a contractor shall be responsible for providing the full scope of covered services to each member from the effective date of eligibility until the time of notification of termination, suspension, or transfer of the member's enrollment. This responsibility includes providing treatment for all of a member's pre-existing conditions.
  2. A contractor or subcontractor shall not adopt or use any procedure to identify individuals who have an existing or anticipated medical or psychiatric condition in order to discourage or exclude the individuals from enrolling in the contractor's health plan or encourage the individuals to enroll in another health plan.

**R9-31-502. Availability and Accessibility of Service**

- 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 members, 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 physi-

cians 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 for communicating emergency services information to a member's primary care provider, and other appropriate organizational units;
  6. An appointment standard as specified in contract for the following:
    - a. Emergency appointments,
    - b. Urgent care appointments, and
    - c. Routine care appointments.
  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 care provider or specialist providing inpatient services to a member shall have staff privileges in a minimum of 1 general acute care hospital under subcontract with the contractor, within the service area of the contractor.

**R9-31-503. Reinsurance**

- A.** Contractor-acquired reinsurance. As specified in A.R.S. § 36-2988, 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 Title XXI contract year. This limitation does not apply to reinsurance obtained by a contractor to cover the cost of services provided by noncontracting providers and nonproviders to a member 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.
- C.** Encounter submission. A contractor shall prepare, review, verify, certify, and submit, encounters for consideration to the Administration.

*Arizona Administrative Register*  
**Notices of Exempt Rulemaking**

1. The contractor shall certify that the services listed were actually rendered, medically necessary, and within the scope of Title XXI benefits.
  2. The contractor shall submit encounters in the format prescribed by the Administration.
  3. The contractor shall initiate and evaluate an encounter for probable 1st and 3rd-party liability before submitting the encounter for reinsurance consideration to the Administration, unless the encounter involves underinsured or uninsured motorist liability insurance, 1st- and 3rd-party liability insurance, or a tort-feasor.
  4. The Administration shall not consider a reinsurance claim for payment unless the claim is received by the AHCCCS Claims Administration not later than 9 months from the close of the contract year in which the claim is incurred or 9 months after the date of eligibility posting, whichever is later. If a claim meets the 9-month limitation, the contractor shall file a clean claim which is received by the AHCCCS Claims Administration not later than 12 months from the close of the contract year in which the claim is incurred or 12 months after the date of eligibility posting, whichever is later. The 9 month deadline for an inpatient hospital claim begins on the date of discharge for each claim.
- D. Encounter processing.** The Administration shall process reinsurance associated or related encounters submitted by a contractor.
1. The Administration shall accept for processing only those encounters that are submitted directly by a Title XXI contractor and that comply with the conditions in subsections (B), (C), (E), and (F) of this Section.
  2. The Administration shall establish and maintain separate records of all reinsurance cases established and all payments and case reviews made to the contractor as a result of these cases.
  3. The Administration shall subject a contractor to utilization of services and other evaluative reviews of care provided to a member that result in a reinsurance case.
- E. Payment of reinsurance cases.** The Administration shall reimburse a contractor for costs incurred in excess of the applicable deductible level calculated according to the provisions of A.A.C. R9-22-703.
- F. The Administration may limit reinsurance reimbursement to a lower or alternative level of care if the Director or designee determines that the less costly alternative could and should have been used by the contractor. A contractor whose reinsurance case is reduced or denied shall be notified in writing by the Administration. The notification shall include the cause for reduction or denial and describe the applicable grievance and appeal process available under 9 A.A.C. 31, Article 8.**
- G. The Administration or its contractors may arrange special contractual reinsurance terms 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 Administration when a member is identified for possible reimbursement of Title XXI-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.

**R9-31-504. Marketing; Prohibition against Inducements; Misrepresentations; Discrimination; Sanctions**

- A. A contractor or the contractor's marketing representative shall not offer or give any form of compensation or reward, or engage in any behavior or activity that may be reasonably construed as coercive, to induce or procure Title XXI enrollment. A contractor may make Title XXI applications available, but shall not assist with the completion of an application or steer an applicant into a particular contractor. Any marketing solicitation offering a benefit, good, or service, in excess of the covered services in 9 A.A.C. 31, Article 2 shall be deemed an inducement.**
- B. A marketing representative shall not misrepresent itself, the contractor represented, or the Title XXI program, through false advertising, false statements, or in any other manner to induce a member of another contracting entity to enroll in the represented contractor.**
1. The Administration shall deem violations of this subsection to include, but not be limited to, false or misleading claims, inferences, or representations that:
    - a. A member will lose benefits under the Title XXI program or any other health or welfare benefits to which the member is legally entitled, if the member does not enroll in the represented contractor;
    - b. Marketing representatives are employees of the state or representatives of the Administration, a county, or any contractor other than the contractor with whom they are employed, or by whom they are reimbursed; and
    - c. The represented contractor is recommended or endorsed as superior to its competition by any state or county agency, or any organization, unless the organization has certified its endorsement in writing to the health plan and the Administration.
- C. A marketing representative shall not engage in any marketing or pre-enrollment practice that discriminates against a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.**
- D. The Administration shall hold a contractor responsible for the performance of any marketing representative, subcontractor or agent, program, or process under its employ or direction and shall make the contractor subject to the contract sanctions in this Chapter.**

**R9-31-505. Approval of Advertisements and Marketing Materials**

- A. A contractor shall submit its proposed advertisements, marketing materials, and paraphernalia for review and approval by the Administration before distributing the materials or implementing the activities.**
- B. A contractor shall submit all proposed marketing materials in writing to the Administration.**
- C. The Administration shall review and approve or disapprove all marketing materials. 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, a contractor may submit the marketing materials in draft form, subject to final approval and filing of a proof or final copy.**
- E. A contractor shall provide 2 copies of the proof or final approved copy of marketing materials to the Administration.**

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

**R9-31-506. Reserved**

**R9-31-507. Member Record**

As specified in A.R.S. § 36-2986, 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.

**R9-31-508. Limitation of Benefit Coverage for Illness or Injury due to 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 that results from, or is greatly aggravated by, a catastrophic occurrence, including an act of declared or undeclared war, that occurs after enrollment.

**R9-31-509. Transition and Coordination of Member Care**

**A.** As specified in A.R.S. § 36-2986, the Administration shall coordinate and implement disenrollment and re-enrollment procedures when a member's change of residency requires a change in contractor.

**B.** A contractor shall assist in the transition of members to and from other contractors.

1. Both the receiving and relinquishing contractor shall:
    - a. Coordinate with the other contractor to facilitate and schedule appointments for medically necessary services for the transitioned member within the Administration's timelines specified in the contract. 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 transitioning members who have significant medical conditions, are receiving ongoing services, or have, at the time of the transition, received prior authorization or approval for undelivered, specific services.
  2. The relinquishing contractor shall notify the receiving contractor of relevant information about the member's medical condition and current treatment regimens within the timelines defined in contract;
  3. The relinquishing contractor shall forward medical records and other 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 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.** A contractor shall not use a county or nonprovider health resource alternative that diminishes the contractor's contractual responsibility or accountability for providing the full scope of covered services. Referrals made to other health agencies by a contractor, primarily to reduce expenditures incurred by the contractor on behalf of its members, may

result in the application of sanctions described in this Chapter.

**D.** A contractor may transfer a member as specified in A.R.S. § 36-2986, from a noncontracting provider to a contracting provider's facility as soon as a transfer will not be harmful to the member's health as authorized by the member's primary care provider or the contractor's Medical Director. A member's plan shall pay the cost of transfer.

**R9-31-510. Transfer of Members**

As specified in A.R.S. § 36-2989, a contractor shall implement procedures to allow a member to transfer from the primary care provider of record to another primary care provider within the same contracting organization. Criteria for a transfer include, but are not be limited 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 any problem between the member and the primary care provider, resulting in deterioration of the primary care provider - member relationship.

**R9-31-511. Fraud or Abuse**

As specified in A.R.S. §§ 36-2986 and 36-2992, a contractor, provider, or nonprovider shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse.

**R9-31-512. Release of Safeguarded Information by the Administration and Contractors**

- A.** The Administration, a contractor, a provider, and a noncontracting provider shall safeguard information concerning an applicant 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 uniquely identify an applicant or member.
- C.** The Administration, a contractor, a provider, and a noncontracting provider shall use or disclose information concerning an applicant or member only under the conditions specified in subsection (D), (E), and (F) of this Section 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 for only:
1. An applicant;
  2. A member; or
  3. An unemancipated minor, with written permission of a parent, custodial relative, or designated representative, if:

*Arizona Administrative Register*  
Notices of Exempt Rulemaking

- a. An Administration employee or its authorized representative, 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.
4. A purpose as specified in R9-31-512(F).
- E. An eligibility case record, medical record, and any other Title XXI-related confidential and safeguarded information regarding a member, applicant, or unemancipated minor shall be released to individuals authorized by the member, applicant, or unemancipated minor only under the following conditions:
- 1. Authorization for release of information is obtained from the 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, applicant, or designated representative. If the member, or applicant is a minor, the signature of a parent, custodial relative, or designated representative shall be required. If the 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 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 Title XXI program include:
    - a. Establishing eligibility and premiums, as applicable;
    - b. Determining the amount of medical assistance;
    - c. Providing services for members;
    - d. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the Title XXI program;
    - e. Performing evaluations and analyses of Title XXI 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 Title XXI 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 or member:
    - 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, providers, and subcontractors;
    - g. Employees of the Arizona Attorney General's Office; or
    - h. Qualifying community health centers as specified in A.R.S. § 36-2907.06 and hospitals as specified in A.R.S. § 36-2907.08.
3. Law enforcement officials:
- a. Information may be released to law enforcement officials without the applicant'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 Title XXI 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 in situations of suspected of fraud or abuse against the Title XXI 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. § 36-2986, without the consent of the applicant or member.
5. 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 or member shall obtain written consent from the former applicant or member before transmitting the medical record to a primary care provider.
- H. Subcontractors are not required to obtain written consent from a member before transmitting the member's medical records to a physician who:
- 1. Provides a service to the 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.
- R9-31-513.Discrimination Prohibition
- A. A contractor, provider, and nonprovider shall not discriminate against a member because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, or physical or mental disability in accordance with Title VI of the U.S. Civil Rights Act of 1964, 42 U.S.C. 2000d, and rules and regulations promulgated according to, or as otherwise provided by law. For the purpose of providing covered service under contract according to A.R.S. Title 36, Ch. 29, discrimination includes, but is not limited to, the following if done on the grounds of the member's race, color,

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, or physical or mental disability:

1. Denying or providing a member any covered service or availability of a facility;
2. Providing to a member any covered service that is different, or is provided in a different manner or at a different time from that provided to other Title XXI members under contract, other public or private members, or the public at large except when medically necessary;
3. Subjecting 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 the enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and
4. Assigning to a member times or places for the provision of services that are different from those assigned to other Title XXI members under contract.

**B.** 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 disability, except where medically indicated.

**R9-31-514. Equal Opportunity**

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.

**R9-31-515. Reserved**

**R9-31-516. Reserved**

**R9-31-517. Reserved**

**R9-31-518. Information to Enrolled Members**

**A.** As specified in A.R.S. § 36-2986, each contractor shall produce and distribute printed information materials to each member within 10 days of receipt of notification of enrollment from the Administration. The information materials shall be written in English and all languages used by 200 members or 5%, whichever is greater, of the enrolled population. The information materials must meet the requirements specified in the contractor's current contract.

**B.** A contractor shall provide a member with the name, address, and telephone number of the member's primary care provider within 10 days from the date of enrollment. This notice shall include information on how the member may change primary care providers, if dissatisfied with the primary care provider assigned.

**C.** A contractor shall revise and distribute to members a service guide insert describing any change that the contractor proposes to make in services provided or service locations. The insert shall be distributed to all affected members at least 14 days 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.** A contractor shall submit informational and educational materials for approval by the Administration before distributing the materials to members.

**R9-31-519. Reserved**

**R9-31-520. Financial 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.

**B.** A contractor shall provide the Administration with the following:

1. An annual certified financial report prepared by a certified public accountant submitted no later than 120 days after the close of the contractor's fiscal year. The certified public accountants who prepare the report shall be independent of the contractor, subcontracting entities, their officers or directors, and any affiliates.
2. Quarterly financial statements no later than 60 days after the end of the reporting month.
3. Monthly financial statements, if required by the Administration submitted no later than 60 days after the end of the reporting period.
4. Disclosure of information on ownership and control required by 42 CFR 455, Subpart B, September 30, 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.
5. Cost reporting, audits, and financial reporting as specified in contract or provider agreement.

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

**R9-31-521. Program Compliance Audits**

**A.** As specified in A.R.S. § 36-2986, 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 program compliance audit less useful, a contractor will be notified approximately 3 weeks in advance of the date of an on-site program compliance audit. The Administration may conduct, without prior notice, inspections of contractor facilities or perform other elements of a program compliance audit, either in conjunction with the program compliance audit or as part of an unannounced inspection program.

**B.** 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 the contractor's administrative staff including, but not limited to, the contractor's principal management persons;
2. Examine records, books, reports, and papers of the contractor and any management company, and all providers or subcontractors providing health care and other services to the health plan. The examination may include, but not be limited to: minutes of medical staff meetings; peer review and quality of care review records; duty rosters of medical personnel; appointment records; written procedures for the internal operation of the health plan; contracts and correspondence with members and with providers of health care services and other services to

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

the plan, and additional documentation deemed necessary by the Administration to review the quality of medical care.

**R9-31-522. Quality Management/Utilization Management (QM/UM) Requirements**

- A.** As specified in A.R.S. §§ 36-2986 and 36-2990, a contractor shall comply with Quality Management/Utilization Management (QM/UM) requirements specified in this Section and in contract. The contractor shall ensure compliance with QM/UM requirements that are accomplished through delegation or subcontract with another party.
- B.** A contractor shall:
- 1.** Submit a written QM/UM plan that includes a description of the systems, methodologies, protocols, and procedures to be used in:
    - a.** Monitoring and evaluating the types of services,
    - 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 QM/UM plan on an annual basis within timelines specified in contract. If the QM/UM plan is changed during the year, the contractor shall submit the revised plan before implementation;
  - 3.** Receive approval from the Administration before implementing the initial QM/UM plan;
  - 4.** Ensure that a QM/UM committee operates under the control of the contractor's medical director, and includes representation from medical and executive management personnel. The committee shall:
    - a.** Oversee the development, revision and implementation of the QM/UM plan; and
    - b.** Ensure and allocate qualified QM/UM personnel and sufficient resources to implement the contractor's QM/UM activities.
  - 5.** Ensure that the QM/UM activities include at least:
    - a.** Prior authorization for non-emergency or scheduled hospital admissions;
    - b.** Concurrent review of inpatient hospitalization;
    - c.** Retrospective review of hospital claims;
    - d.** Program and provider audits designed to detect over or under utilization, service delivery effectiveness, and outcome;
    - e.** Medical records audits;
    - f.** Surveys to determine satisfaction of members;
    - g.** Assessment of the adequacy and qualifications of the contractor's provider network;
    - h.** Review and analysis of QM/UM data; and
    - i.** Other activities necessary to improve the quality of care and the efficient, cost effective delivery and utilization of services.
- C.** A member's primary care provider shall maintain medical records that:
- 1.** 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 a 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.** 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 QM/UM requirements and adherence to the contractor QM/UM plan.

- 1.** A contractor and its providers shall cooperate with the Administration in the performance of its QM/UM monitoring activities, and
- 2.** A contractor and its providers shall develop and implement mechanisms for correcting deficiencies identified through the Administration's QM/UM monitoring.

**R9-31-523. Financial Resources**

**A.** As specified in A.R.S. § 36-2986, a contractor or offeror shall demonstrate upon request to the Administration that it has:

- 1.** Adequate financial reserves,
- 2.** Administrative abilities, and
- 3.** Soundness of program design to carry out its contractual obligations.

**B.** As specified in A.R.S. § 36-2986, 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.

**R9-31-524. Continuity of Care**

As specified in A.R.S. § 36-2986, a contractor shall establish and maintain a system to ensure continuity of care which shall, at a minimum, include:

- 1.** Referring members who need specialty health care services,
- 2.** Monitoring members with chronic medical conditions,
- 3.** Providing hospital discharge planning and coordination including post-discharge care, and
- 4.** Monitoring operation of the system through professional review activities as specified in A.R.S. § 36-2986.

**R9-31-525. Reserved**

**R9-31-526. Reserved**

**R9-31-527. Reserved**

**R9-31-528. Reserved**

**R9-31-529. Reserved**

**ARTICLE 6. REQUEST FOR PROPOSAL (RFP)**

**R9-31-601. General Provisions for RFP**

**A.** The Director has full operational authority to adopt rules or to use the appropriate rules for contract administration and oversight of contracts as specified in A.R.S. § 36-2986.

**B.** The Administration shall follow the provisions specified in 9 A.A.C. 22, Article 6 for offerors and are subject to the limitations and exclusions specified in that Article, unless otherwise specified in this Chapter.

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

**ARTICLE 7. STANDARDS FOR PAYMENTS**

**R9-31-701. General: Scope of the Administration's Liability; and Payment to a Contractor**

- A.** The Director has full operational authority to adopt rules or to use the appropriate rules adopted for the development and management of a contractor payment system as specified in A.R.S. §§ 36-2986 and 36-2987.
- B.** If the federal government eliminates federal funding for the program or significantly reduces the federal funding below the estimated federal expenditures, the Administration shall immediately stop processing all applications and shall provide at least 30 days advance notice to contractors and members that the program shall terminate as specified in A.R.S. § 36-2985.
- C.** The Administration shall bear no liability for providing covered services to or completing a plan of treatment for any member beyond the date of termination of the member's eligibility or enrollment as specified in A.R.S. § 36-2987.
- D.** The Administration shall make all payments to a contractor in accordance with the terms and conditions of the contract executed between the contractor and the Administration and in accordance with these rules as specified in A.R.S. § 36-2986.
- E.** The Administration shall bear no liability for subcontracts that a contractor executes with other parties for the provision of administrative or management services, medical services, or covered health care services, or for any other purpose. A contractor shall indemnify and hold the Administration harmless from any and all liability arising from the contractor's subcontracts, shall bear all costs of defense of any litigation over the liability, and shall satisfy in full any judgment entered against the Administration in litigation involving the contractor's subcontracts.
- F.** The Administration shall make capitation payments monthly to a contractor who meets the requirements in A.R.S. § 36-2987.

**R9-31-702. Prohibitions Against Charges to Members**

- A.** A contractor, subcontractor, or other provider of care or services shall not charge, submit a claim, demand, or otherwise collect payment from a member or a person acting on behalf of a member for any covered service except to collect an authorized co-payment or payment for additional services. A contractor shall have the right to recover from a member that portion of payment made by a 3rd party to the member when the payment duplicates Title XXI paid benefits and has not been assigned to the contractor. A contractor who makes a claim under this provision shall not charge more than the actual, reasonable cost of providing the covered services.
- B.** A provider shall not bill or make any attempt to collect payment, directly or through a collection agency, from an individual claiming to be Title XXI eligible without 1st receiving verification from the Administration that the individual was ineligible for Title XXI on the date of service or that the services provided were not covered by Title XXI as specified in A.R.S. § 36-2987.
- C.** A provider, including a noncontracting provider, may bill a member for medical expenses incurred during a period of time when the member willfully withheld material information from the provider or gave false information to the provider pertaining to the member's Title XXI eligibility or enrollment status that caused payment to be denied.

**R9-31-703. Claims**

- A.** Claims submission to contractors. A provider shall submit to a contractor all claims for services rendered to a member enrolled with the contractor.
- B.** Overpayments for Title XXI services. When a Title XXI overpayment is made to a contractor, the contractor shall notify the Administration that an overpayment was made. The Administration shall recoup an overpayment from a future claim cycle, or, at the discretion of the Director, require the contractor to return the incorrect payment to the Children's Health Insurance Program Fund.

**R9-31-704. Transfer of Payments**

- A. Payments permitted. Payments may be made to other than the contractor as follows:**
  - 1.** When payment is made in accordance with an assignment to a government agency or an assignment made according to a court order: or
  - 2.** When payment is made to a business agent, such as a billing service or accounting firm, who renders statements and receives payment in the name of a contractor providing that the agent's compensation for this service is:
    - a.** Reasonably related to the cost of processing the statements,
    - b.** Not dependent upon the actual collection of payment.
- B. Prohibition of payments to factors. Payment for covered services furnished to a member by a contractor shall not be made to, or through a factor, either directly, or by virtue of a power of attorney given to the factor.**

**R9-31-705. Payments by Contractors**

- A. Authorization. A contractor shall pay for all admissions and covered services rendered to its members if the covered services or admissions have been arranged by the contractor's agents or employees, subcontracting providers, or other individuals acting on the contractor's behalf and if necessary authorization has been obtained. A contractor is not required to pay a claim for covered services that is submitted more than 6 months after the date of the service or that is submitted as a clean claim more than 12 months after the date of the service.**
- B. Timeliness of provider claim payment.**
  - 1.** A contractor shall reimburse or provide written notice for a claim that is denied or reduced by a contractor to a subcontracting and a noncontracting provider for the provision of medically necessary health care services to a contractor's member, within the time period specified by the contract between a contractor and a subcontracting entity.
  - 2.** Unless the subcontract specifies otherwise, a contractor shall pay 90% of valid clean claims within 30 days of the date of receipt of a claim and 99% of valid the clean claims within 90 days of the date of receipt of a claim, as specified in 42 U.S.C. 1396u-2, as of August 5, 1997, which is 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.
  - 3.** The notice for a denied or a reduced claim shall be sent within the time-frames specified in this Section, and shall include a statement describing a provider's right to grieve the contractor's denial or reduction of the claim as specified in A.A.C. R9-22-Article 8.

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

- C.** Date of claim. A contractor's date of receipt of an inpatient or outpatient hospital claim shall be the date the claim is received by the contractor as indicated by the date stamp on the claim, the claim reference number, or the date-specific number system assigned by the contractor. A hospital claim shall be considered paid on the date indicated on the disbursement check. A denied hospital claim shall be considered adjudicated on the date of its denial. Claims that are pending for additional supporting documentation will receive new dates of receipt upon receipt of the additional documentation; however, claims that are pending for documentation other than the minimum required documentation specified in either A.R.S. §§ 36-2987 or 36-2904, as applicable, will not receive new dates of receipt. A contractor and a hospital may, through a contract approved in accordance with R9-31-715(A), adopt a method for identifying, tracking, and adjudicating claims that is different from the method described in this subsection.
- D.** Payment for medically necessary outpatient hospital services.
1. A contractor shall reimburse subcontracting and noncontracting providers for the provision of outpatient hospital services rendered at either a rate specified by subcontract or, in absence of a subcontract, the AHCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges. Subcontract rates, terms, and conditions are subject to review, and approval or disapproval under A.R.S. §§ 36-2987, 36-2904, and R9-31-715.
  2. A contractor shall pay for all emergency care services rendered to its members by noncontracting providers or nonproviders when the services:
    - a. Are rendered according to the prudent layperson standard.
    - b. Conform to the definitions of emergency medical and acute mental health services in Article I of this Chapter, and
    - c. Conform to the notification requirements in Article 2 of this Chapter.
- E.** Payment for inpatient hospital services. A contractor shall reimburse out-of-state hospitals for the provision of hospital services at negotiated discounted rates, the AHCCCS average cost-to-charge ratio multiplied by covered charges or, if reasonably and promptly available, the Medicaid rate that is in effect at the time services are provided in the state in which the hospital is located, whichever is lowest. A contractor shall reimburse in-state subcontractors and noncontracting providers for the provision of inpatient hospital services at either a rate specified by subcontract or, in absence of a subcontract, the prospective tiered-per-diem amount in A.R.S. §§ 36-2987, 36-2904, 36-2903.01, A.A.C. R9-22-712, and A.A.C. R9-22-718, as applicable. Discounts and penalties shall be as specified in A.R.S. § 36-2987(C). Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. §§ 36-2987, 36-2904, and R9-31-715.
- F.** Payment for observation days. A contractor may reimburse subcontracting and noncontracting providers for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges.
- G.** Review of hospital claims.
1. If a contractor and a hospital do not agree on reimbursement levels, terms, and conditions, the reimbursement levels established under A.R.S. §§ 36-2987, 36-2904,

36-2903.01, and A.A.C. R9-22-712 or R9-31-718 shall apply. In these cases, a hospital shall obtain prior authorization from the appropriate contractor for nonemergency admissions. A contractor shall consider the medical condition of the member, length of stay, and other factors when issuing its prior authorization. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of their contract regarding utilization control activities that may include prior authorization of nonemergency admissions. Failure to obtain prior authorization when it is required shall be cause for nonpayment or denial of the claim. A hospital shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and make the hospital's medical records, specific to a member enrolled with the contractor, available for review.

2. Regardless of prior authorization or concurrent review activities, all hospital claims, including outlier claims, are subject to prepayment medical review and post-payment review by the contractor. Post-payment reviews shall be consistent with A.R.S. § 36-2987, and erroneously paid claims are subject to recoupment. If prior authorization was given for a specific level of care, but medical review of the claim indicates that a different level of care was appropriate, the contractor may adjust the claim to reflect the more appropriate level of care. An adjustment in level of care shall be effective on the date when the different level of care was medically appropriate.
  3. A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures different from those in this subsection if the subcontract binds both parties and meets the requirements of R9-31-715.
- H.** Timeliness of hospital claim payment. Payment by a contractor for inpatient hospital admissions and outpatient hospital services shall be subject to A.R.S. §§ 36-2987, 36-2904, and 36-2903.01.

**R9-31-706. Reserved**

**R9-31-707. Payments for Newborns**

If a mother is enrolled on the date of her newborn baby's birth, a contractor shall be financially liable under the mother's capitation to provide all Title XXI-covered services to the newborn baby from the date of birth until the Administration is notified of the birth.

**R9-31-708. Reserved**

**R9-31-709. Contractor's Liability to Hospitals for the Provision of Emergency and Subsequent Care**

- A.** For purposes of program and contractor liability, an emergency medical or acute mental health condition of a member shall be subject to reimbursement only until the member's condition is stabilized and the member is transferable, or until the member is discharged following stabilization subject to the requirements of A.R.S. § 36-2989 and Article 2 of this Chapter.
- B.** Subject to subsection (A), if a member cannot be transferred following stabilization to a facility that has a subcontract with the contractor of record, the contractor of record shall pay for all appropriately documented, prior authorized, and medically necessary treatment provided the member before the date of discharge or transfer in accordance with payment standards in R9-31-705.

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

C. If a member refuses transfer from a nonprovider or noncontracting hospital to a hospital affiliated with the member's contractor of record, neither the Administration nor the contractor shall be liable for any costs incurred after the date of refusal if:

1. After consultation with the member's contractor of record, the member continues to refuse the transfer; and
2. The member has been provided and signs a written statement, before the date of transfer of liability, informing the member of the medical and financial consequences of refusing to transfer. If the member refuses to sign a written statement, a statement signed by 2 witnesses indicating that the member was informed may be substituted.

**R9-31-710. Reserved**

**R9-31-711. Copayments**

- A. Contractors shall be responsible for collecting a \$5.00 copayment from a member for non-emergency use of the emergency room.
- B. A contractor shall ensure that a member is not denied services because of the member's inability to pay a copayment.

**R9-31-712. Reserved**

**R9-31-713. Payments Made on Behalf of a Contractor; Recovery of Indebtedness**

- A. The Administration may make payments on behalf of a contractor in order to prevent a suspension or termination of Title XXI services when either:
  1. No payment period is specified by subcontract and a valid accrued claim is not paid within 30 days of receipt by the contractor, or
  2. A valid accrued claim is not paid within the period under subcontract.
- B. In the event a payment is made by the Administration according to this Article, the Administration shall reduce the capitation payment due a contractor by the amount of payment made, plus a 10% administrative fee for each claim that is paid.
- C. If a contractor or a subcontracting provider receives an overpayment or otherwise becomes indebted to the Administration, the contractor or subcontracting provider shall immediately remit such funds to the Administration for deposit in the Children's Health Insurance Program Fund.
- D. The action of the Administration to recover amounts from contractors or subcontracting providers may include the following:
  1. Negotiation of a repayment agreement executed with the Administration.
  2. Withholding or offsetting against current or future prepayments or other payments to be paid to the contractor or subcontracting provider.
  3. Enforcement of, or collection against, the performance bond or withhold as specified in A.R.S. § 36-2986.
- E. Except as specifically provided for in these rules, the Administration shall not be liable for payment for medical expenses incurred by members enrolled with contractors.

**R9-31-714. Reserved**

**R9-31-715. Hospital Rate Negotiations**

- A. Effective for inpatient hospital admissions and outpatient hospital services contractors that negotiate with hospitals for inpatient or outpatient services shall reimburse hospitals for member care based on the prospective tiered-per-diem amount, the AHCCCS hospital-specific outpatient cost-to-

charge ratio multiplied by covered charges in A.R.S. § 36-2987 and A.A.C. R9-22-712, or the negotiated rate that, when considered in the aggregate with other hospital reimbursement levels, does not exceed what would have been paid under A.R.S. § 36-2987 and A.A.C. R9-22-712.

1. Contractors may engage in rate negotiations with hospitals at any time during the contract period.
2. Within 7 days of the completion of the agreement process, contractors shall submit copies of their negotiated rate agreements, including all rates, terms, and conditions, with hospitals to the Administration for approval. Contractors shall demonstrate to the Administration that the effect of their negotiated rate agreement will, when considered in the aggregate, be the same as or produce greater dollar savings than would have been paid under A.R.S. § 36-2987 and A.A.C. R9-22-712.
  - a. To demonstrate the aggregate effect of its negotiated rate agreement, contractors shall present their assumptions related to projected utilization of various hospitals to the Administration. The contractor may consider inpatient assumptions related to:
    - i. Member mix;
    - ii. Admissions by AHCCCS-specified tiers;
    - iii. Average length of stay by tier and pattern of admissions, excluding emergency admissions;
    - iv. Outliers; and
    - v. Risk-sharing arrangements.
  - b. The contractor also may consider outpatient assumptions related to member mix and outpatient service utilization. The Administration reserves the right to approve, deny, or require mutually-agreed-to modifications of these assumptions.
  - c. When a contractor adjusts or modifies an assumption, the reason for the adjustment or modification shall be presented to the Administration, as well as the new assumption. The Administration may approve, deny, or require mutually-agreed-to modification of an assumption.
  - d. To determine whether a negotiated rate agreement produces reimbursement levels that do not in the aggregate exceed what would be paid under A.R.S. § 36-2987 and A.A.C. R9-22-712, a contractor shall require its independent auditors to evaluate the reasonableness of its assumptions as part of its annual audit. The contractor shall ensure that its independent auditor's audit program is consistent with AHCCCS audit requirements and is submitted to the Administration for prior approval.
  - e. Negotiated inpatient or outpatient rate agreements with hospitals with a contractor has a related-party interest are subject to additional related party disclosure and evaluation. These evaluations are in addition to the procedures described in subsection (A)(2)(c) and shall be performed by the contractor's independent auditors, or, at the contractor's option, by the Administration.
  - f. The Administration shall subject a contractor's independent auditor's report to any examination or review necessary to ensure accuracy of all findings related to aggregate rate determinations.
  - g. The Administration shall use its standards, consistent with the Request for Proposals and R9-31-502, to determine whether a contractor's inpatient or outpatient hospital subcontractors will limit the availability or accessibility of services. The

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

Administration reserves the right to reject hospital subcontracts that limit the availability or accessibility of services.

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

**R9-31-716. Specialty Contracts**

The Director may at any time negotiate or contract on behalf of contractors for specialized hospital and medical services including, but not limited to, transplants, neonatology, neurology, cardiology, and burn care. If the Director contracts for specialized services, contractors of record may be required to include the services within their delivery networks and make contractual modifications necessary to carry out this Section. Specialty contractors shall take precedence over all other contractual arrangements between contractors of record and their subcontractors. Specialty contractors may require interim payments to specialty contractors on behalf of contractors of record for contract services received by members. Interim payments to specialty contractors may be deducted from capitation payments, performance bonds, or other monies for payment on behalf of contractors of record. If the Administration and a hospital that performed a transplant surgery on a member does not have a contracted rate, the system shall not reimburse the hospital more than the contracted rate established by the Administration.

**R9-31-717. Hospital Claims Review**

- A.** The contractors shall review hospital claims that are timely received as specified in A.A.C. R9-22-703(B).
- B.** A charge for hospital services provided to a member during a time when the member was not the financial responsibility of the contractor shall be denied.
- C.** Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
  - 1. Patient care kit,
  - 2. Toothbrush,
  - 3. Toothpaste,
  - 4. Petroleum jelly,
  - 5. Deodorant,
  - 6. Septi soap,
  - 7. Razor,
  - 8. Shaving cream,
  - 9. Slippers,
  - 10. Mouthwash,
  - 11. Disposable razor,
  - 12. Shampoo,
  - 13. Powder,
  - 14. Lotion,
  - 15. Comb, and
  - 16. Patient gown.
- D.** The following hospital supplies and equipment, if medically necessary and used, are covered services:
  - 1. Arm board,
  - 2. Diaper,
  - 3. Underpad,
  - 4. Special mattress and special bed,
  - 5. Gloves,
  - 6. Wrist restraint,
  - 7. Limb holder,

- 8. Disposable item used in lieu of a durable item.
- 9. Universal precaution,
- 10. Stat charge, and
- 11. Portable charge.
- E.** The hospital claims review shall determine whether services rendered were:
  - 1. Title XXI-covered services;
  - 2. Medically necessary;
  - 3. Provided in the most appropriate, cost-effective, least restrictive setting; and
  - 4. Substantiated by the minimum documentation specified in A.R.S. §§ 36-2987.
- F.** If a claim is denied by the contractor, a grievance challenging the denial may be filed against the entity denying the claim. The grievance shall be filed no later than 12 months from the date of service or 60 days from the date of notice of adverse action, whichever is latest. Any grievance challenging a post-payment review recoupment action shall be filed by the provider no later than 12 months from the date of service or 60 days from the date of the notice of recoupment, whichever is latest.

**ARTICLE 8. GRIEVANCE AND APPEAL PROCESS**

**R9-31-801. General Provisions For All Grievances and Appeals**

- A.** As specified in A.R.S. § 36-2986, the Director shall, by rule, establish a grievance and appeal procedure.
- B.** All grievances and appeals shall be filed and processed according to A.A.C. R9-22-801. In eligibility appeals, the Administration is the respondent.
- C.** The AHCCCS chief hearing officer or designee may deny a request for a hearing if either of the following occurs:
  - 1. The sole issue presented is a federal or state law requiring an automatic change adversely affecting some or all applicants or members, or
  - 2. The Administration reaches the maximum number of members the program shall serve as specified in A.R.S. § 36-2985.
- D.** A parent or legal guardian may file a grievance only over a denial of a covered service or a claim for a covered service, as specified in R9-31-803. A parent or legal guardian may not file an eligibility appeal and is not entitled to receive a continued service on appeal. If the parent or legal guardian prevails in the AHCCCS grievance process, the contractor shall provide any service or pay any claim determined to be medically necessary regardless of whether judicial review is sought. A provider may file a grievance regarding a denial of a covered service or a claim for a covered service of a parent or legal guardian.

**R9-31-802. Eligibility Appeals and Hearing Requests For an Applicant and a Member**

- A.** Adverse eligibility actions. An applicant or a member may appeal and request a hearing concerning either of the following adverse eligibility actions:
  - 1. Denial of eligibility, or
  - 2. Discontinuance of eligibility.
- B.** Notice of an adverse eligibility action. Notice of an adverse eligibility action shall be personally delivered or mailed to the affected individual by regular mail. For purposes of this Section, the date of the Notice of Action shall be the date of personal delivery to the individual or the postmark date, if mailed.
- C.** Appeals and requests for hearing.
  - 1. An applicant or a member may appeal and request a hearing regarding an adverse eligibility action by com-

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

pleting and submitting the AHCCCS Request for Hearing form or by submitting a written request containing the following information:

- a. The case name.
- b. The adverse eligibility action being appealed, and
- c. The reason for appeal.

2. For denials, the request for hearing shall be filed not later than 20 days from the date of the notice of adverse action. For discontinuances, the request for hearing shall be filed not later than 10 days after the effective date of action. The request for hearing shall be filed by mailing or delivering it to either the Title XXI eligibility office or the Administration, Office of Grievance and Appeals. For this Section only, the date of the request for hearing shall be the postmark date, if mailed, or the date of personal delivery.

**D. Eligibility office responsibilities.**

1. The eligibility office shall maintain a register which documents the date on which a request for hearing is submitted.
2. If requested, the eligibility office shall assist the appellant or designated representative in the completion of the Request for Hearing form.
3. A Pre-Hearing Summary shall be completed by the eligibility office and shall summarize the facts and factual basis for the adverse eligibility action.
4. The eligibility office shall send to the Administration, Office of Grievance and Appeals, the Pre-Hearing Summary, a copy of the case file, documents pertinent to the adverse action, and the Request for Hearing, which must be received by the Administration, Office of Grievance and Appeals, not later than 10 days from the date the request is received. If the request is submitted directly to the Administration, Office of Grievance and Appeals, the eligibility office shall send the materials to the Office of Grievance and Appeals, not later than 10 days from the date of a request for the materials.

**E. Title XXI coverage during the appeal process.**

1. Applicants appealing a denial of Title XXI coverage. A denial is an adverse eligibility decision which finds the applicant ineligible for Title XXI benefits. In the event that a timely request for hearing is filed and the denial is overturned, the effective date of Title XXI coverage shall be established by the Director in accordance with applicable law.
2. Members appealing a discontinuance. A discontinuance is a termination of Title XXI benefits. For actions requiring 10 days advance notice, a member who requests a hearing before the effective date of the adverse action shall continue to receive Title XXI benefits until an adverse decision on the appeal is rendered, unless the program is suspended or terminated as specified in A.R.S. § 36-2985.
3. Member's financial responsibility for benefits. A member whose benefits have been continued shall be financially liable for all Title XXI benefits received during a period of ineligibility if a discontinuance decision is upheld by the Director.

**R9-31-803. Grievances**

All grievances regarding Title XXI shall be filed and processed according to A.A.C. R9-22-804. For purposes of this Chapter, a member's grievance does not need to state with particularity the legal or factual basis for the requested relief.

**R9-31-804. Grievance and Appeal Process For Behavioral**

**Health**

- A. All Title XXI grievances relating to an adverse action, decision, or policy regarding behavioral health issues shall be processed according to the standards set by the Administration, as specified in contract with ADHS, contractors, and provider agreements.
- B. An appeal of a grievance decision under subsection (A) shall be conducted as a contested case according to R9-31-801 and R9-31-803.

**ARTICLE 9. QUALITY CONTROL**

**R9-31-901. General Provisions**

- A. The Director has full operational authority to adopt rules or to use the appropriate rules for administration and oversight of quality control as specified in A.R.S. § 36-2986.
- B. As specified in A.R.S. § 36-2982, the Administration has the authority to establish a process to audit eligibility determinations made by AHCCCS or the entities with which the Administration contracts or enters into an intergovernmental agreement.

**ARTICLE 10. 1ST- AND 3RD-PARTY LIABILITY AND RECOVERIES**

**R9-31-1001. 1st- and 3rd-Party Liability and Coordination of Benefits**

**A. General provisions.**

1. As specified in A.R.S. §§ 36-2986 and 36-2987, the Director has full operational authority to adopt rules or to use the appropriate rules adopted for coordination of benefits provided under this Article for any member.
2. The Administration may subcontract distinct administrative functions as permitted by A.R.S. § 36-2986.

- B. Cost avoidance. The System shall cost avoid all claims or services that are subject to 1st- or 3rd-party liability source, and may deny a service to a member if it knows that a 1st- or 3rd-party will provide the service. The requirement to cost avoid applies to all Title XXI covered services, unless otherwise specified in this Section.

1. Responsible parties. The following parties shall take reasonable measures to identify legally liable 1st- or 3rd-party sources:

- a. Administration,
- b. Contractor,
- c. Provider,
- d. Nonprovider,
- e. Noncontracting provider, and
- f. Member.

2. Coordination of benefits. As specified in A.R.S. § 36-2986, if a contractor does not know whether a particular service is covered by a 1st- and 3rd-party insurer, and the service is medically necessary, the contractor shall contact the 1st- and 3rd-party, and determine whether the service is covered rather than requiring a member to contact the 1st- or 3rd-party. If the contractor knows that the 1st- and 3rd-party insurer will neither pay for nor provide the covered service, and the service is medically necessary, the contractor shall neither deny the service nor require a written denial letter.

3. Copayment, coinsurance, deductible. If a 1st- or 3rd-party insurer (other than Medicare) requires a member to pay any copayment, coinsurance, or deductible, the contractor must decide whether it is more cost effective to provide the service:

- a. Within its network for continuity of care, or

*Arizona Administrative Register*  
**Notices of Exempt Rulemaking**

- b. Outside its network for continuity of care under the following conditions:
  - i. Advance payments. If an insurer requires payment in advance of a copayment, coinsurance, or deductible, the contractor shall make the payment in advance for the member.
  - ii. Limitation of copayment, coinsurance, and deductible amounts. A contractor that meets the requirements in subsection (B)(5) is not responsible for paying a copayment, coinsurance, or deductible that is in excess of what the contractor would have paid for the entire service, per a written contract with the provider performing the service minus any amount paid by the 1st- and 3rd-party.
- 4. Exceptions. A contractor shall provide the following services, and then coordinate payment with a 1st- and 3rd-party payor:
  - a. Emergency service, and
  - b. Emergency transportation as specified in A.R.S. § 36-2989.
- 5. Medically necessary service. A contractor shall ensure that its cost avoidance efforts do not prevent a member from receiving a medically necessary service, and that a member is not required to pay any copayment, coinsurance, or deductible for use of the other insurer's provider;
- 6. Pre-natal and preventive services. The Administration may require a contractor to provide pre-natal and preventive pediatric services, and then coordinate payment with a liable 1st- or 3rd-party.
- C. Member participation. A member shall cooperate in identifying potentially liable 1st- or 3rd- parties and assist the Administration, contractor, provider, nonprovider, or noncontracting provider in pursuing any 1st- or 3rd-party who may be liable to pay for covered services.
- D. Collections.
  - 1. The following parties shall cooperate, identify, and notify the Administration of all potential sources of 1st- or 3rd-party liability:
    - a. Provider,
    - b. Nonprovider, and
    - c. Noncontracting provider.
  - 2. The following parties shall pursue collection or reimbursement from all potential sources of 1st- or 3rd-party liability:
    - a. The Administration,
    - b. Provider,
    - c. Nonprovider, and
    - d. Noncontracting provider.
  - 3. Contractors shall cooperate, identify, and notify the Administration of all potential sources of 1st- or 3rd-party liability and pursue collection or reimbursement according to R9-31-1002(B).
  - 4. Recoveries: Contractor. A contractor may retain up to 100% of its 1st- and 3rd-party collections if:
    - a. Total payments received do not exceed the total amount of the contractor's financial liability for the member. Payments in excess of the contractor's liability shall be reimbursed as described in 42 CFR 433.154, May 12, 1980, 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. Title XXI reinsurance benefits or both have not duplicated the recovery. Any duplicated benefits received shall be reimbursed to the Administration. Payments by the Administration for covered services may supplement payment or benefits from 1st- or 3rd-parties to the extent authorized by this Chapter or applicable contracts.
  - c. The recovery is not prohibited by federal or state law, and
  - d. The payments collected are reflected in reduced capitation rates. The Administration may require a contractor to reimburse the Administration up to 100% of collected 1st- and 3rd-party payments that are not reflected in reduced capitation rates.
  - 5. Recoveries: Administration. The Administration may retain its 1st- and 3rd-party collections, reinsurance payments, administrative costs, capitation payments, and any other payments made by the System. The funds collected shall be deposited in the Children's Health Insurance Program Fund as specified in A.R.S. § 36-2995.
- R9-31-1002. 1st- and 3rd-Party Liability Monitoring and Compliance**
- A. 1st- or 3rd-party liability sources. The Administration shall monitor 1st- or 3rd-party liability payments to a contractor, provider, nonprovider, or noncontracting provider, which may include but are not limited to payments by or for:
    - 1. Private health insurance;
    - 2. Employment related disability and health insurance;
    - 3. Other federal programs not excluded by statute;
    - 4. Court ordered or non-court ordered medical support from an absent parent;
    - 5. State worker's compensation;
    - 6. Automobile insurance, including underinsured and uninsured motorists insurance;
    - 7. Court judgment or settlement from a liability insurer including settlement proceeds placed in a trust;
    - 8. First-party probate estate recovery;
    - 9. Adoption related payment; and
    - 10. Tortfeasor.
  - B. Contractor responsibility. A contractor shall:
    - 1. Recover 1st- and 3rd-party payments from the sources identified in subsections (A)(1) through (A)(4); and
    - 2. Recover 1st- and 3rd-party payments from the sources identified in subsections (A)(5) through (A)(8), when directed by the Administration.
  - C. Monitoring. The Administration shall determine whether a contractor, provider, nonprovider, or noncontracting provider is in compliance with the requirements in this Article by inspecting claim submissions and payment documentation for cost avoidance and recovery activities.
  - D. Notification for perfection, recording, and assignment of Title XXI liens.
    - 1. County requirements. The Administration may preserve its lien rights according to A.R.S. §§ 36-2986(M), 36-2915 and 36-2916.
    - 2. Hospital requirements. Hospitals providing emergency or urgent medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a 1st- or 3rd-party shall notify the Administration according to subsection (E) within 30 days after discharge. A hospital may satisfy the requirement of this subsection also by mailing to the Administration a copy of the lien it proposes to record or has recorded according to A.R.S. § 36-2986 within 30 days after discharge.

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

3. Contractor, provider, nonprovider, and noncontracting provider requirements. A contractor, provider, nonprovider, or noncontracting provider, other than a hospital, rendering medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a 1st- or 3rd-party shall notify the Administration according to subsection (E) within 30 days after providing the services.
- E. Notification information for liens. To satisfy notification requirements, all of the following information shall be mailed to the Administration:
1. Name of the contractor, provider, nonprovider, or noncontracting provider;
  2. Address of the contractor, provider, nonprovider, or noncontracting provider;
  3. Name of the member;
  4. The member's Social Security number or Title XXI identification number;
  5. Address of the member;
  6. Date of the member's admission;
  7. Amount estimated to be due for care of the member;
  8. Date of the member's discharge;
  9. Name of county in which injuries were sustained; and
  10. Name and address of all persons, firms, and corporations and their insurance carriers claimed by the member or legal representative to be liable for damages.
- F. Notification of health insurance information. A contractor, provider, nonprovider, or noncontracting provider shall provide notification of health insurance information to the Administration. To satisfy notification requirements, all of the following health insurance information shall be submitted to the Administration within 10 days of receipt of the health insurance information:
1. Name of the member;
  2. The member's Social Security number or Title XXI identification number;
  3. Insurance carrier name;
  4. Insurance carrier address;
  5. Policy number, if available;
  6. Policy begin and end dates, if available; and
  7. Insured's name and Social Security number.

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

**R9-31-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims**

- A. Establishment and management of a system to prevent fraud. As specified in A.R.S. § 36-2986(A), the Director has full operational authority to adopt rules for the establishment and management of a system to prevent fraud by members, contractors, and health care providers.
- B. Determination and collection of civil penalties. As specified in A.R.S. §§ 36-2991 and 36-2993 the Director may adopt rules that prescribe procedures for the determination and collection of civil penalties.
- C. Federal fraud and abuse controls. As specified in A.R.S. § 36-2991, in addition to the requirements of state law, any applicable fraud and abuse controls that are enacted under federal law apply to a person who is eligible for services under this Chapter and to contractors and noncontracting providers who provide services under this Chapter.
- D. Unpaid civil penalties. As specified in A.R.S. § 36-2991, if a civil penalty imposed according to this Article is not paid, the state may file an action to collect the civil penalty in the superior court in Maricopa county.

- E. Circumstances for imposing a penalty and assessment. The Director or designee shall impose a penalty and assessment under the circumstances described in A.R.S. § 36-2991. For the purposes of this Article, the term "reason to know" means that a person, with respect to information, acts in deliberate ignorance of the truth or falsity of the information or with reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.
- F. Violation of agreement. As specified in A.R.S. § 36-2992, the Director's or designee's determination of whether a person knew or had reason to know that each claim or request for payment was claimed in violation of an agreement with the Administration or a contractor may be based on the terms of the agreement.

**R9-31-1102. Determinations Regarding the Amount of the Penalty and Assessment**

- A. Factors for determining a penalty and assessment. The Director or designee shall take into account the following factors in determining the amount of a penalty and assessment:
1. The nature of each claim or request for payment and the circumstances under which it is presented.
  2. The degree of culpability of a person submitting each claim or request for payment.
  3. The history of prior offenses of a person submitting each claim or request for payment.
  4. The financial condition of a person presenting each claim or request for payment.
  5. The effect on patient care resulting from the failure to provide medically necessary care by a person submitting each claim or request for payment, and
  6. Other matters as justice may require.
- B. Types of claim circumstances. As specified in A.R.S. § 36-2991, in determining the amount of a penalty and assessment, the Director or designee shall consider both mitigating circumstances and aggravating circumstances surrounding submission of each claim or request for payment.
- C. Mitigating circumstance guidelines. The Director or designee shall consider the following mitigating circumstance guidelines when determining the amount of a penalty and assessment:
1. Nature and circumstances of each claim or request for payment. The nature and circumstances of each claim or request for payment and the circumstances under which it is presented are a mitigating circumstance if:
    - a. All the items and services subject to a penalty and assessment are of the same type.
    - b. All the items and services subject to a penalty and assessment occurred within a short period of time.
    - c. There are few items and services, and
    - d. The total amount claimed for the items and services was less than \$1,000.
  2. Degree of culpability. The degree of culpability of a person submitting a claim or request for payment is a mitigating circumstance if:
    - a. Each item or service is the result of an unintentional and unrecognized error in the process the person followed in presenting the item or service.
    - b. Corrective steps were taken promptly after the error was discovered, and
    - c. A fraud and abuse control plan was adopted and operating effectively at the time each claim or request for payment was submitted.
  3. Financial condition. The financial condition of a person presenting a claim or request for payment is a mitigating circumstance if the imposition of a penalty and assess-

*Arizona Administrative Register*  
**Notices of Exempt Rulemaking**

ment without reduction will jeopardize the ability of the person to continue as a health care provider. The resources available to the person may be considered when determining the amount of the penalty and assessment; or

4. Other matters as justice may require. Other circumstances of a mitigating nature will be taken into account if, in the interest of justice, the circumstances require a reduction of the penalty and assessment.

**D. Aggravating circumstance guidelines. The Director or designee shall consider the following aggravating circumstance guidelines when determining the amount of a penalty and assessment:**

1. Nature and circumstances of each claim or request for payment. The nature and circumstances of each claim or request for payment and the circumstances under which it is presented are an aggravating circumstance if:
  - a. The items and services subject to a penalty and assessment are of several types.
  - b. The items and services subject to a penalty and assessment occurred over a lengthy period of time.
  - c. There are many items or services (or the nature and circumstances indicate a pattern of claims for the items or services), or
  - d. The total amount claimed for the items and services is \$1,000 or greater.
2. Degree of culpability. The degree of culpability of a person submitting each claim or request for payment is an aggravating circumstance if:
  - a. The person knew that each item or service was not provided as claimed;
  - b. The person knew that no payment could be made because the person had been excluded from system reimbursement; or
  - c. Payment would violate the terms of an agreement between the person and the State, the Administration or a contractor.
3. Prior offenses. The prior offenses of a person submitting each claim or request for payment is an aggravating circumstance if, at any time before the presentation of any claim or request for payment subject to a penalty and assessment under this Article, the person was held liable for a criminal, civil, or administrative sanction in connection with:
  - a. A Medicaid program,
  - b. A Medicare program,
  - c. A Title XXI program, or
  - d. Any other public or private program of reimbursement for medical services.
4. Effect on patient care. The seriousness of an adverse effect that resulted, or could have resulted, from the failure of a person submitting a claim or request for payment to provide medically necessary care is an aggravating circumstance; or
5. Other matters as justice may require. Other circumstances of an aggravating nature shall be taken into account if, in the interest of justice, the circumstances require an increase of the penalty and assessment.

**E. Amount of penalty and assessment. As specified in A.R.S. § 36-2993 and this Article, the aggregate amount of a penalty and assessment shall never be less than double the approximate amount of damages sustained by the State, the Administration or contractor, unless there are extraordinary mitigating circumstances.**

**F. Compromise. The Director or designee may compromise a penalty and assessment using the guidelines in subsections (C) and (D).**

**R9-31-1103. Notice of Proposed Determination and Rights of Parties**

**A. Administration's responsibilities. If the Director or designee proposes to impose a penalty and assessment, the Director or designee shall deliver or send by certified mail, return receipt requested, to a person, written notice of intent to impose a penalty and assessment. The notice shall include:**

1. Reference to the statutory basis for the penalty and assessment,
2. A description of each claim or request for payment for which the penalty and assessment are proposed,
3. The reason why each claim or request for payment subjects the person to a penalty and assessment, and
4. The amount of the proposed penalty and assessment.

**B. Individual's responsibilities. A person may submit within 35 days from the date of the adverse action:**

1. A written statement accepting imposition of the penalty and assessment,
2. As specified in A.R.S. § 36-2993 a written request for a compromise of the penalty and assessment stating any reasons that the person contends should result in a reduction or modification of the penalty and assessment. If a request is submitted, the time period for filing an appeal and request for hearing according to subsection (C) shall be tolled until the Director's or designee's decision on the request for compromise, or
3. A grievance in accordance with the provider grievance provision in 9 A.A.C. 31, Article 8 of this Chapter.

**C. The Director or designee may impose a proposed penalty and assessment or any less severe penalty and assessment if a person does not request a hearing within the time prescribed by subsections (B)(2) or (B)(3). A person has no right to appeal a penalty and assessment if the person has not timely requested a hearing.**

**R9-31-1104. Issues and Burden of Proof**

**A. Preponderance of evidence. In any hearing conducted according to this Article, the Director or designee shall prove by a preponderance of the evidence that a person who requested a hearing presented or caused to be presented each claim or request for payment in violation of R9-31-1101. A person who requests a hearing shall bear the burden of producing and proving by a preponderance of the evidence any circumstance that would justify reducing the amount of the penalty and assessment.**

**B. Statistical sampling.**

1. The Director or designee may introduce the results of a statistical sampling study as evidence of the number and amount of claims or requests for payment that were presented or caused to be presented by the person in meeting the burden of proof described in subsection (A). A statistical sampling study shall constitute prima facie evidence of the number and amount of claims or requests for payment, if based upon an appropriate sampling and computed by valid statistical methods.
2. The burden of proof shall shift to the person to produce evidence reasonably calculated to rebut the findings of the statistical sampling study once the Director or designee has made a prima facie case as described in subsection (A). The Director or designee will be given the opportunity to rebut this evidence.

**ARTICLE 12. COVERED BEHAVIORAL HEALTH SERVICES**

**R9-31-1201. General Requirements**

- A.** The Administration shall administer the program as specified in A.R.S. § 36-2982 and behavioral health services shall be provided in compliance with A.R.S. § 36-2989 and this Chapter.
- B.** The Director has full operational authority to adopt rules or to use the appropriate rules adopted as specified in A.R.S. § 36-2986. Specifications in this Article shall apply to:
1. ADHS, RBHAs and a behavioral health provider under contract with a RBHA; and
  2. A contractor and its subcontracted behavioral health providers.
- C.** Behavioral health services shall be provided through an IGA with ADHS for a member enrolled with a RBHA and who is under 18 years of age, or is 18 years of age and determined SMI. ADHS shall:
1. Contract with a RBHA for the provision of, at a minimum, behavioral health services specified in this Article and in contract. A RBHA shall provide services directly or through subcontract with qualified service providers within and, if unavailable, outside their service areas.
  2. Use its established diagnostic and evaluation program for referral of a child who is not already enrolled and who may be in need of behavioral health services. In addition to an evaluation, the ADHS shall also identify a child who may be eligible under A.R.S. §§ 36-2901 or 36-2931 and shall refer the child to the appropriate agency responsible for making the final eligibility determination.
  3. Refer a member who is 18 years old who is not SMI to a member's assigned contractor for behavioral health services.
- D.** A contractor shall provide, at a minimum, behavioral health services specified in this Article and in contract for a member who is 18 years of age and is not SMI. A contractor shall:
1. Provide services directly or through subcontract with qualified behavioral health providers within and, if unavailable, outside their service areas.
  2. Refer a member who is under 18 years of age, or who is 18 years old and SMI, to a RBHA for behavioral health services.
  3. For a member other than an 18 year old non-SMI, emergency crisis stabilization services not to exceed three days per episode and 12 days per year contract year for a member not yet enrolled with a RBHA.
- E.** ADHS, its subcontractors and AHCCCS acute care contractors shall cooperate as specified in contract when a transition from one entity to another becomes necessary. For a Title XXI member, this transition shall include tracking and reporting of services used by a member toward the annual limitations prior to the transfer of care.
- F.** Behavioral health services provided to a member shall be medically necessary and provided in collaboration with the member's primary care provider.
- G.** Services shall be rendered in accordance with state and federal laws and regulations, the *Arizona Administrative Code* and AHCCCS contractual requirements.
- H.** Experimental services as determined by the Director, or services provided primarily for the purpose of research, shall not be covered.
- I.** Services or items, if furnished gratuitously, are not covered and payment shall be denied.
- J.** Behavioral health services shall not be covered if provided to:
1. An inmate of a public institution;
  2. A person who is a resident of an institution for the treatment of tuberculosis; or
  3. A person who is in an institution for the treatment of mental diseases at the time of application, or at the time of redetermination.
- K.** Services shall be provided by personnel or facilities, appropriately licensed or certified to provide the specific service and registered with AHCCCS.
- L.** Payment for services or items requiring prior authorization may be denied if prior authorization is not obtained.
1. Prior authorization for behavioral health services provided to a RBHA member shall be obtained from a RBHA in which a member is enrolled.
  2. A contractor shall provide prior authorization for a behavioral health service to be provided to a member not yet enrolled with a RBHA and an 18 year old non-SMI member.
  3. An emergency behavioral health service does not require prior authorization. Services for unrelated conditions, requiring additional diagnostic and treatment procedures, require additional prior authorization from the responsible contractor.
- M.** Behavioral health services rendered to a member shall be provided within the member's service area except when:
1. A covered service that is medically necessary for a member is not available within the service area;
  2. A net savings in behavioral health service delivery costs can be documented without requiring undue travel time or hardship for a member or a member's family;
  3. A member is placed in a treatment facility located out of the service area; or
  4. The service is otherwise authorized based on practice patterns, and cost or scope of service considerations.
- N.** When a member is traveling or temporarily residing out of the service area, covered services are restricted to emergency care, unless otherwise authorized by the member's RBHA or contractor.
- O.** If a member requests the provision of a behavioral health service that is not covered under these rules or is not authorized, the service may be rendered to a member by an AHCCCS-registered behavioral health service provider under the following conditions:
1. A document that lists the requested services and the itemized cost of each is prepared and provided to a member; and
  2. The signature of the member, or the member's guardian, is obtained in advance of service provision indicating that the services have been explained to the member or guardian and that the member or guardian accepts responsibility for payment.
- P.** If a member is referred out of the contractor's service area to receive an authorized medically necessary behavioral health service for an extended period of time, all other medically necessary covered services for the member shall also be provided by the contractor during that time.
- Q.** The restrictions, limitations, and exclusions in this Article shall not apply to a contractor and a ADHS RBHA when electing to provide a noncovered service.
1. The costs associated with providing any noncovered service to a member shall not be included in development or negotiation of capitation.

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

2. Noncovered services shall be paid from administrative revenue or other funds, unrelated to Title XXI services.
- R. Behavioral health and substance abuse disorders are covered services in this Article.
- S. The grievance and appeal process specified in 9 A.A.C. 31, Article 8 shall apply to behavioral health services.
- T. Payment terms and conditions specified in 9 A.A.C. 31, Article 7 shall apply to a contractor and a ADHS RBHA for behavioral health services.
- U. Quality management and utilization management requirements specified in 9 A.A.C. 31, Article 5 shall apply to a behavioral health service delivery.

**R9-31-1202. Inpatient Behavioral Health Services**

- A. Inpatient care shall include accommodations and appropriate staffing, supplies, equipment and behavioral health services. Services shall be provided in:
1. A general acute care hospital.
  2. A psychiatric hospital, or
  3. An inpatient psychiatric facility for persons under 21 years of age.
- B. The following limitations shall apply to inpatient care:
1. Services are limited to a maximum of 30 days during each contract year.
  2. Only psychiatrists, certified psychiatric nurse practitioners, and psychologists may bill independently for authorized services provided. All other services shall be included in the facility reimbursement rate. Professional services by psychiatrists, certified nurse practitioners, and psychologists, which are provided in an inpatient setting do not count toward the 30 day 30 visit annual limitation.
  3. Medical detoxification services may be initially authorized for up to 4 days. When medically necessary, additional days may be authorized if ordered by a psychiatrist or certified psychiatric nurse practitioner and approved by a Medical Director of a RBHA or a contractor.

**R9-31-1203. Partial Care**

- A. Partial care shall be provided on either an intensive or basic level of care as medically necessary to meet a member's needs for behavioral health treatment and prevent placement in a higher level of care or more restrictive environment.
- B. The following limitations shall apply to partial care services:
1. Services are counted toward the maximum of 30 days during each contract year.
    - a. Each full day of partial care, basic or intensive, counts as 1/2 day of inpatient care.
    - b. Each 1/2 day of partial care, basic or intensive, counts as 1/4 day of inpatient care.
  2. Intensive partial care services shall be limited to a member whose emotional, behavioral, or substance abuse problems indicates a serious emotional disturbance and or both evidence of abuse or neglect.
  3. Prevocational or vocational activities, school attendance and educational hours shall not be included as an intensive and basic partial care service and shall not be billed simultaneously with these services.

**R9-31-1204. Outpatient Services**

- A. Outpatient services as specified in contract shall include the following services:
1. Evaluation and diagnosis;
  2. Counseling including individual therapy, group and family therapy;

3. Behavior management; and
  4. Psycho-social rehabilitation.
- B. The following limitations shall apply to outpatient services:
1. The total number of all outpatient services shall not exceed a maximum of 30 visits during each contract year.
  2. Each outpatient service except group therapy or group counseling shall count as 1 visit. Each group therapy or group counseling service shall count as 1/2 visit.
  3. Only psychiatrists, certified psychiatric nurse practitioners and psychologists may bill independently for services provided.
  4. Other behavioral health professionals and behavioral health technicians shall be affiliated with, and their services billed through, a licensed behavioral health agency.

**R9-31-1205. Behavioral Health Emergency and Crisis Stabilization Services**

- A. Behavioral health emergency and crisis stabilization services may be provided on either an inpatient or outpatient basis by qualified personnel and be available 24 hours per day, 7 days per week in each RHBA's service area.
- B. Consultation provided by a psychiatrist, a certified psychiatric nurse practitioner, or a psychologist shall be covered as an emergency service if required to evaluate or stabilize an acute episode of mental illness or substance abuse.
- C. Limitations on behavioral health emergency or crisis stabilization services:
1. Contractors shall provide inpatient behavioral health emergency or crisis stabilization services not to exceed 3 days per episode and 12 days per year, from the time of a member's enrollment under Title XXI, for a member who is under age 18 or is 18 years old and SMI, but not enrolled with a RHBA.
  2. Inpatient service limitations shall apply to emergency or crisis stabilization services provided on an inpatient basis as specified in R9-31-1202(B).
  3. Emergency or crisis intervention services provided on an outpatient basis by a psychiatrist, certified psychiatric nurse practitioner, psychologist, or qualified facility shall not count towards the outpatient service limitation as specified in R9-31-1204(B)(1) and (2).

**R9-31-1206. Other Behavioral Health Services**

- The following services are covered but are not included in the visit limitations:
1. Laboratory and radiology services for behavioral health diagnosis and medication management;
  2. Psychotropic medication(s) included in the Title XXI formulary of a member's RBHA or contractor;
  3. Medication monitoring, administration and adjustment for psychotropic medications; and
  4. Case management to identify, obtain and coordinate Title XXI behavioral health services as specified in contract.

**R9-31-1207. Transportation Services**

- A. Emergency transportation shall be covered for behavioral health emergencies as specified in R9-31-211 and shall be limited to situations where there is an imminent threat of harm to the member if care is not rendered expeditiously.
- B. Non-emergency transportation for behavioral health services is excluded.

**ARTICLE 13. MEMBERS' RIGHTS AND RESPONSIBILITIES**

**R9-31-1301. General Provisions**

- A. The Administration shall administer the program as specified in A.R.S. § 36-2982.
- B. The Director has full operational authority to adopt rules or to use the appropriate rules adopted as specified in A.R.S. § 36-2986.
- C. This Article defines the notice and appeal process when a contractor reduces, suspends or terminates a service and provides a member with the opportunity for an expedited hearing.
- D. For the purpose of this Article:
  - 1. Contractor means a health plan, a qualifying plan, a RBHA or ADHS.
  - 2. Request for hearing means a clear expression by a member or an authorized representative that a member wants the opportunity to present the member's case to a reviewing authority.

**R9-31-1302. Denial of a Request for a Service**

A contractor shall provide a member with a written notice no later than 3 business days from the date when authorization for a requested service is denied by the party giving notice.

**R9-31-1303. Reduction, Suspension, or Termination of a Service**

Except as permitted under R9-31-1305 and R9-31-1306, a contractor shall provide a member with a written Notice of Intended Action at least 10 days prior to the date of the action by a contractor when there is a reduction, suspension, or termination of a service currently provided by a contractor.

**R9-31-1304. Content of Notice**

A notice, required under R9-31-1302 or R9-31-1303 of this Article, shall contain the following:

- 1. A statement of what action a contractor intends to take;
- 2. The succinct and specific reasons for the intended action;
- 3. The specific law or rule that supports the action, or a change in federal or state law that requires an action;
- 4. An explanation of:
  - a. A member's right to request an evidentiary hearing; and
  - b. The circumstances under which the Administration or a contractor shall grant a hearing in cases of an action based on a change in the law;
- 5. An explanation of the circumstance under which a contractor shall continue a covered service if a member requests a hearing to appeal an action for a:
  - a. Reduction,
  - b. Suspension, or
  - c. Termination of a service.

**R9-31-1305. Exceptions from an Advance Notice**

A contractor may mail a notice of a reduction, suspension, or termination of a service not later than the date of action if a contractor:

- 1. Has factual information that confirms the death of a member,
- 2. Receives a clear written statement signed by the member that:
  - a. Services are no longer wanted, or
  - b. Provides information which requires a reduction or termination of a service and indicates that a member understands that a reduction or termination of a

service shall be the result of providing that information.

- 3. Learns that a member has been admitted to an institution which makes a member ineligible for further services,
- 4. Does not know a member's whereabouts and the post office returns mail directed to a member indicating no forwarding address,
- 5. Has established a fact that a member has been accepted for Title XXI services outside the state of Arizona, or
- 6. Knows that a member's primary care provider has prescribed a change in the level of medical care.

**R9-31-1306. Notice in a Case of Probable Fraud**

A contractor may shorten the period of advance notice to 5 days before the date of action if:

- 1. The facts indicate that action should be taken because of probable fraud by a member; and
- 2. The facts have been verified through secondary resources, if possible.

**R9-31-1307. Expedited Hearing Process**

- A. Alternative hearing process. This Section provides an alternative expedited hearing process for denials defined in R9-31-113 and an alternative expedited hearing process and continued services for actions defined in R9-31-113. Except as stated in this Section, the provisions of 9 A.A.C. 31, Article 8 do not apply. If the Administration determines that a request for hearing filed according to this Section was not timely or not a proper appeal of a denial or action as defined in R9-31-113, the request for hearing shall instead be considered a grievance according to 9 A.A.C. 31, Article 8 and, if appropriate, forwarded to the contractor for processing according to 9 A.A.C. 31, Article 8. In this event, services shall not be continued as provided in this Section. If a member does not seek continued services or an expedited hearing, a member may file a grievance according to 9 A.A.C. 31, Article 8. A member shall not receive continued behavioral health services on appeal beyond the statutory limitation on such services.
- B. Time-frames. If a contractor determines to deny a service that requires authorization or determines to reduce, suspend, or terminate existing services; and a member desires to appeal the determination and either requests continued services during the hearing process or requests an expedited hearing of a denial for authorization, a member must file a request for hearing:
  - 1. No later than 10 business days from the date of personal delivery of the Notice of Intended Action to the member; or
  - 2. No later than 15 business days from the postmark date, if mailed, of the Notice of Intended Action.
- C. Expedited hearing. A hearing according to this Section shall be held no sooner than 20 days and not later than 40 days from the Administration's receipt of the request for hearing. Alternatively, the hearing may be held sooner than 20 days upon the agreement of all of the parties or upon a written motion of 1 of the parties establishing, in the discretion of the Administration, extraordinary circumstances or the possibility of irreparable harm if the hearing is not held sooner.
- D. Notice of hearing date. The Administration shall provide notice of the hearing date to the member or the authorized representative and to all other parties to the appeal.
- E. Responsibilities of a contractor. A contractor shall provide the current level of an existing service during the expedited hearing process, if a request for hearing and request to continue services are properly filed according to this Section.

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

- F.** Previously authorized service. If a member's primary care provider orders a service that has been previously authorized for a member, a contractor may issue a written denial according to R9-31-1302, if a contractor considers the request new and independent of any previous authorization. If a member's primary care provider asserts that the requested service or treatment is merely a necessary continuation of the previous authorization, and a member challenges the denial on this basis, then the service will be continued pending appeal, unless the parties reach some other agreement a contractor believes the primary care provider's request endangers the member. A contractor and a provider shall reserve any dispute over reimbursement until a later date when a provider submits a claim.
- G.** Responsibility of a member. A member whose service is continued during the expedited hearing process is financially liable for the service received if the Director upholds the decision to reduce, suspend, or terminate a member's service.
- H.** General provisions. The expedited hearing process shall be conducted according to A.A.C. R9-22-801(A),(E),(G), and (M)

**R9-31-1308. Maintenance of Records**

The party providing notice shall ensure that written records are maintained, that written notification was given to the member, including the date the notification was provided.

**R9-31-1309. Member Handbook**

A contractor shall furnish each member with a handbook that clearly explains a member's right to file a grievance or appeal concerning a denial or action that affects a member's receipt of medical services, as specified in contract.

**ARTICLE 14. RESERVED**

**ARTICLE 15. RESERVED**

**ARTICLE 16. SERVICES FOR NATIVE AMERICANS**

**R9-31-1601. General Requirements**

- A.** R9-31-1601 through R9-31-1624 apply to the acute care services provided to an enrolled member by IHS, a Tribal Facility, or a referral provider. R9-31-1618 through R9-31-1622 and R9-31-1625 apply to behavioral health services provided by the IHS, a Tribal Facility, RBHA or TRBHA.
- B.** As specified in A.R.S. § 36-2982, the Administration shall administer the program subject to the limitations on funding specified in A.R.S. § 36-2985.
- C.** As specified in A.R.S. § 36-2986, the Director has full operational authority to adopt rules or to use the appropriate rules adopted for this Article.
- D.** A Native American who is eligible for Title XXI may receive covered acute care services specified in this Article from:
1. An IHS Area Office as specified in A.R.S. § 36-2982 which has a signed IGA with the Administration.
  2. A Tribal Facility as specified in A.R.S. § 36-2982.
  3. A contractor which includes a health plan or a qualifying plan as defined in A.R.S. § 36-2981, or
  4. A qualifying health center as specified in A.R.S. § 36-2907.06.
- E.** The IHS and a Tribal Facility shall comply with:
1. Federal and state law;
  2. The IGA, if applicable; and
  3. The appropriate rules as specified in this Chapter.
- F.** An individual or an entity that provides covered services for the IHS or a Tribal Facility shall be a registered provider who meets the appropriate certification standards established by the Administration. A provider shall be responsible for:

1. Supervising, coordinating, and providing initial and primary care to the member;
  2. Initiating referrals for specialty care;
  3. Maintaining continuity of member care; and
  4. Maintaining an individual medical record for each assigned member.
- G.** The IHS and a Tribal Facility shall maintain medical records that:
1. Conform to professional medical standards and practices for documentation of medical, diagnostic and treatment data;
  2. Include a detailed record of:
    - a. All medically necessary services provided to a member by the IHS or a Tribal Facility.
    - b. All emergency services provided by a provider or a nonprovider for a member enrolled with the IHS or receiving services from a Tribal Facility, and
  3. Facilitate follow-up treatment.
- H.** As specified in A.R.S. §§ 36-2986 and 36-2992, the IHS or a Tribal Facility shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse.

**R9-31-1602. General Requirements for Scope of Services**

- A.** In addition to the requirements and the limitations specified in this Chapter, the following general requirements apply:
1. As specified in A.R.S. § 36-2989 and R9-31-1625, covered services provided to a member shall be medically necessary and provided by, or under the direction of, the IHS, a Tribal Facility, a provider, or a dentist. Specialist services shall be provided under referral from the IHS or a Tribal Facility provider.
  2. If the IHS can not provide a covered service due to the circumstances delineated in the signed Settlement Agreement CV-86-1105-PHX-RGS, a member shall be referred to a non-IHS provider or a non-IHS facility for the service and a referral form shall be completed and referred to the Administration based on procedures established by the Administration.
  3. Experimental services as determined by the Director, or services provided primarily for the purpose of research, shall not be covered;
  4. Services or items, if furnished gratuitously, are not covered and payment shall be denied;
  5. Personal care items are not covered and payment shall be denied; and
  6. Services shall not be covered if provided to:
    - a. An inmate of a public institution.
    - b. A person who is a resident of an institution for the treatment of tuberculosis.
    - c. A person who is in an institution for the treatment of mental diseases at the time of application or at the time of redetermination, or
    - d. A person prior to the date of eligibility.
- B.** Services shall be provided by AHCCCS registered personnel or facilities which are appropriately licensed or certified to provide the services.
- C.** Payment for services or items requiring prior authorization as defined in this Article may be denied if prior authorization from the Administration is not obtained. Emergency services do not require prior authorization.
1. Services for unrelated conditions, requiring additional diagnostic and treatment procedures, require additional prior authorization.
  2. Written documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.

**D.** As specified in A.R.S. § 36-2989, covered services rendered to a member shall be provided within the service area of the IHS or a Tribal Facility except when:

1. An IHS or a Tribal Facility refers a member out of the area for medical specialty care or behavioral health services.
2. A covered service that is medically necessary for a member is not available within the service area.
3. A member is placed in a nursing facility located out of the service area.

**E.** If a member requests the provision of a service that is not covered by the program or not authorized by the IHS or a Tribal Facility, the service may be rendered to a member by an AHCCCS-registered service provider under the following conditions:

1. A document lists the requested services and the itemized cost of each is prepared by a provider or a nonprovider and provided to a member, and
2. The signature of a member is obtained in advance of service provision indicating that the services have been explained to a member and that a member accepts responsibility for payment.

**F.** Noncovered services provided to a member by the IHS, a Tribal Facility or under referral may be paid by the IHS or a Tribal Facility, but not with Title XXI funds.

**R9-31-1603. Inpatient General Hospital Services**

**A.** Inpatient services provided in a general hospital may include:

1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
  - a. Maternity care.
  - b. Neonatal intensive care (NICU).
  - c. Intensive care (ICU).
  - d. Surgery.
  - e. Nursery.
  - f. Routine care, and
  - g. Behavioral health (psychiatric) care as specified in A.R.S. § 36-2989 and 9 A.A.C. 31, Article 12.
2. Ancillary services as specified by the Director:
  - a. Labor, delivery and recovery rooms, and birthing centers;
  - b. Surgery and recovery rooms;
  - c. Laboratory services;
  - d. Radiological and medical imaging services;
  - e. Anesthesiology services;
  - f. Rehabilitation services;
  - g. Pharmaceutical services and prescribed drugs;
  - h. Respiratory therapy;
  - i. Blood and blood derivatives;
  - j. Central supply items, appliances, and equipment not ordinarily furnished to all patients and which are customarily reimbursed as ancillary services;
  - k. Maternity services; and
  - l. Nursery and related services.

**B.** The following limitations apply to general inpatient hospital services that are provided by a fee-for-service provider and for which the Administration is financially responsible:

1. The cost of an inpatient hospital accommodation for a member shall be incorporated into the rate paid for the level of care in subsection (A)(1) of this Section.
2. Prior authorization shall be obtained from the Administration for a member referred out of the IHS or a Tribal Facility for the following inpatient hospital services provided to a member:
  - a. Non-emergency and elective admission, prior to the scheduled admission;

b. Elective surgery prior to the surgery;

c. An emergency hospitalization that exceeds 3 days or an intensive care unit admission that exceeds 1 day;

d. Hospitalization beyond the number of days initially authorized shall be covered only if determined medically necessary through the Administration's concurrent team review; or

e. A service or an item furnished to cosmetically reconstruct appearance after the on-set of trauma or serious injury shall be authorized prior to service delivery.

**R9-31-1604. Physician and Primary Care Physician and Practitioner Services**

**A.** Primary care services shall be furnished by a physician or a primary care practitioner. Primary care services may be provided in an inpatient or outpatient setting and shall include:

1. Periodic health examinations and assessments.
2. Evaluations and diagnostic workups.
3. Prescriptions for medications and medically necessary supplies and equipment.
5. Referrals to a specialist or other health care professional when medically necessary as specified in A.R.S. § 36-2989.
6. Patient education.
7. Home visits when determined medically necessary.
8. Covered immunizations, and
9. Covered preventive health services.

**B.** As specified in A.R.S. § 36-2989, a 2nd opinion procedure may be required to determine coverage for surgeries for a member referred out of the IHS or a Tribal Facility. Under this procedure, documentation must be provided by at least 2 physicians as to the need for the proposed surgery.

**C.** The following limitations and exclusions apply to physician and practitioner services and primary care provider services for a member referred out of the IHS or a Tribal Facility:

1. Specialty care and other services provided to a member upon referral from a primary care provider shall be limited to the services or conditions for which the referral is made, or for which authorization is given;
2. If a physical examination is performed with the primary intent to accomplish 1 or more of the objectives listed in subsection (A), it may be covered by the IHS or a Tribal Facility except if there is an additional or alternative objective to satisfy the demands of an outside public or private agency. Alternative objectives may include physical examinations and resulting documentation for:
  - a. Qualification for insurance.
  - b. Pre-employment physical evaluation.
  - c. Qualification for sports or physical exercise activities.
  - d. Pilot's examination (FAA).
  - e. Disability certification for establishing any kind of periodic payments.
  - f. Evaluation for establishing 3rd-party liabilities, or
  - g. Physical ability to perform functions that have no relationship to primary objectives listed in subsection (A).
3. The following services shall be excluded from Title XXI coverage:
  - a. Infertility services, reversal of surgically induced infertility (sterilization), and sex change operations;
  - b. Services or items furnished solely for cosmetic purposes;

- c. Hysterectomies, unless determined to be medically necessary;
- d. Abortion counseling or abortion except according to federal law;
- e. Chiropractic services; and
- f. Licensed midwife service for prenatal care and home births.

**R9-31-1605. Organ and Tissue Transplantation Services**

- A. The following organ and tissue transplantation services are covered for a member as specified in A.R.S. § 36-2989 if prior authorized by the Administration:
  - 1. Kidney transplantation.
  - 2. Simultaneous Kidney/Pancreas transplant.
  - 3. Cornea transplantation.
  - 4. Heart transplantation.
  - 5. Liver transplantation.
  - 6. Autologous and allogenic bone marrow transplantation.
  - 7. Lung transplantation.
  - 8. Heart-lung transplantation, and
  - 9. Other organ transplantation if the transplantation is required by federal law and if other statutory criteria are met.
- B. Immunosuppressant medications, chemotherapy, and other related services provided in an IHS, a Tribal Facility, or by a referral provider do not need to be prior authorized.

**R9-31-1606. Dental Services**

Medically necessary dental services shall be provided for children under age 19 as specified in A.R.S. § 36-2989.

**R9-31-1607. Laboratory, Radiology, and Medical Imaging Services**

As specified in A.R.S. § 36-2989, laboratory, radiology, and medical imaging services may be covered services if:

- 1. Prescribed for a member by an IHS, a Tribal Facility care provider or a dentist, or if prescribed by a physician or a practitioner upon referral from the IHS, a Tribal Facility provider or a dentist;
- 2. Provided in a hospital, a clinic, a physician office, or other health care facility by IHS or a Tribal Facility provider; or
- 3. Provided by an IHS or a Tribal Facility provider that meets all applicable state and federal license and certification requirements and provides only services that are within the scope of practice stated in a provider's license or certification.

**R9-31-1608. Pharmaceutical Services**

- A. Pharmaceutical services may be provided by the IHS, a Tribal Facility, or under referral from an IHS or a Tribal Facility provider.
- B. As specified in A.R.S. § 36-2989, pharmaceutical services shall be covered if prescribed for a member by the IHS, a Tribal Facility provider or a dentist, or if prescribed by a specialist upon referral from the IHS or a Tribal Facility provider.
- C. The following limitations shall apply to pharmaceutical services:
  - 1. A medication personally dispensed by a physician or a dentist is not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
  - 2. A prescription in excess of a 30-day supply or a 100-unit dose is not covered unless:
    - a. The medication is prescribed for chronic illness and the prescription is limited to no more than a

- 100-day supply or 100-unit dose, whichever is more.
- b. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.
- c. A member lives in an area not readily accessible to a pharmacy and the prescription is limited to 100-days or 100-unit dose, whichever is more.

- 3. A nonprescription medication is not covered unless an appropriate alternative over the counter medication is available and less costly than a prescription medication.
- 4. A prescription is not covered if filled or refilled in excess of the number specified, or if an initial prescription or refill is dispensed after 1 year from the original prescribed order.
- 5. Approval by an authorized prescriber is required for all changes in, or additions to, an original prescription. The date of a prescription change is to be clearly indicated and initialed by a dispensing pharmacist.

- D. The IHS or a Tribal Facility shall monitor and take necessary actions to ensure that a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being, is provided sufficient services to eliminate any gap in the required pharmaceutical regimen.

**R9-31-1609. Emergency Services**

Emergency medical services provided by the IHS, a Tribal Facility, or a referral provider outside the service area shall be provided based on the prudent layperson standard to a member by the IHS or a Tribal Facility provider registered with AHCCCS to provide services as specified in A.R.S. § 36-2989.

**R9-31-1610. Transportation Services**

- A. Emergency ambulance services.
  - 1. As specified in A.R.S. § 36-2989, emergency ambulance transportation services shall be a covered service for a member. Payment shall be limited to the cost of transporting a member in a ground or air ambulance:
    - a. To the nearest appropriate provider or medical facility capable of meeting a member's medical needs, and
    - b. When no other means of transportation is both appropriate and available.
  - 2. A ground or an air ambulance transport that originates in response to a 9-1-1 call or other emergency response system shall be reimbursed by the Administration for a member if the medical condition at the time of transport justified a medically necessary ambulance transport. No prior authorization is required for reimbursement of these transports.
  - 3. Determination of whether transport is medically necessary shall be based upon the medical condition of a member at the time of transport.
  - 4. Notification to the Administration of emergency transportation provided is not required but a provider shall submit documentation with the claim which justifies the service.
- B. Air ambulance services shall be covered only if:
  - 1. The air ambulance transport is initiated upon the request of an emergency response unit, a law enforcement official, a hospital, a clinic medical staff member, the IHS or a Tribal Facility provider, a physician, or a practitioner;
  - 2. The point of pickup is inaccessible by ground ambulance, or great distances, or other obstacles are involved

*Arizona Administrative Register*  
**Notices of Exempt Rulemaking**

- in getting emergency services to a member or transporting a member to the nearest hospital or other provider with appropriate facilities; and
3. The medical condition of a member requires timely ambulance service and ground ambulance service will not suffice.
- C. Medically necessary member transfers provided by an emergency air or a ground transportation provider may be covered when a member receiving inpatient services requires transport to another level of care or requires round trip transport to another facility to obtain necessary specialized diagnostic treatment services if:**
1. A member's condition is such that the use of any other method of transportation would be harmful to a member's health, and
  2. Services are not available in the facility where a member is a patient.
- D. Meals, lodging and escort services.**
1. Expenses for meals and lodging for a member while en route to, or returning from, an approved and prior authorized health care service site out of a member's service area shall be a Title XXI covered service.
  2. Expenses of an escort, who may be a family household member accompanying a member out of a member's service area shall be covered if the services of an escort are ordered in writing by an IHS or a Tribal Facility provider, an attending physician or a practitioner.
  3. Meals, lodging and escort services provided by a provider shall be prior authorized by the Administration.
- E. Limitations.**
1. Expenses shall be allowed only when a member requires a covered service that is not available in the service area;
  2. If a member is admitted to an inpatient facility, expenses for an escort shall be covered only when accompanying a member en route to, and returning from, the inpatient facility; and
  3. A salary for an escort shall be covered if an escort is not a part of a member's family household.
- F. Non-emergency transportation services are not covered as specified in A.R.S. § 36-2989.**
- R9-31-1611. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices**
- A. As specified in A.R.S. § 36-2989, medical supplies, durable equipment, and orthotic and prosthetic devices shall be covered services if prescribed for a member by the IHS or a Tribal Facility provider or if prescribed by a physician or a practitioner upon referral from the IHS or a Tribal Facility provider unless referral is waived by a contractor.**
- B. Medical supplies include consumable items covered under Medicare that are provided to a member and that are not reusable.**
- C. Medical equipment includes any durable item, an appliance, or a piece of equipment that is designed for a medical purpose, is generally reusable by others, and is purchased or rented for a member.**
- D. Prosthetic and orthotic devices include only those items that are essential for the habilitation or rehabilitation of a member.**
- E. The following limitations apply:**
1. If medical equipment cannot be reasonably obtained from alternative resources at no cost, the medical equipment shall be furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the equipment shall not exceed the cost of the equipment if purchased.
2. Reasonable repair or adjustment of purchased medical equipment shall be covered if necessary to make the equipment serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.
  3. Changes in, or additions to, an original order for medical equipment shall be approved by a member's IHS or a Tribal Facility provider or an authorized prescriber and shall be indicated clearly and initialed by a vendor.
  4. Rental fees shall terminate:
    - a. No later than the end of the month in which the IHS or a Tribal Facility provider or an authorized prescriber certifies that a member no longer needs the medical equipment.
    - b. When a member is no longer eligible for Title XXI service, or
    - c. When a member is no longer enrolled with the IHS with the exception of transitions of care as specified by the Director.
  5. Personal incidentals including items for personal cleanliness, body hygiene, and grooming shall not be covered unless needed to treat a medical condition and provided according to a prescription.
  6. First aid supplies shall not be covered unless they are provided according to a prescription.
- F. Liability and ownership.**
1. Purchased durable medical equipment provided to a member but which is no longer needed may be disposed of as specified in the policy of the IHS or a Tribal Facility.
  2. If customized durable medical equipment is purchased for a member, the equipment will remain with the member during times of transition, or upon loss of eligibility.
    - a. For purposes of this Section, customized durable medical equipment refers to equipment that has been altered or built to specifications unique to a member's medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.
    - b. Customized equipment obtained fraudulently by a member shall be returned for disposal to the Administration.
- G. A provider shall obtain prior authorization from the Administration before providing the following services to a member referred out of the IHS or a Tribal Facility:**
1. Consumable medical supplies exceeding \$50.00 per month.
  2. Durable medical equipment, prosthetic or orthotic devices for a member for all rentals if the cost to purchase the equipment or device exceeds \$200.00.
- R9-31-1612. Health Risk Assessment and Screening Services**
- A. As specified in A.R.S. § 36-2989, the following services shall be covered for a member less than 19 years of age:**
1. Screening services, including:
    - a. Comprehensive health, behavioral health and developmental histories;
    - b. Comprehensive unclothed physical examination;
    - c. Appropriate immunizations according to age and health history; and
    - d. Health education, including anticipatory guidance.
  2. Vision services as specified in A.R.S. § 36-2989 including:
    - a. Treatment for medical conditions of the eye.
    - b. 1 eye examination per contract year, and
    - c. Provision of 1 pair of prescriptive lenses per contract year.

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

3. Hearing services, including:
  - a. Diagnosis and treatment for defects in hearing.
  - b. Testing to determine hearing impairment, and
  - c. Provision of hearing aids.

- B.** All providers of services shall meet the following standards:
1. Provide services by or under the direction of a member's IHS or a Tribal Facility provider or a dentist.
  2. Perform tests and examinations in accordance with the Administration's Periodicity Schedule.
    - a. Refer a member as necessary for dental diagnosis and treatment, and necessary specialty care;
    - b. Refer a member as necessary for behavioral health evaluation and treatment services as specified in this Article.
- C.** The IHS or a Tribal Facility shall meet the following additional conditions for a member:
1. Provide information to a member and a member's parent or guardian concerning services, and
  2. Notify a member and a member's parent or guardian regarding the initiation of screening and subsequent appointments according to the Administration's Periodicity Schedule.
- D.** A member with special health care needs may be referred to the Children's Rehabilitative Service program.

**R9-31-1613. Other Medical Professional Services**

- A.** The following medical professional services provided to a member by the IHS or a Tribal Facility or for a member referred out of the IHS or a Tribal Facility shall be covered services as specified in A.R.S. § 36-2989 when provided in an inpatient, an outpatient, or an office setting within limitations specified below:
1. Dialysis;
  2. Family planning services including medications, supplies, devices, and surgical procedures provided to delay or prevent pregnancy. Family planning services are limited to:
    - a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service; and
    - b. Natural family planning education or referral.
  3. Midwife services provided by a certified nurse practitioner;
  4. Podiatry services when ordered by an IHS or a Tribal Facility provider;
  5. Respiratory therapy;
  6. Ambulatory and outpatient surgery facilities services;
  7. Home health services;
  8. Private or special duty nursing services when medically necessary and prior authorized;
  9. Rehabilitation services including physical therapy, occupational therapy, audiology and speech therapy within limitations in this Article;
  10. Total parenteral nutrition services; and
  11. Chemotherapy.
- B.** The Administration shall prior authorize services in subsections (A)(4) through (A)(10) of this Section for a member referred out of the IHS or a Tribal Facility.

**R9-31-1614. Nursing Facility Services**

- A.** Nursing facility services including room and board shall be covered for a maximum of 90 days per contract year if the medical condition of a member is such that, if nursing facility

services are not provided, hospitalization of an individual would result.

- B.** Except as otherwise provided in 9 A.A.C. 28, the following services shall be excluded for purpose of separate billing if provided in a nursing facility:

1. Nursing services including but not limited to:
    - a. Administration of medication,
    - b. Tube feedings,
    - c. Personal care services (assistance with bathing and grooming),
    - d. Routine testing of vital signs, and
    - e. Maintenance of catheters.
  2. Basic patient care equipment and sickroom supplies, including, but not limited to:
    - a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over the counter remedies;
    - b. Bathing and grooming supplies;
    - c. Identification devices;
    - d. Skin lotions;
    - e. Medication cups;
    - f. Alcohol wipes, cotton balls, and cotton rolls;
    - g. Rubber gloves (non sterile);
    - h. Laxatives;
    - i. Beds and accessories;
    - j. Thermometers;
    - k. Ice bags;
    - l. Rubber sheeting;
    - m. Passive restraints;
    - n. Glycerin swabs;
    - o. Facial tissue;
    - p. Enemas;
    - q. Heating pads; and
    - r. Diapers.
  3. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating;
  4. Any services that are included in a nursing facility's room and board charge or services that are required of a nursing facility to meet federal mandates, state licensure standards, or county certification requirements;
  5. Physical therapy; and
  6. Assistive devices and durable medical equipment.
- C.** Each nursing facility admission out of the IHS or a Tribal Facility's service area shall be prior authorized by the Administration.

**R9-31-1615. Eligibility and Enrollment**

The eligibility and enrollment provisions specified in 9 A.A.C. 31, Article 3 apply to a Native American who elects to receive services through the IHS or a Tribal Facility.

**R9-31-1616. Standards for Payments**

- A.** The Administration shall bear no liability for providing covered services to or completing a plan of treatment for any member beyond the date of termination of a member's eligibility or enrollment as specified in A.R.S. § 36-2987.
- B.** The Administration shall make payments to the IHS, a Tribal Facility, or under referral from an IHS or a Tribal Facility provider based on the Administration's capped fee schedule as specified in 9 A.A.C. R9-22-710 for outpatient services.
- C.** The Administration shall make payments to the IHS or a Tribal Facility based on the all inclusive inpatient rates published in the *Federal Register*.
- D.** The Administration shall pay inpatient and outpatient hospital services provided by a provider under referral from the

**Arizona Administrative Register**  
**Notices of Exempt Rulemaking**

IHS or a Tribal Facility provider based on A.R.S. §§ 36-2987, 36-2904, 36-2903.01, 9 A.A.C. R9-22-712 and A.A.C. R9-22-718 as applicable. Discounts and penalties shall be as specified in A.R.S. § 36-2987(C).

- E.** The Administration shall bear no liability for a subcontract that the IHS or a Tribal Facility executes with other parties for the provision of administrative or management services, medical services, or covered health care services, or for any other purpose. The IHS or a Tribal Facility shall indemnify and hold the Administration harmless from any and all liability arising from the IHS or a Tribal Facility's subcontracts, shall bear all costs of defense of any litigation over the liability, and shall satisfy in full any judgment entered against the Administration in litigation involving the IHS or a Tribal Facility's subcontracts.

**R9-31-1617. Prior Authorization**

A provider and a nonprovider shall request prior authorization from the Administration according to this Article. The following inpatient hospital services provided to a member enrolled with the IHS out of the IHS or a Tribal Facility require prior authorization from the Administration:

1. Nonemergency and elective admission, shall be authorized prior to admission;
2. Elective surgery, excluding voluntary sterilization, shall be authorized prior to the surgery;
3. An emergency hospitalization that exceeds 3 days or an intensive care admission that exceeds 1 day;
4. Hospitalization beyond the number of days initially authorized shall be covered only if determined medically necessary through the Administration's concurrent team review; and
5. Services or items furnished to cosmetically reconstruct appearance after the on-set of trauma or serious injury shall be authorized prior to service delivery.

**R9-31-1618. Claims**

**A.** Claims submission to the Administration.

1. The IHS, a Tribal Facility, a TRBHA, or a provider under referral shall ensure that a claim for covered services provided to a member is initially received by the Administration not later than 9 months from the date of service or 9 months from the date of eligibility posting, whichever is later. The Administration shall deny a claim not received within the 9 month period from the date of service or 9 months from the date of eligibility posing, whichever is later. If a claim meets the 9 month limitation, the IHS, a Tribal Facility, a TRBHA, or a provider under referral shall file a clean claim which is received by the Administration not later than 12 months from the date of service or 12 months from the date of eligibility posting, whichever is later.
2. The 9 and 12 month deadlines for an inpatient hospital claim begin on the date of discharge for each claim.

**B.** Claims processing.

1. If a claim contains erroneous or conflicting information, exceeds parameters, fails to process correctly, does not match the Administration's files, or requires manual review to be resolved, the Administration shall report the claim to a provider with a remittance advice.
2. The Administration shall process a hospital claim in accordance with 9 A.A.C. R9-22-712.

- C.** Overpayments for Title XXI services. An IHS or a Tribal Facility provider, a nonprovider, or a Tribal Facility, shall notify the Administration if a Title XXI overpayment is made. The Administration shall recoup an overpayment from

a future claim cycle, or, at the discretion of the Director, require the IHS or a Tribal Facility provider or a nonprovider, to return the incorrect payment to the Administration.

**R9-31-1619. Hospital Claims Review**

The IHS and a Tribal Facility shall follow the procedures for a hospital claims review as specified in 9 A.A.C. R9-22-717.

**R9-31-1620. Prohibitions Against Charges to Members**

- A.** The IHS or a Tribal Facility or other provider of care or services shall not charge, submit a claim, demand, or otherwise collect payment from a member or a person acting on behalf of a member for any covered service except to collect an authorized copayment or payment for additional services. The Administration shall have the right to recover from a member that portion of payment made by a 3rd-party to a member when the payment duplicates Title XXI paid benefits and has not been assigned to the IHS or a Tribal Facility. The IHS or a Tribal Facility who makes a claim under this provision shall not charge more than the actual, reasonable cost of providing the covered services.
- B.** An IHS or a Tribal Facility provider shall not bill or make any attempt to collect payment, directly or through a collection agency, from an individual claiming to be Title XXI eligible without 1st receiving verification from the Administration that the individual was ineligible for Title XXI on the date of service or that the services provided were not covered by Title XXI as specified in A.R.S. § 36-2989.

**R9-31-1621. Transfer of Payments**

Payments permitted. Payments may be made to other than the IHS, a Tribal Facility, or a referral provider as follows:

1. Payment made in accordance with an assignment to a government agency or an assignment made according to a court order; or
2. Payment made to a business agent, such as a billing service or accounting firm, who renders statements and receives payment in the name of the IHS, a Tribal Facility, or a provider providing that an agent's compensation for this service is:
  - a. Reasonably related to the cost of processing the statements, and
  - b. Not dependent upon the actual collection of payment.

**R9-31-1622. The Administration's Liability to Hospitals for the Provision of Emergency and Subsequent Care**

- A.** Liability to the Administration for an emergency medical condition of a member who is provided care outside the IHS or a Tribal Facility's service area shall be subject to reimbursement only until a member's condition is stabilized and a member is transferable, or until a member is discharged following stabilization subject to the requirements of A.R.S. § 36-2989.
- B.** Subject to subsection (A) of this Section, if a member cannot be transferred following stabilization to the IHS or a Tribal Facility, the Administration shall pay for all appropriately documented, prior authorized, and medically necessary treatment provided to a member before the date of discharge or transfer according to payment standards in R9-31-705.
- C.** If a member refuses transfer from a nonprovider or a noncontracting hospital to the IHS or a Tribal Facility, the Administration shall not be liable for any costs incurred after the date of refusal if:
1. After consultation with a member's IHS or a Tribal Facility, a member continues to refuse the transfer; and

*Arizona Administrative Register*  
**Notices of Exempt Rulemaking**

2. A member has been provided and signs a written statement, before the date of transfer of liability, informing a member of the medical and financial consequences of refusing to transfer. If a member refuses to sign a written statement, a statement signed by 2 witnesses indicating that a member was informed may be substituted.

**R9-31-1623. Copayments**

- A. The IHS or a Tribal Facility shall be responsible for collecting a \$5.00 copayment from a member for non-emergency use of the emergency room.
- B. The IHS or a Tribal Facility shall ensure that a member is not denied services because of a member's inability to pay a copayment.

**R9-31-1624. Specialty Contracts**

The Director may at any time negotiate or contract for specialized hospital and medical services including, but not limited to, transplants, neonatology, neurology, cardiology, and burn care. Specialty contractors shall take precedence over all other contractual arrangements between the IHS or a Tribal Facility. If the Administration and a hospital perform a transplant surgery on a member that does not have a contracted rate, the system shall not reimburse a hospital more than the contracted rate established by the Administration.

**R9-31-1625. Behavioral Health Services**

- A. The IHS, a contractor, a TRBHA, a RBHA or a Tribal Facility may provide any or all of the behavioral health services specified in 9 A.A.C. 31, Article 12, subject to the limitations and specifications stated in 9 A.A.C. 31, Article 12, to a Native American who is eligible for Title XXI services.
- B. It is the responsibility of the IHS, a Tribal Facility, a contractor, a TRBHA or a RBHA to monitor the limitations and specifications prescribed in 9 A.A.C. 31, Article 12. Services provided in excess of the limitations and specifications prescribed in 9 A.A.C. 31, Article 12 shall not be reimbursed by the Administration.
- C. The IHS, a Tribal Facility, a contractor, a TRBHA or a RBHA shall cooperate as specified in contract IGA, or this Chapter when the transition from 1 entity to another becomes necessary. For a Title XXI member, this transition shall include tracking and reporting of services used by a member toward the annual limitations prior to the transfer of care.
- D. The IHS and a Tribal Facility shall be considered a provider for the provision of behavioral health services and shall be subject to the requirements of:
  1. A TRBHA if 1 is operating in a service area, or
  2. A RBHA in a service area that does not have a TRBHA or a contractor for a Native American member with respect to prior authorization and service authorizations.
- E. If either the IHS or a Tribal Facility cannot provide a non-emergency inpatient or an outpatient behavioral health ser-

vice, the IHS or a Tribal Facility shall determine if a member is:

1. Less than 18 years old or 18 years old and SMI. A member who is less than 18 years old or 18 years old and SMI, shall be referred to either a TRBHA or a RBHA for the provision of all nonemergency behavioral health services.
  2. 18 years old and not SMI. For a member who is 18 years old and not SMI, the IHS or a Tribal Facility must determine if a member is enrolled with a contractor or the IHS. Depending on the enrollment, a referral shall be done in the following manner for nonemergency behavioral health services:
    - a. If a member is enrolled with a contractor, the IHS or a Tribal Facility shall refer a member to a contractor for the provision of all nonemergency behavioral health services.
    - b. If a member is enrolled with IHS, the IHS shall refer a member to an appropriate provider for all nonemergency behavioral health services. A Tribal Facility shall refer a member to IHS and IHS shall refer a member to an appropriate provider.
- E. Behavioral health emergency and crisis stabilization services shall be handled as follows:
1. If a member is enrolled with the IHS or a contractor and is not enrolled with a TRBHA or a RBHA, the IHS or a contractor is responsible for the provision of emergency behavioral health services. For an 18 year old, non SMI member, the IHS or a contractor is responsible for all medically necessary treatment subject to the 30 day, 30 visit limitation. For a member under age 18, or an 18 year old SMI member, the IHS or a contractor is responsible for up to 3 days per admission, not to exceed 12 days per contract year, and shall refer a member to a TRBHA or a RBHA.
  2. Inpatient service limitations shall apply to emergency or crisis stabilization services provided on an inpatient basis.
  3. Emergency or crisis intervention services provided on an outpatient basis by a psychiatrist, a certified psychiatric nurse practitioner, a psychologist, or a qualified facility shall not count towards the outpatient service limitation.
- G. Prior authorization must be obtained for all inpatient hospitalizations and partial care services as authorized in R9-31-1202 and R9-31-1203.
- H. A provider shall comply with the requirements specified in subsections (B), (C) & (D) of this Section or payment may be denied, or if paid, may be recouped by the Administration.
- I. A behavioral health service provided by the IHS or a Tribal Facility shall be reimbursed as specified in R9-31-1616.