

Notices of Final Rulemaking

This rule becomes effective upon filing with the Secretary of State. This immediate effective date is allowed under A.R.S. § 41-1032(A)(1) and A.R.S. § 41-1032 (A)(2). This rulemaking will help to preserve public health and safety by requiring more detailed and current continuing education requirements which help to ensure that licensees remain up-to-date in their practice. The rulemaking also avoids violation of federal law by implementing new federal requirements for contact lens prescriptions.

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

Notice of Rulemaking Docket Opening: 10 A.A.R. 3664, September 3, 2004

Notice of Proposed Rulemaking: 10 A.A.R. 4238, October 22, 2004

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

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6. An explanation of the rule, including the agency's reason for initiating the rule:

This rulemaking is for the purpose of correcting certain inadvertent typographical errors contained in the rules approved at the March 2005 meeting. The Board is amending 4 A.A.C. 21 to update its rules by addressing licensing and regulatory changes made by Laws 2001, Chapter 331 and Laws 2003, Chapter 5. Specifically, the rules are amended to accurately reflect optometric standards and practices, current Board policy, consistency with state statutes, and rulemaking format and style requirements. In addition, this rulemaking will update language and terminology used in the rules to improve consistency and clarity. Changes include:

- A. Delegating licensing and regulation duties to the Executive Director,
- B. Clarifying endorsement and regular application processes,
- C. Modifying the license renewal process and prorated renewal fees,
- D. Updating approval of continuing education programs,
- E. Clarifying licensee record retention,
- F. Technical corrections, and
- G. Defining new terminology.

Some definitions are amended and new definitions are added in R4-21-101 so that intended audiences may use the rules effectively and consistently. R4-21-102 is repealed because it duplicates statute. R4-21-103 is amended to allow proration of licensing fees and establish a new late renewal fee, verification fees, and receipt fees. The prorated licensing fees are implemented to promote equitable fees based upon the date of license issuance and birthday renewal. R4-21-201 through R4-21-204 are amended to reflect statutory changes and current licensing and renewal practices. R4-21-206 is being amended to comply with statutory changes regarding certificates of special qualification. R4-21-207 is amended to comply with statutory changes regarding certificates of special qualification. R4-21-208 updates continuing education requirements to current standards and new statute. R4-21-209 is rewritten for clarity and conformance with current board policy. R4-21-210 is repealed. R4-21-301 through R4-21-303 are amended to conform to statutory changes and rule writing style requirements. R4-21-304 and R4-21-305 are amended to conform to current federal & state regulatory practices, statutory changes, and style. R4-21-306 is amended to accurately reflect the current industry practice. R4-21-307 is repealed. R4-21-308 is amended to reflect current statute. Article 4 is repealed to reflect current statute. Article 5 is added to define Executive Director duties.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The agency did not review any study relevant to the rule.

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:

Annual cost/revenue changes are designated as minimal when less than \$1,000, moderate when between \$1,000 and \$10,000, and substantial when greater than \$10,000.

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This rulemaking impacts applicants, licensed optometrists, consumers seeking treatment, patients of licensed optometrists, continuing medical education providers, and the Board.

Most of the rulemaking clarifies the current rules and thus, amends existing requirements already established in rule.

The overall economic impact of the rulemaking is expected to be moderate with the benefits outweighing the costs. The retention of requirements already in rule should have little or no direct impact. New requirements for approval of continuing education should have a minimal impact as they allow better access to more quality programs.

The approximately 870 individuals currently licensed in the state will be affected by the rules. A licensee will bear no additional costs in the form of fees with the exception of those not renewing on time.

The Board will bear moderate costs to implement the change mandated by statute with certificates of special qualification because statute requires notice to the pharmacy industry.

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

Non-substantive clarifying, grammatical and technical changes were made to the rule. Many of these changes were made at the suggestion of the Governor's Regulatory Review Council staff. In addition, changes were made to the contact lens prescription portion of the rules as specified in #11.

11. A summary of the comments made regarding the rule and the agency response to them:

The Board received written comment from the Arizona Optometric Association regarding R4-21-305, requesting that certain changes be made to clarify that contact lenses presented for cosmetic reasons are ophthalmic devices and that certain information requested in an optometric prescription be added. The Board has incorporated those requested amendments into this rulemaking. These changes are required by federal law, the Fairness to Contact Lens Consumers Act.

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

None

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

None

14. Was this rule previously made as an emergency rule?

No.

15. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 21. BOARD OF OPTOMETRY

ARTICLE 1. GENERAL PROVISIONS

Section

R4-21-101.	Definitions
R4-21-102.	Meetings <u>Repealed</u>
R4-21-103.	Fees

ARTICLE 2. LICENSING PROVISIONS

Section

R4-21-201.	Licensure
R4-21-202.	License Examination and Appeal
R4-21-203.	Time-frames for Licensure, Renewal of License, Certificates of Special Qualification, and Course of Study Approval
R4-21-204.	License Renewal
R4-21-205.	Course of Study Approval
R4-21-206.	<u>Use of Pharmaceutical Agent Agents Certificate of Special Qualification</u>
R4-21-207.	<u>Submission of Fee</u> ; Issuance and Display of License; Surrender of License
R4-21-208.	Continuing Education Requirements; Program Criteria and Procedures
R4-21-209.	Discretionary Exemption
R4-21-210.	<u>Equipment and Supplies Repealed</u>
Table 1.	Time-frames (in calendar days)

ARTICLE 3. REGULATORY PROVISIONS

Section

- R4-21-301. Styles of Optometric Practice; Staff Responsibility
- R4-21-302. ~~False Advertising~~
- R4-21-303. ~~Affirmative Disclosures in Advertising and Practice; Warranties, Service, or Ophthalmic Goods Replacement Agreements~~
- R4-21-304. ~~Vision Examination Standards; Records~~
- R4-21-305. ~~Prescription Standards; Release to Patients~~
- R4-21-306. ~~Low-Vision Rehabilitation and Vision Therapy~~
- R4-21-307. ~~Subpoenas Repealed~~
- R4-21-308. ~~Rehearing or Review of Administrative Decision~~

ARTICLE 4. PUBLIC PARTICIPATION PROCEDURES Repealed

Section

- R4-21-401. ~~Agency Record; Directory of Substantive Policy Statements Repealed~~
- R4-21-402. ~~Petition for Rulemaking; Review of Agency Practice or Substantive Policy Statement; Objection to Rule Based Upon Economic, Small Business or Consumer Impact Repealed~~
- R4-21-403. ~~Public Comments Repealed~~
- R4-21-404. ~~Oral Proceedings Repealed~~
- R4-21-405. ~~Petition for Delayed Effective Date Repealed~~
- R4-21-406. ~~Written Criticism of Rule Repealed~~

ARTICLE 5. EXECUTIVE DIRECTOR DUTIES

Section

- R4-21-501. Issuing Licenses
- R4-21-502. Denial of License
- R4-21-503. Issuing Subpoenas
- R4-21-504. Continuing Education Approval

ARTICLE 1. GENERAL PROVISIONS

R4-21-101. Definitions

In addition to the definitions established in A.R.S. § 32-1701, the following terms apply to this Chapter:

1. ~~“Accredited” means that an educational institution is officially approved by the New England Association of Schools and Colleges, Middle States Association of Colleges and Secondary Schools, North Central Association of Colleges and Schools, Northwest Association of Schools and Colleges, Southern Association of Colleges and Schools, Western Association of Schools and Colleges, or the American Optometric Association Council on Optometric Education to offer courses in optometry. “ACOE” means the Accreditation Council on Optometric Education.~~
2. ~~“Application” means forms, documents, and additional information the Board requires to be submitted by an individual who requests licensure. “Applicant” means an individual who applies for a license to practice optometry in this state under A.R.S. §§ 32-1722 and 32-1723, but has not yet been granted the license.~~
3. ~~“Board” means the state board of optometry. A.R.S. § 32-1701 (1)~~
- 4.3. ~~“Certificate of special qualification” means a document that specifies that the holder may prescribe, administer, and dispense one or more of pharmaceutical agent categories identified in A.R.S. § 32-1728 (B) (1), (2), or (3) or may practice optometry without the use of pharmaceutical agents allows the holder to practice in a specific area of optometry specified in A.R.S. §32-1728.~~
4. ~~“Correspondence course” means continuing education delivered by video, audio, electronic or digital means, scientific journals or periodicals, or any other media as approved by the Board.~~
5. ~~“Incompetence” means: lack of professional skill, fidelity, or physical or mental fitness, or substandard examination or treatment while practicing the profession of optometry.~~
 - a. ~~Lack of professional skill or fidelity in performing the practice of optometry;~~
 - b. ~~Treatment in a manner contrary to accepted optometric practices, or~~
 - c. ~~Lack of physical or mental fitness to discharge professional duties.~~
6. ~~“Licensure by examination” means an applicant meets the examination requirements of A.R.S. §32-1724. “Negligence” means conduct that falls below the standard of care for the protection of patients and the public against unrea-~~

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sonable risk of harm and that is a departure from the conduct expected of a reasonably prudent licensee under the circumstances.

7. "Licensure by reciprocity" means an applicant satisfies all of the requirements of A.R.S. §32-1723.
- 8.7. "Low-vision rehabilitation" means evaluation, diagnosis, management, and treatment of a limited vision, including the prescribing of corrective spectacles, contact lenses, prisms, or filters; or the employment of any means for the adaptation of lenses.
9. "National Board" means the National Board of Examiners in Optometry.
10. "National Board Exam" means the optometry examination administered by the National Board.
- 11.8. "Pharmaceutical" or "pharmaceutical agent" means a prescription or nonprescription substance, or a schedule III controlled substance used for examination, diagnosis or treatment of conditions of the human eye and its adnexa. A.R.S. § 32-1701 (5). Pharmaceutical and pharmaceutical agent agents include the following categories:
 - a. "Topical diagnostic agents" means externally applied medicine used to diagnose disease and conditions of the eye and its adnexa;
 - a.b. "TPA" (topical "Topical diagnostic and therapeutic pharmaceutical agent) means an externally applied medicine medicines used to diagnose, treat, and manage disease of the eye and its adnexa;
 - b.c. "Oral pharmaceutical" means an ingested medicine medication used to diagnose, treat, and manage disease of the eye and its adnexa; and
 - e.d. "Anti-anaphylactic agent" means an intramuscular dose of epinephrine used for the emergency treatment of allergic reactions and delivered by a self-injecting syringe.
9. "Practice management" means the study of management of the affairs of optometric practice.
- 12.10. "Vision therapy" means an individualized course of treatment and education program prescribed to improve or rehabilitate conditions such as strabismus or amblyopia of the human eye or adnexa. Vision therapy is designed to help individuals learn, relearn, or reinforce specific vision skills, including eye movement control, focusing control, eye coordination, and the teamwork of the two 2 eyes. Vision therapy ~~it~~ includes, but is not limited to: ~~may include~~ prescribing of corrective spectacles, contact lenses, prisms or filters, or the employment of any means for the adaptation of lenses: optical, non-optical, electronic, or other treatments.
11. "Vision rehabilitation" means development of an individual plan specifying clinical therapy and instruction in compensatory approaches.

R4-21-102. Meetings Repealed

The Board shall conduct meetings at least 6 times each year at times and places designated by the Board of the Governor.

R4-21-103. Fees

- A. In addition to fees established by A.R.S. § 32-1727, the Board shall charge license fees as follows:
 1. License issuance fee: \$200 in even numbered years and \$400 in odd numbered years. of \$400 that is prorated from date of issuance to date of renewal.
 2. Biennial license renewal fee: of \$400; that is prorated to the licensee's renewal date if less than biennial renewal period.
 3. Late renewal fee of \$200.
- B. A person requesting public records shall pay the following fees for searches and copies of Board records under A.R.S. §§ 39-121.01 or 39-121.03:
 1. Noncommercial copy:
 - a. 5¢ per name and address for directory listings or 15¢ each if printed on labels, and
 - b. 25¢ per page for other records.
 2. Commercial copy:
 - a. 25¢ per name and address for directory listings or 35¢ each if printed on labels, and
 - b. 50¢ per page for other records.
 3. Record searches: \$25 per hour, with a minimum charge of \$10 (this fee shall be waived for other government agencies); ~~and~~ The Board shall waive fees for other government agencies.
 4. Pamphlets containing optometry statutes and rules: \$5.
 5. Written or certified license verifications: \$10.
 6. Duplicate or replacement renewal receipts: \$10.
- C. An applicant for registration or biennial registration renewal as a nonresident contact lens dispenser shall pay to the Board a registration fee of \$500.

ARTICLE 2. LICENSING PROVISIONS

R4-21-201. Licensure

- A. A person applying for licensure shall submit the following information on a licensure application form provided by the Board not later than 30 days before the date of an examination the Board-designated jurisprudence exam:
 1. The applicant's full name and social security number;

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2. The applicant's place and date of birth;
 3. The applicant's current mailing address;
 4. The applicant's residence addresses for the past ~~10~~ five years;
 5. The applicant's educational background;
 6. The applicant's previous optometric experience;
 7. ~~The applicant's previous optical experience;~~
 - 8-7. The applicant's work experience or occupation for the past ~~10~~ five years;
 - 9-8. A list of the applicant's previous state board examinations;
 - 10-9. A list of the states in which the applicant is or has been licensed and, if a license is no longer valid, the reasons why;
 - 11-10. Whether the applicant has ever been denied the right to take an examination for optometric licensure by any state or jurisdiction;
 - 12-11. Whether the applicant has ever been refused an optometric license or renewal in any state or jurisdiction;
 - 13-12. Whether the applicant has ever had a license or certificate of registration to practice optometry suspended or revoked by any optometric licensing agency, board, or equivalent;
 - 14-13. Whether any disciplinary action has ever been instituted against the applicant by any optometric licensing agency or equivalent;
 - 15-14. Whether the applicant has ever been convicted of, pled guilty or no contest to, or entered into diversion in lieu of prosecution for any criminal offense in any jurisdiction of the United States or foreign country;
 - 16-15. Whether the applicant has been addicted to narcotic substances or habitually abused alcohol within the last 10 years;
 - 17-16. Whether the applicant is presently addicted to narcotic substances or habitually abuses alcohol;
 - 18-17. The applicant shall submit a complete explanation of the details ~~If~~ if the answer to any of the questions in subsections (A)(11) (A)(12) through (A)(17) (A)(16) is affirmative, ~~a complete explanation of the details, including dates;~~
 19. ~~The character reference letter from 3 professional or business persons, unrelated to the applicant, who have known the applicant for at least the past 3 years;~~
 - 20-18. ~~A sworn statement sworn~~ under oath by the applicant verifying the truthfulness of the information provided ~~by the applicant; and~~
 - 21-19. ~~A 2" by 3" two inch by three inch passport style photograph of the applicant taken within the past 6 six months of the applicant showing head and shoulders.~~
- B. In addition to the requirements of subsection (A), an applicant for licensure shall submit: ~~or arrange to have submitted:~~
1. A completed Arizona Department of Public Safety fingerprint card accompanied by a separate nonrefundable fee in the form of a cashier's check, certified check, or money order in an amount determined by and payable to the Arizona Department of Public Safety ~~for the procurement of background information;~~
 2. The \$150 filing application fee ~~fees required~~ authorized by ~~pursuant to~~ A.R.S. §32-1727;
 3. Evidence of the successful completion of an approved course of study ~~prescribed by~~ under A.R.S. §32-1722(A)(3). Acceptable evidence includes:
 - a. An official transcript showing that the applicant has passed the required optometry course or courses; ~~if the applicant graduated from a school of optometry on or after August 6, 1999, or~~
 - b. A certificate of completion issued by the sponsoring institution specifying the subject matter and hours completed, ~~if the applicant graduated from a school of optometry before August 6, 1999; and~~
 4. An official transcript received directly from the ~~accredited institution~~ optometry school from which the applicant graduated with a degree in optometry. ~~The transcript need not be filed with the application, but shall be received by the Board at least 10 days before the applicant's examination date.~~
- C. An applicant for licensure by reciprocity endorsement shall submit at least 30 days before the date of the Board designated jurisprudence exam; ~~to the Board all of the information required by subsections (A) and (B) not later than 60 days before the date of the licensing examination, together with the following additional materials:~~
1. ~~A State Certification form provided by the Board, completed by the agency responsible for licensing optometrists in the state from which the applicant is seeking reciprocity; A license verification from all states in which the endorsement applicant has practiced in the five years before the date of application that provides the following information:~~
 - a. ~~Confirmation that the state accords similar reciprocity privileges to optometrists licensed in Arizona;~~
 2. Current status of the license;
 - b. ~~Confirmation that the applicant has been engaged in the practice of optometry in or under the authority of that state for at least 4 of the 5 years preceding the date of the application;~~
 3. Scope of practice; and
 - c. ~~Explanation of the basis for and result of any disciplinary action taken against the applicant within the preceding 10 years, including censure, probation, suspension, or revocation of the applicant's license;~~
 4. Date of licensure, license number, whether any disciplinary action has been taken, complaints against the licensee on file, and any pending investigations.
 - d. ~~Description of any pending investigations or complaints regarding the applicant;~~

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- e. Statement that the applicant is in good standing to practice optometry in that state;
 - f. Statement whether the applicant is known to have been licensed to practice optometry in any other state and, if so, the name of that state; and
 - g. a certified copy of the applicant's license from the board of registration in the profession of optometry in the state where the applicant was licensed.
2. The applicant's sworn and notarized statement on a form provided by the Board that affirms that the applicant satisfies each of the requirements of A.R.S. § 32-1723(A)(3), (A)(4), and (A)(6).
- D.** The Board shall permit an applicant to take an examination only if the applicant completes an application and files transcripts before the deadlines.
- D.** Review and approval of regular and endorsement applications. The Board may approve a regular or endorsement application based upon any combination of education or experience as specified in A.R.S. §§ 32-1722 and 1723.

R4-21-202. License Examination and Appeal

- A.** An applicant All applicants for licensure shall take a Jurisprudence exam. A passing score on the examination is at least 75% and above, a written and practical examination.
1. No later than the 1st Board meeting of a calendar year, the Board shall announce for that calendar year that the Board shall either:
- a. Under A.R.S. § 32-1724, administer a written examination to applicants, or
 - b. Accept documentation that an applicant has passed Board-designated parts of the written examination administered by the National Board and designate the parts of the exam that must be passed.
2. If the Board administers a written examination, the Board shall grade each written examination subject separately, and calculate an overall average of the subjects separately from any practical exam score. All written questions remain the property of the Board and applicants shall return them to the Board at the end of the examination.
3. An applicant for licensure shall complete a practical examination. The practical examination may include clinical procedures and written responses to questions about slides of eye conditions. The Board may require an applicant to examine a patient as part of the practical examination. An applicant shall supply any hand-held instruments or equipment needed for use in the patient examination.
- B.** An applicant who fails either the Jurisprudence written or practical portion of the examination may retake the examination one time within six months from the date of the original exam, and applies for re-examination in a subsequent year. An applicant who fails the Jurisprudence exam a second time shall wait at least six months to submit another application with required fees, shall retake the entire examination given in the re-examination year. An applicant for re-examination shall pay the regular examination fee.
- C.** An applicant who fails the Board's written examination, practical examination, or both may appeal the Board's score determinations as follows:
1. Within 60 days of license denial, the applicant or the applicant's attorney may make an appointment to examine the applicant's most recent examination answers in the Board's office during regular business hours for a total time of 2 hours. The applicant may take notes and shall provide a copy of the notes to the Board to retain and review to protect the integrity of the examination. Dissemination of confidential testing material is grounds for license denial.
2. An applicant shall file an original and 7 copies of a petition for review within 60 days after the licensing examination scores are mailed by the Board. The applicant shall type or print the petition that shall contain:
- a. A specific statement of grading errors;
 - b. Supporting evidence, and
 - c. The signature of the applicant or the applicant's attorney.
3. If the Board affirms the original test score, the applicant may request a hearing on the license denial pursuant to the provisions of A.R.S. Title 41, Chapter 6, Article 6 and 10.

R4-21-203. Time-frames for Licensure, Renewal of License, Certificates of Special Qualification, and Course of Study Approval

- A.** For each type of license, renewal of license, certificate, or approval, or renewal issued by the Board, the overall time-frame described in A.R.S. §41-1072(2) is listed in Table 1.
- B.** For each type of license, renewal of license, certificate, or approval, or renewal issued by the Board, the administrative completeness review time-frame described in A.R.S. § 41-1072(1) is listed in Table 1 and begins on the date the Board receives an application.
1. If the application is not administratively complete, the Board shall send a deficiency notice to ~~an~~ the applicant.
- a. The deficiency notice shall state each deficiency and the information needed to complete the application and documents.
 - b. The deficiency notice shall require the applicant to respond to the deficiencies Within within the time provided in Table 1 for response to the deficiency notice, beginning on the mailing date of the deficiency notice, the applicant shall submit the missing information specified in the deficiency notice to the Board.
2. The time-frame for the Board to finish the administrative completeness review is suspended from the date the Board

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mails the deficiency notice to the applicant until the date the Board receives the missing information.

- 2-3. If the application is administratively complete, the Board shall send a written notice of administrative completeness to the applicant.
 - 3-4. If the applicant fails to respond timely and completely to the deficiency notice, the Board shall send a written notice to the applicant informing the applicant that the Board considers the application withdrawn. Under A.R.S. § 32-1727(b), fees are nonrefundable except as provided in A.R.S. § 41-1077(A).
 5. An applicant may request an extension of the time to satisfy the deficiency notice.
- C. For each type of license, renewal of license, certificate, or approval, or renewal issued by the Board, the substantive review time-frame described in A.R.S. §41-1072(3) is listed in Table 1 and begins on the date of receipt of the notice of administrative completeness, as prescribed in subsection (D), depending on the manner in which the Board transmits the written notice of administrative completeness to the applicant.
1. During the substantive review time-frame, the Board may make 1 one comprehensive written request for additional information. The applicant shall submit to the Board the requested additional information Within within the time provided in Table 1. for response to a comprehensive written request for additional information, the applicant shall submit to the Board the requested additional information. The time frame for the Board to finish the substantive review is suspended from the date calculated as prescribed in subsection (D), until the Board receives the requested additional information.
 2. If, under A.R.S. § 32-1722(C), the Board determines that a hearing under A.R.S. § 32-1722(C) is needed to obtain information on the character of an applicant, the Board shall include a notice of the hearing in its comprehensive written request for additional information.
 3. The Board shall issue a written notice of denial of a license, renewal of license, certificate, or approval if the Board determines that the applicant does not meet all of the substantive criteria required by statute or this Chapter.
 4. The Board shall issue a written notice informing the applicant that the Board considers the application withdrawn if the applicant does not submit the requested additional information within the time frame in Table 1 unless the applicant requests formal denial in writing within 20 days of the written notice. Under A.R.S. § 32-1727(B), fees are non-refundable except as provided in A.R.S. § 41-1077(A).
 - 5-4. If the applicant meets all of the substantive criteria required by statute and this Chapter for licensure, renewal of license, certificate, or approval, the Board shall notify the applicant that the qualifications for licensure have been met and the license shall be issued as specified in R4-21-207 after receipt of the license issuance fee.
- D. In computing any A period of time as prescribed in this Section, the Board shall does not include the day of the initial act, event, or default after which the designated period of time begins to run. The time period begins on the date of personal service, receipt, or the date shown as received on a certified mail receipt. The last day of the time-frame period is included unless it is falls on a Saturday, Sunday, or a state holiday in which case, the time period ends on the next business day, in which event the period runs until the end of the next day that is not a Saturday, Sunday, or a state holiday. The computation includes intermediate Saturdays, Sundays, and holidays. The time period begins on the date of personal service, date shown as received on a certified mail receipt, or postmark date.

R4-21-204. License Renewal

- A. A license renewal To renew a license, an applicant shall, before August 31 of the biennial license renewal year, submit the renewal fee under R4-21-103 and the following information to the Board: on a renewal form provided by the Board:
1. Any change in the applicant's mailing or residential address;
 2. A list of all practice permanent and temporary practice addresses and phone numbers;
 3. A list of continuing education courses and if requested, proof of attendance and course completion; at 32 hours of Board-approved courses and programs in continuing education; pursuant to R4-21-208;
 4. The state where the applicant currently practices and the date when the practice commenced;
 5. Whether the applicant is retired from the practice of optometry;
 4. Whether the applicant has ever been denied the right to take an examination for optometric licensure by any state or jurisdiction within the preceding two years;
 5. Whether the applicant has ever been refused an optometric license or renewal in any state or jurisdiction;
 6. Whether the applicant has had a license or certificate of registration to practice optometry suspended or revoked by any optometric licensing agency, board, or equivalent within the preceding two years;
 7. Whether any disciplinary action has been instituted against the applicant by any optometric licensing agency or equivalent within the preceding two years;
 - 6-8. Whether the applicant has ever been convicted of, pled guilty or no contest to, or entered into diversion in lieu of prosecution for any criminal offense in any jurisdiction of the United States or foreign country within the preceding two years, and if so, an explanation; and
 9. Whether the applicant has been addicted to narcotic substances or habitually abused alcohol within the preceding two years;
 10. Whether the applicant is presently addicted to narcotic substances or habitually abuses alcohol;
 11. Whether the applicant has been sued for malpractice within the preceding two years;

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12. Whether the applicant has had the authority to prescribe, dispense, or administer medication limited, restricted, modified, denied, surrendered, or revoked by a federal or state agency within the preceding two years;

13. A complete explanation of the details if the answer to any of the questions in subsections (A)(4) through (A)(12) is affirmative; and

~~7-14.~~ A statement verifying the truthfulness of the information provided.

B. All certificates held by an applicant remain in effect upon license renewal.

C. A license is void if an applicant does not submit a completed renewal application and renewal fee under R4-21-103 before August 31 of the year the license expires; within four months from the date of expiration.

R4-21-205. Course of Study Approval

A. Any ~~accredited~~ educational institution may apply to the Board for approval of a course of study covering didactic education, pharmacology, and clinical training in the examination, diagnosis, and treatment of conditions of the human eye and its adnexa, and prescribing, dispensing, and administering pharmaceutical agents. The institution's authorized representative shall provide the following information on the application:

1. The name and address of the ~~accredited~~ educational institution;

2. Certification that the course of study is equivalent in scope and content to ~~courses provided to current graduates of~~ to the curriculum currently offered to graduating students by the ~~accredited~~ educational institution;

3. The names and qualifications of ~~proposed~~ faculty and staff;

4. A ~~120-hour~~ course outline that includes:

a. Didactic pharmacology and clinical training in the diagnosis and treatment of:

i. Anterior segment disease;

ii. Posterior segment disease;

iii. Glaucoma; and

iv. Systemic diseases and emergencies with all pharmaceutical agents and the specific agents listed in A.R.S. §32-1706(A), (B), (C), and (E).

b. A minimum of 12 hours of pharmacologic principles in the side effects, adverse reactions, drug interactions, and use of systemic antibiotics, analgesics, antipyretics, antihistamines, over-the-counter medications, and medications and procedures to counter the affect of adverse reactions.

B. To be approved, A ~~an~~ accredited educational institution that offers an approved course of study shall grant a certificate of completion or its equivalent for the course of study when ~~if~~ a student obtains a score of at least 75% on a closed book, proctored, written examination. The examination shall covering cover prescribing, dispensing, and administering pharmaceutical agents, and ~~be~~ is commensurate with courses of study taken by current doctoral candidates in colleges of optometry.

R4-21-206. Use of Pharmaceutical Agent Agents Certificate of Special Qualification

~~A. An optometrist who is licensed on September 13, 2000 may apply for a pharmaceutical agent certificate of special qualification to prescribe, dispense, and administer pharmaceutical agents.~~

~~1-A. If the optometrist a licensee does not currently hold a TPA any certificate of special qualification issued before August 6, 1999, the optometrist shall: Board shall grant a licensee the authority to prescribe, administer, and dispense pharmaceutical agents pursuant to A.R.S. §32-1706 if the licensee:~~

~~a.1. Take Takes and passes a course of study that meets the requirements of R4-21-205 (A); and~~

~~b.2. Provide Provides the Board with a copy of current CPR certification; and~~

~~c. Request the National Board or the issuing educational institution to send the Board documentation showing the optometrist passed the National Board's Treatment and Management of Ocular Disease examination or other examination approved by the Board after July 17, 1993.~~

~~2. If the optometrist holds a TPA certificate of special qualification issued before August 6, 1999, the optometrist shall:~~

~~a. Request that the issuing educational institution send the Board a certificate of completion showing the optometrist passed a Board approved course meeting the criteria specified in R4-21-205 (A)(4)(b), and~~

~~b. Provide the Board with a copy of current CPR certification.~~

~~3. If the optometrist graduated after August 6, 1999 and is licensed by the Board, the optometrist shall provide the Board with a copy of current CPR certification.~~

B. Licensees holding a license issued prior to July 1, 2000, and not holding any certificate of special qualification shall not prescribe any pharmaceutical agents pursuant to A.R.S. 32-1728. The Board shall issue a certificate of special qualification specifying use of no pharmaceutical agents to the licensee.

~~B-C. An optometrist A licensee who is denied certification of special qualification by the Board may appeal the decision by filing an appeal written request with the Board within 30 days following receipt of the notice of denial or disapproval. The hearing shall be conducted under A.R.S. Title 41, Chapter 6, Article 10.~~

R4-21-207. Submission of Fee; Issuance and Display of License; Surrender of License

A. An applicant shall submit the license issuance fee established in R4-21-103 to the Board within 20 days following notification by the Board that the applicant has met the qualifications for licensure. The Board shall issue a license at the next

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Board meeting following receipt of payment.

B.A. License display. An optometrist A licensee shall conspicuously display:

1. An optometry license or a Board-issued duplicate at all places where the optometrist is registered to practice optometry, and
2. The the appropriate Board-issued pharmaceutical-agent certificate of limited qualification or wall license at each location.

C.B. An optometrist A licensee shall surrender to the Board all licenses, certificates, and duplicates upon disciplinary order of the Board.

R4-21-208. Continuing Education Requirements; Program Criteria and Procedures

A. All continuing education courses or programs approved by the Board are based on the following:

1. The education has optometric application;
2. The education is available to all optometrists and students of optometry;
3. The instructor has expertise in the field in which the instructor is teaching;
4. The learning objectives are reasonably and clearly stated;
5. The teaching methods are appropriate and clearly stated; and
6. Documentation of attendance is provided to those attending.

A. A licensee shall complete 32 hours of continuing education per biennial license renewal period as follows:

1. The licensee shall have at least four hours in the area of diagnosis, treatment, and management of disease of the human eye and adnexa and pharmaceutical use appropriate to the authority held by the licensee.
2. The licensee shall not claim more than 12 hours by correspondence courses identified as self-instructed continuing education.
3. The licensee shall not claim more than four hours in the area of practice management.
4. The licensee may claim one credit hour of continuing education for each day of instruction in a full-time program approved under R4-21-205, or for less than a full-time program on a pro-rata basis.
5. The licensee shall not carry over hours accumulated from any previous renewal period.
6. A licensee shall not use courses taken before graduation from an accredited optometry school as credit for continuing education requirements.
7. A licensee who is licensed for the first time in the state shall obtain continuing education hours on a pro-rata basis.

B. The Board shall grant a licensee continuing education credit for the following:

1. Participating in an internship, residency, or fellowship at a teaching institution approved by the Association of Schools and Colleges of Optometry, Accreditation Council on Optometric Education, National Board of Examiners in Optometry, or the American Optometric Association;
2. Participating in a medical education program designed to provide understanding of current developments, skills, procedures, or treatments related to the practice of optometry that is provided by an organization or institution accredited by the Association of Schools and Colleges of Optometry or the Accreditation Council on Optometric Education or approved by the Council on Optometric Practitioner Education, or a national, regional or local Optometric association; and
3. Publishing or presenting a paper, report, or book that deals with current developments, skills, procedures, or treatments related to the practice of Optometry. The licensee may receive one credit hour for each hour preparing, writing, and presenting materials to a maximum of four hours per renewal period.

B.C. An optometrist A licensee may apply to the Board for approval of continuing education, not otherwise authorized, by submitting to the Board 45 days before the date the course or program is offered, an application including a description of the program content, instructors and their qualifications, sponsor of the program, if any, conditions of availability, and time and place offered.

C. Correspondence courses may include written, computer, and on-line education courses, but not more than 6 hours of correspondence courses may be used for license renewal.

D. Not more than 4 hours of practice management and administration continuing education may be used for license renewal.

E. An Optometrist shall not carry over hours accumulated in any 1 biennial license period to a subsequent license period.

R4-21-209. Discretionary Exemption

A. In emergency situations or circumstances involving extreme hardship to an optometrist, the The Board may, at its discretion and for good cause shown, reduce the number of hours of continuing education required or grant an extension of time for completion of all or part of the continuing education requirement for a particular biennial licensure period at the written request of the licensee. The Board shall grant an extension to a licensee who has suffered a serious or disabling illness that prevented the licensee from complying with the requirements of R4-21-208 during the 12 months immediately before the license renewal date.

B. At least 90 days prior to the date of license renewal, a licensee who desires a reduction or extension to complete continuing education shall submit documentation to the Board of the emergency situation or circumstances involving extreme hardship that prevent the licensee from complying with the continuing education requirement in R4-21-208.

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R4-21-210. Equipment and Supplies Repealed

- A.** An optometrist shall maintain the following equipment and supplies in the treatment room to counteract an anaphylactic reaction:
1. A telephone with access to an emergency medical number;
 2. Auto-injectors of epinephrine, and
 3. Oral diphenhydramine hydrochloride (Benadryl).
- B.** Except for a licensed Diagnostic Pharmaceutical Agent, an optometrist shall maintain the following uniform prescription form

TPA # _____ PA # _____	Doctor's Name _____ Doctor's Address _____ City, State, Zip Code _____ Telephone Number _____ Fax Number _____	License # _____ DEA # _____ (Optional)
Name _____ Date: _____		
Address: _____		
Poc: _____		
Disp: _____		
Sig: _____		
Refill _____ Times		
Dispense as Written _____		Substitution Permissible _____

Table 1. Time-frames (in calendar days)

Type of License	Overall Time-frame	Administrative Review Time-frame	Time to Respond to Deficiency Notice	Substantive Review Time-frame	Time to Respond to Request for Additional Information
Initial Licensure by Examination A.R.S. § 32-1722	90	30	20	60	20
Initial Licensure by Reciprocity endorsement R4-21-201	120	60	20	60	20
Renewal of License R4-21-204	90	60	20	30	20
Board Approved Course of Study R4-21-205	180	90	20	90	20
Certificates of Special Qualification R4-21-206	120	60	20	60	20
Continuing Education Program Approval R4-21-208	120	60	20	60	20
Registration of nonresident dispenser of replacement soft contact lenses A.R.S. § 32-1773	120	60	20	60	20

ARTICLE 3. REGULATORY PROVISIONS

R4-21-301. Styles of Optometric Practice; Staff Responsibility

- A. ~~An optometrist~~ A licensee shall practice the profession of optometry only as a sole practitioner, a partner with other optometrists, licensees, an employee of ~~an optometrist~~, a licensee, or an optometric professional corporation. In any of these styles of practice, ~~an optometrist~~ a licensee may practice as an independent contractor and shall practice only under the name, which may include a trade name, by under which the ~~optometrist~~ licensee is registered with the Board.
- B. ~~An optometrist and particularly an optometrist~~ A licensee practicing the profession of optometry as an independent contractor shall:
1. Be solely responsible for patient examination, diagnosis, and treatment; ~~and for the procedures used for scheduling and recordkeeping; and~~
 2. Conduct the practice of optometry free of any control by a person not licensed to practice the profession of optometry; ~~and~~
- C. ~~An optometrist shall ensure~~ Ensure that the ~~optometrist's~~ licensee's staff complies with the requirements of the laws and rules of Arizona that govern the practice of optometry this Chapter and A.R.S. Title 32, Chapter 16.

R4-21-302. False Advertising

- A. ~~An optometrist~~ A licensee shall not knowingly make, publish, or use an advertisement, printed, oral, or otherwise, that contains any false, fraudulent, deceptive, or misleading representations concerning ophthalmic goods or optometric services, or the manner of their sale or distribution.
- B. ~~An optometrist~~ A licensee shall only advertise as a specialist if the ~~optometrist~~ licensee has been certified by the American Academy of Optometry as a diplomat in that specialty or as a fellow in the College of Optometrists in Vision Development. ~~An optometrist~~ A licensee may advertise that the ~~optometrist~~ licensee has a practice limited in some way, provided that if the ~~optometrist~~ licensee shall does not use the term "specialist" or any derivative of that term.
- C. ~~An optometrist~~ A licensee shall have knowledge of and be professionally responsible for the contents of any advertisement or directory that includes the name and address of the ~~optometrist~~ licensee.

R4-21-303. Affirmative Disclosures in Advertising and Practice; Warranties, Service, or Ophthalmic Goods Replacement Agreements

- A. An advertisement for or by a licensee ~~an optometrist~~ offering ~~ophthalmic goods or optometric goods or services for a stated price or discount~~ shall clearly indicate ~~in the spoken word or in type size equivalent to the address line~~ within the advertisement:
1. ~~If for spectacle lenses or contact lenses whether~~ Whether spectacle lenses or contact lenses they are single vision, multi-focal, or other;
 2. Whether the price includes the frame and lenses for spectacles;
 3. Whether the price includes an eye examination;
 4. Whether the price for contact lenses includes all dispensing fees, follow-up care, a contact lens accessory kit, and, if an accessory kit is included, the specific features of the kit;
 5. Whether restrictions are imposed upon delivery, if delivery time is advertised;
 6. The applicable refund policy if refunds are advertised; and
 7. If applicable, a statement that other restrictions apply.
- B. ~~An optometrist~~ A licensee shall inform a patient of the ~~optometrist's fee policy~~ all professional fees ~~prior to~~ before providing treatment.
- C. ~~An optometrist~~ A licensee who refers a patient to a facility in which the ~~optometrist~~ licensee or a member of the ~~optometrist's~~ licensee's family has an ownership or employment interest shall advise the patient at the time of the referral.
- D. ~~An optometrist~~ A licensee who charges a patient a fee for a warranty, or service or ophthalmic goods replacement agreement, shall give the patient a written copy of the warranty, or service or ophthalmic goods replacement agreement, that explains the coverage and any limitations. ~~An optometrist~~ The licensee shall document the transaction by making a written entry on the patient's records, or ~~and~~ by placing a copy of the warranty, or service or ophthalmic goods replacement agreement, signed by the patient, in the patient's records.

R4-21-304. Vision Examination Standards; Records

- ~~An optometrist shall conduct eye examinations in accordance with the standards of care established by the following American Optometric Association practice guidelines which are incorporated by this reference and on file with the Secretary of State. The materials incorporated contain no later editions or amendments:~~
1. ~~Comprehensive Adult Eye and Vision Examination, 1994, American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881;~~
 2. ~~Pediatric Eye and Vision Examination, 1994, American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881;~~
 3. ~~Care of the Patient with Diabetes Mellitus, September 1998, American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881;~~

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4. Care of the Patient with Amblyopia, 1994, American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881;
5. Care of the Patient with Primary Angle Closure Glaucoma, 1994, American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881;
6. Care of the Patient with Age-Related Macular Degeneration, 1994, American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881;
7. Care of the Patient with Anterior Uveitis, 1994, American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881;
8. Care of the Adult Patient with Cataract, March 20, 1999, American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881;
9. Care of the Patient with Open Angle Glaucoma, May 28, 1999, American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881;
10. Care of the Patient with Ocular Surface Disease, June 5, 1999, American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881;
11. Care of the Patient with Conjunctivitis, 1995, American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881;
12. Care of the Patient with Strabismus: Esotropia and Exotropia, 1995, American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881;
13. Care of the Patient with Retinal Detachment and Related Peripheral Vitreoretinal Disease, 1995, American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881;
14. Care of the Patient with Low Vision, June 11, 1997, American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881;
15. Care of the Patient with Myopia, August 9, 1997, American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881;
16. Care of the Patient with Hyperopia, August 9, 1997, American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881;
17. Care of the Patient with Presbyopia, March 20, 1998, American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881; and
18. Care of the Patient with Accommodative and Vergence Dysfunction, March 20, 1998, American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, MO 63141-7881;

- A.** A licensee shall conduct all eye examinations in accordance with the current standards of care.
- B.** An optometrist-A licensee shall establish and maintain a complete and legible record of each examination including all findings. The Board shall consider an illegible record to be an incomplete examination. An optometrist-A licensee shall ensure that a patient record reflects the name of the person who makes each entry, and is maintained for at least 10 seven years after the last contact with a patient. The patient record shall include and includes:
1. Complete case history;
 2. Visual acuity of each eye: entering, and best corrected;
 3. Ocular health examination;
 4. Assessment of intraocular and extraocular extra-ocular muscle function;
 5. Objective or subjective refraction of the eyes;
 6. Diagnosis, treatment, and disposition;
 7. The type and dosage of each use of a pharmaceutical agent used;
 8. Any final prescription given; and
 9. Any corrective procedure program prescribed.
- C.** An optometrist-A licensee who discontinues practice for any reason shall arrange for patient records to be available to a patient for 10 seven years from the date the licensee's practice is discontinued and shall notify the Board of the permanent location of patient records from that practice before discontinuing practice. An optometrist-A licensee who acquires or succeeds to a practice or patient records of an optometrist another licensee who has discontinued practice shall maintain the records or make arrangements for the records to be available to a patient for 10 seven years after the practice was discontinued.
- D.** An optometrist-A licensee shall, upon written request of a patient, transmit a copy of the patient's requested records within five business days of the request, to any designated person designated by the patient. The optometrist-licensee may charge a fee to cover clerical and mailing costs. The optometrist-licensee shall maintain a record of the transfer or transmittal for 10 seven years from the date of the transfer release of the records.
- E.** Any record required to be maintained by a licensee may be maintained in an electronic format if:
1. The electronic record accurately reflects the information contained in the written record as the record was first generated and in its final form as an electronic record or otherwise; and
 2. The electronic record remains accessible.

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R4-21-305. Prescription Standards; Release to Patients

- A. An optometrist A licensee shall not charge a patient a fee in addition to the examination fee as a condition for release of the patient's prescription. The licensee shall ensure that A an optometric prescription shall include includes:
1. For ophthalmic lenses other than contact lenses:
 - a. The refractive power of the lenses;
 - b. The interpupillary distance;
 - c. The printed name of the optometrist licensee, the location of the office, and the signature of the optometrist licensee; and
 - d. The date of the examination and the expiration date of the prescription;
 2. For contact lenses, including plano lenses:
 - a. ~~If For~~ a patient who has not completed a trial period appropriate under the circumstances and desires to have a prescription, the prescription need only contain the information required for ophthalmic lenses other than contact lenses; the patient to purchase the trial lenses at another optical establishment or location;
 - b. If a patient has completed a trial period appropriate under the circumstances for the lenses prescribed, all information necessary to accurately reproduce the contact lenses;
 - c. ~~The printed name of the licensee, the location~~ practice address of the office, telephone number, facsimile number, and the signature of the licensee; and
 - d. The name of the patient, date of the examination, the issue and expiration date of the prescription, the power, material, or manufacturer, or both, of the prescribed contact lens, the base curve or appropriate designation of the prescribed contact lens, the diameter, when appropriate, of the prescribed contact lens, and in the case of a private label contact lens, the name of the manufacturer, trade name of the private label brand and, if applicable, trade name of equivalent brand name; and the number of lenses that can be dispensed prior to the expiration date.
 3. For topical pharmaceutical agents:
 - a. The date of issuance;
 - b. The name and address of the patient;
 - c. The name, strength, and quantity;
 - d. The directions for use;
 - e. The name and address of the prescribing optometrist licensee;
 - f. The written signature of the prescribing optometrist licensee;
 - g. ~~The topical pharmaceutical agent certificate~~ DEA number of the prescribing optometrist licensee; and
 - h. Two adjacent signature lines, under the left of which are the printed words "dispense as written", and under the right, the printed words "substitution permissible";
 4. A prescription may include any additional information the optometrist licensee considers necessary.
- B. An optometrist A licensee who dispenses or directs the dispensing of ophthalmic materials shall ensure that a prescriptions prescription are is filled accurately.
- C. An optometrist A licensee shall be available to verify that a prescription written by the optometrist licensee but filled dispensed by another provider of ophthalmic goods has been is accurately filled. The optometrist licensee may charge a fee for verification of the accuracy or quality of ophthalmic goods dispensed by another provider.

R4-21-306. Low-Vision Rehabilitation and Vision Therapy

An optometrist A licensee may employ any objective or subjective means or methods other than surgery, to diagnose or treat with topical pharmaceutical agents any visual, muscular, neurological, or anatomical anomaly of the eye. The optometrist licensee may use any instrument or device to train the visual system or correct any abnormal condition of the eye, including the use of low-vision rehabilitation and vision therapy.

R4-21-307. Subpoenas Repealed

~~The Board shall approve all summons and subpoenas issued by the Secretary or the Executive Director of the Board in connection with Board investigations or disciplinary proceedings pursuant to Title 32, Chapter 21.~~

R4-21-308. Rehearing or Review of Administrative Decision

- ~~A. Except as provided in subsection (G), any party in a contested case or appealable agency action before the Board who is aggrieved by a decision rendered by the Board may file a written motion for rehearing of the decision with the Board not later than 30 days after service of the decision. The motion shall specify the particular grounds for the rehearing. For purposes of this subsection, a decision is served when personally delivered or mailed by certified mail to a party at the party's last known residence or place of business.~~
- ~~B. A party may amend a motion for rehearing under this Section at any time before it is ruled upon by the Board. A response may be filed within 10 days after service of the motion or amended motion by any other party. The Board may require the filing of written briefs upon the issues raised in the motion and may permit oral argument.~~
- ~~C. A. Under A.R.S. Title 41, Chapter 6, Article 10, Uniform Administrative Appeals Procedures, The the Board may, upon written request, reconsider grant a rehearing or review of the a decision for any of the following causes materially affecting the moving party's rights:~~

ify the grounds therefore.

~~F.~~ When a motion for rehearing is based upon affidavits, a party making the motion shall serve the affidavits with the motion. Within 10 days after service an opposing party may serve opposing affidavits. The Board may extend the 10-day period an additional 10 days, for good cause or upon written stipulation of the parties. The Board may permit reply affidavits.

~~G-D.~~ If the Board makes a specific finding in a decision that the immediate effectiveness of the decision is necessary for the preservation of the public peace, health, or safety and that a rehearing of the decision is impracticable, unnecessary, or contrary to the public interest, the Board may issue the decision as a final decision without opportunity for a rehearing. If a Board decision is issued as a final decision without an opportunity for rehearing, a party seeking judicial review of the decision shall make application to the superior court within the time limits permitted for application for judicial review of the Board's final decision.

~~H-E.~~ The terms "contested case" and "party" have the same meaning as in A.R.S. Title 41, Chapter 6.

ARTICLE 4. PUBLIC PARTICIPATION PROCEDURES Repealed

~~R4-21-401. Agency Record; Directory of Substantive Policy Statements Repealed~~

~~The official rulemaking record and directory of substantive policy statements is located in the office of the Board and may be reviewed any week day, 8:00 a.m. until 5:00 p.m., except state holidays.~~

~~R4-21-402. Petition for Rulemaking; Review of Agency Practice or Substantive Policy Statement; Objection to Rule Based Upon Economic, Small Business or Consumer Impact Repealed~~

~~A petition to adopt, amend, or repeal a rule or to review an existing agency practice or substantive policy statement that the petitioner alleges to constitute a rule under A.R.S. § 41-1033 or to object to a rule in accordance with A.R.S. § 41-1056.01 shall be filed with the Board as prescribed in this Section. Each petition shall contain:~~

- ~~1. The name and current address of the petitioner;~~
- ~~2. For the adoption of a new rule, the specific language of the proposed rule;~~
- ~~3. For the amendment of a current rule, the citation for the applicable Arizona Administrative Code number and rule title. The request shall include the specific language of the current rule, any language to be deleted shall be stricken through but legible, and any new language shall be underlined;~~
- ~~4. For the repeal of a current rule, the citation for the applicable A.A.C. number and title of the rule proposed for repeal;~~
- ~~5. The reasons a rule should be adopted, amended, or repealed, and if in reference to an existing rule, why the rule is inadequate, unreasonable, unduly burdensome, or otherwise not acceptable. The petitioner may provide additional supporting information, including:
 - ~~a. Any statistical data or other justification, with clear reference to an attached exhibit;~~
 - ~~b. For a review of an existing rule, why the rule should be repealed, how they would be affected, existing Board practice or substantive policy statement constitutes a rule and the proposed action requested of the Board.~~~~
- ~~7. For an objection to a rule based upon the economic, small business, or consumer impact, evidence that:
 - ~~a. The actual economic, small business, or consumer impact significantly exceeded the impact estimated in the eco-~~~~

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- conomic, small business, and consumer impact statement submitted during the making of the rule; or
- b. The actual economic, small business, or consumer impact was not estimated in the economic, small business, and consumer impact statement submitted during the making of the rule and that actual impact imposes a significant burden on persons subject to the rule.
8. The signature of the person submitting the petition.

R4-21-403. Public Comments Repealed

- A. On or before the date of the close of record, a person may comment upon a rule proposed by the Board by submitting written comments on the proposed rule or upon any other matter noticed for public comment in the Arizona Administrative Register to the Board.
- B. The Board considers a written comment submitted on the date it is received by the Board, except if a comment is mailed the date of receipt shall be the postmarked date.
- C. The Board shall consider all written comments that conform with A.R.S. § 41-1023.

R4-21-404. Oral Proceedings Repealed

- A. A person requesting oral proceedings, as prescribed in A.R.S. § 41-1023(C), shall:
 - 1. File the request with the Board;
 - 2. Include the name and current address of the person making the request; and
 - 3. Refer to the proposed rule and include, if known, the date and issue of the Arizona Administrative Register in which the notice was published.
- B. The Board shall record an oral proceeding either electronically or stenographically, and any cassette tapes, transcripts, registers, and written comments received shall become part of the official record.
- C. The presiding officer shall utilize the following guidelines to conduct oral proceedings:
 - 1. Registration of attendees. Registration of attendees shall be voluntary;
 - 2. Registration of persons intending to speak. Registration information shall include the registrant's name, representative capacity, if applicable, a notation of the registrant's position with regard to the proposed rule and the approximate length of time the registrant wishes to speak;
 - 3. Opening of the record. The presiding officer shall open the proceeding by identifying the rules to be considered, the location, date, time, and purpose of the proceeding, and present the agenda;
 - 4. A statement by Board representative. The Board representative shall explain the background and general content of the proposed rules;
 - 5. A public oral comment period. The presiding officer may limit comments to a reasonable time period, as determined by the presiding officer. Oral comments may be limited to prevent undue repetition; and
 - 6. Closing remarks. The presiding officer shall announce the location where the written public comments are to be sent.

R4-21-405. Petition for Delayed Effective Date Repealed

- A. A person wanting to delay the effective date of a rule under A.R.S. § 41-1032 shall file a petition with the Board. The petition shall contain:
 - 1. The name and current address of the person submitting the petition;
 - 2. Identification of the proposed rule;
 - 3. The need for the delay, specifying the undue hardship or other adverse impact that may result if the request for a delayed effective date is not granted, and the reasons why the public interest will not be harmed by the later date; and
 - 4. The signature of the person submitting the petition.
- B. The Board shall make a decision and notify the petitioner of the decision within 60 days of receipt of the petition.

R4-21-406. Written Criticism of Rule Repealed

- A. Any person may file a written criticism of an existing rule with the Board.
- B. The criticism shall clearly identify the rule and specify why the existing rule is inadequate, unduly burdensome, unreasonable, or otherwise improper.
- C. The Board shall acknowledge receipt of any criticism within 15 days and shall place the criticism in the official record for review by the Board under A.R.S. § 41-1056.

ARTICLE 5. EXECUTIVE DIRECTOR DUTIES

R4-21-501. Issuing Licenses

- A. The executive director or the Board's designee may decide whether to approve an application to practice the profession of optometry and shall issue a license if all of the requirements for licensure have been met as evidenced by the application and governing statutes.
- B. The executive director or the Board's designee shall report to the Board at each regularly scheduled Board meeting a summary of the number and type of applications approved and licenses issued.

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R4-21-502. Denial of License

- A. The executive director or the Board's designee shall deny a license to an applicant who does not meet the minimum requirements to practice the profession of optometry in Arizona.
- B. The executive director or the Board's designee shall provide to the Board at each regularly scheduled Board meeting a list of applicants who were denied a license.

R4-21-503. Issuing Subpoenas

- A. The executive director or the Board's designee may issue a subpoena for the attendance of witnesses and the production of books, records, documents or any other evidence relevant to an investigation or hearing.
- B. The executive director or the Board's designee shall report to the Board at each regularly scheduled Board meeting a summary of the number and type of subpoenas issued.

R4-21-504. Continuing Education Approval

- A. The executive director or the Board's designee may approve continuing education programs under R4-21-208.
- B. The executive director or the Board's designee shall provide to the Board at each regularly scheduled Board meeting a list of approved continuing education programs.

NOTICE OF FINAL RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 46. BOARD OF APPRAISAL

[R05-172]

PREAMBLE

1. Sections Affected

R4-46-101
 R4-46-201
 R4-46-202
 R4-46-203
 R4-46-204
 R4-46-206
 R4-46-207
 R4-46-208

Rulemaking Action

Amend
 Amend
 Amend
 Amend
 Amend
 Amend
 Amend
 Amend

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

Authorizing statutes: A.R.S. §§ 32-3605(B), 32-3612, 32-3613, 32-3614, 32-3619, and 32-3625

Implementing statutes: A.R.S. §§ 32-3605(B)(2), 32-3605(B)(3), 32-3605(B)(4), 32-3605(B)(5), 32-3605(B)(6), 32-3605(B)(8), 32-3625(D), and 32-3625(E)

3. The effective date of the rules:

May 3, 2005

The Board is requesting an immediate effective date for these rules to avoid violation of federal law (Title XI of the Congressional Financial Institution Reform, Recovery, and Enforcement Act of 1989), pursuant to A.R.S. § 41-1032(A)(2). However, to allow a reasonable time-frame for the implementation of the supervising appraiser rules, the Board is requesting an effective date of January 1, 2007, for the definitions of "direct supervision," "practicing appraiser," "supervising appraiser," and "trainee," in R4-46-101, and for R4-46-201(F), consistent with R4-46-201(G).

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

Notice of Rulemaking Docket Opening: 10 A.A.R. 2320, June 11, 2004

Notice of Proposed Rulemaking: 11 A.A.R. 370, January 14, 2005

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

Name: Deborah G. Pearson, Executive Director

Address: 1400 W. Washington, Suite 360
Phoenix, AZ 85007

Telephone: (602) 542-1539

Notices of Final Rulemaking

Fax: (602) 542-1598
E-mail: deborah.pearson@appraisal.state.az.us

6. An explanation of the rule, including the agency's reason for initiating the rule:

The rules are to comply with Title XI of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989, which requires state licensing boards to recognize and ensure that state licensed and certified appraisers meet the minimum criteria issued by the Appraiser Qualifications Board of The Appraisal Foundation, and A.R.S. § 32-3605(B)(2) and A.R.S. § 32-3605(B)(3), which require the Board to adopt criteria for licensing and certification of appraisers that at a minimum are equal to the minimum criteria for licensing adopted by the Appraiser Qualifications Board. *All Interpretations and Supplementary Information as of January 1, 2002, and Appendix I, Criteria Revisions effective January 1, 2003*, have been incorporated into the *Real Property Appraiser Qualification Criteria adopted February 16, 1994, and effective January 1, 1998*, by the Appraisers Qualifications Board (AQB) to clarify its intent and to provide guidance to users of the Criteria. Notwithstanding the incorporated material, the rules do not establish a trainee classification but provide for the regulation of supervising appraisers. Notwithstanding the incorporated material, the rules provide for more stringent criteria concerning education. The rules are consistent with the Board's approved Five-Year Review Report.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The Board did not review any study relevant to the rules.

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:

The rules are being amended to incorporate by reference the minimum criteria for the licensed real property appraiser classification, the certified residential real property appraiser classification, and the certified general real property appraiser classification established by *The Real Property Appraiser Qualification Criteria and Interpretations of the Criteria adopted February 16, 1994, effective January 1, 1998, All Interpretations and Supplementary Information as of January 1, 2002, and Appendix I, Criteria Revisions effective January 1, 2003*, adopted by the Appraiser Qualifications Board (AQB). Notwithstanding the incorporated material, the rules establish parameters for regulation of supervising appraisers in lieu of creating a Trainee Real Property Appraiser Classification, and more stringent criteria concerning education. The major economic impact of the rules will be the indirect beneficial effect for the public and regulated community due to specific interpretation of the criteria, including acceptance of distance education, and the establishment of parameters for regulation of supervising appraisers. The cost, if any, to the regulated community, trainees, and course providers will be minimal. There will be no cost to the public. The Board will bear the cost of incorporating and enforcing the rules.

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

The following substantive changes were made by the Board in response to comments it received: (a) to allow a reasonable time-frame for the implementation of the supervising appraiser rules, the Board changed the effective date to January 1, 2007, in R4-46-201(G) and added the same effective date for the definitions of "direct supervision," "practicing appraiser," "supervising appraiser," and "trainee," in R4-46-101, for consistency; and (b) R4-46-207(A)(2)(d) and R4-46-207(A)(2)(e) regulating the 7-hour National USPAP Update Course were deleted to provide a broader course availability to the appraisers. Minor grammatical and formatting changes were made at the request of the Governor's Regulatory Review Council staff.

11. A summary of the comments made regarding the rule and the agency response to them:

The Board received several comments at its public hearing on the rules amendment held on February 17, 2005, and at that time voted to refer the rules to the Rules and Regulations Committee to receive further comments. The Rules and Regulations Committee met on March 8 and March 11, 2005, received comments, and made its recommendations to the Board on March 17, 2005. The Board accepted the Rules and Regulations Committee's recommendations, and voted to close the record and proceed with the Notice of Final Rulemaking. The comments received and the Board's responses were: (a) Against R4-46-201(F)(1)(b). Response: The personal supervision is necessary to ensure a high quality of training, which is a benefit to the public. (b) Against the effective date of January 1, 2006, in R4-46-201(G). Response: To allow for a reasonable time-frame for the implementation of R4-46-201(F), the Board changed the effective date to January 1, 2007. (c) Against R4-46-207(A)(2)(d) and R4-46-207(A)(2)(e). Response: The Board deleted both paragraphs to allow appraisers a broader course opportunity.

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:

The Real Property Appraiser Qualification Criteria and Interpretations of the Criteria adopted February 16, 1994, effective January 1, 1998, All Interpretations and Supplementary Information as of January 1, 2002, and Appendix I, Criteria Revisions effective January 1, 2003, adopted by the Appraiser Qualifications Board (AQB). The locations in the rules are R4-46-201 and R4-46-207.

14. Was this rule previously made as an emergency rule?

No.

15. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 46. BOARD OF APPRAISAL

ARTICLE 1. GENERAL PROVISIONS

Section

R4-46-101. Definitions

ARTICLE 2. LICENSING AND CERTIFICATION

Section

R4-46-201. Appraiser Qualification Criteria
R4-46-202. Application for License or Certificate
R4-46-203. Procedures for Processing Applications
R4-46-204. Appraiser Examinations
R4-46-206. Hearing on Denial of a License or Certificate
R4-46-207. Renewal of a License or Certificate
R4-46-208. Renewal of an Expired License or Certificate

ARTICLE 1. GENERAL PROVISIONS

R4-46-101. Definitions

“Arizona or State Certified General Appraiser”—No change

“Arizona or State Certified Residential Appraiser”—No change

“Arizona or State Licensed Appraiser”—No change

“Appraisal Foundation”—No change

“Appraiser”—No change

“Board”—No change

“Course Provider”—No change

“Direct supervision” means that a supervising appraiser is physically present to direct and oversee the production of each appraisal assignment. This definition is effective January 1, 2007, consistent with R4-46-201(G).

“Distance education” means any educational process based on the geographical separation of learner and instructor (for example, CD ROM, on-line learning, correspondence courses, video conferencing). For qualifying education, distance education must provide interaction between learner and instructor and include testing.

“Formal Complaint”—No change

“Party”—No change

“Practicing appraiser” means a state licensed or certified appraiser who is actively engaged in performing appraisal assignments. This definition is effective January 1, 2007, consistent with R4-46-201(G).

“Respondent”—No change

“Rules”—No change

“Supervising appraiser” means a state licensed or certified appraiser in good standing with a minimum of four years of experience within the last four years as a practicing appraiser who engages in direct supervision of a trainee pursuing a state license or certificate and provides training for work included within the supervising appraiser’s classification. This definition is effective January 1, 2007, consistent with R4-46-201(G).

“Trainee” means an individual who is being taught to become a state licensed or certified appraiser under the direct supervision of a supervising appraiser. This definition is effective January 1, 2007, consistent with R4-46-201(G).

“USPAP”—No change

ARTICLE 2. LICENSING AND CERTIFICATION

R4-46-201. Appraiser Qualification Criteria

- A. Except as provided in subsections (B) and (C), (C), (D), (E), and (F), an applicant for the applicable classification of license or certificate should meet that classification's Appraiser Qualification Criteria, established by the Appraisal Foundation and dated February 16, 1994, criteria, established by the Appraiser Qualifications Board (AOB), in The Real Property Appraiser Qualification Criteria and Interpretations of the Criteria adopted February 16, 1994, effective January 1, 1998, All Interpretations and Supplementary Information as of January 1, 2002, and Appendix I, Criteria Revisions effective January 1, 2003, which are incorporated by reference and on file with the Board and the Office of the Secretary of State. This incorporation by reference incorporated material includes no future additions or amendments. A copy of the Appraiser Qualification Criteria incorporated material may be obtained from the Board or the The Appraisal Foundation.
- B. The incorporation by reference incorporated material in subsection (A) does not govern an Appraiser's appraiser's scope of practice. The scope of practice for each classification of license or certificate is set forth provided in A.R.S. § 32-3612(A). The incorporation by reference incorporated material in subsection (A) does not govern the minimum amount of experience, measured in hours or years, necessary for certification. The minimum experience required for certification is set forth provided in A.R.S. § 32-3615(A).
- C. An applicant for any classification of a license or certificate shall complete at least two three hours of course work covering A.R.S. Title 32, Chapter 36 and these rules.
- D. Regardless of whether a transaction is federally related:
1. A State Licensed Residential Appraiser is limited to transactions involving one to four family residential real property having a value of less than 1 million dollars and not involving complex one to four family residential real property. the scope of practice in A.R.S. § 32-3612(A)(3), and
 2. A State Certified Residential Appraiser is limited to the scope of practice set forth in A.R.S. § 32-3612(A)(2).
- E. Notwithstanding the criteria incorporated by reference in subsection (A),
1. The American Council on Education's Program on Noncollegiate Sponsored Instruction (ACE/Credit Program) is not an approved organization for distance education course reviews,
 2. An applicant shall not obtain more than 75% of required qualifying education through distance education, and
 3. An applicant shall not obtain the 15-hour National USPAP Course, or its equivalent, approved through the AOB Course Approval Program, through distance education.
- F. Notwithstanding the criteria incorporated by reference in subsection (A), there is no Trainee Real Property Appraiser Classification.
1. A supervising appraiser shall instruct and directly supervise a trainee for any classification of license or certificate in the entire preparation of each appraisal. The supervising appraiser shall approve and sign all final appraisal documents. To demonstrate responsibility for the instruction, guidance, and direct supervision of the trainee, the supervising appraiser shall:
 - a. Sign the appraisal report and certify the report is in compliance with the Uniform Standards of Professional Appraisal Practice,
 - b. Personally supervise the entire physical inspection of each appraised property with the trainee, and
 - c. Review and sign each trainee appraisal report.
 2. A trainee may have more than one supervising appraiser, but a supervising appraiser shall not supervise more than three trainees at any one time. A trainee shall maintain an appraisal log for each supervising appraiser and, at a minimum, include the following in the log for each appraisal:
 - a. Type of property,
 - b. Date of report,
 - c. Property description,
 - d. Description of work performed by the trainee and scope of review and supervision by the supervising appraiser,
 - e. Number of actual work hours by the trainee on the assignment, and
 - f. The signature and state license or certificate number of the supervising appraiser.
 3. A supervising appraiser and trainee shall work in the same geographic area, and in no event shall the supervising appraiser and trainee work in different states.
 4. A supervising appraiser shall provide to the Board in writing the name and address of each trainee within 10 days of engagement, and notify the Board in writing immediately upon termination of the engagement. A state licensed or certified appraiser is not eligible to be a supervising appraiser unless the appraiser's license or certificate is in good standing and the appraiser has not been subject to license or certificate suspension, probation, or mentorship within the last two years.
- G. Subsection (F) is effective January 1, 2007.

R4-46-202. Application for License or Certificate

- A. An applicant for a state certificate or license shall submit a completed application accompanied by the appropriate

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required application fee. Once the application has been filed, fees are ~~non-refundable~~ nonrefundable, unless A.R.S. § 41-1077 is applicable.

- B. To be eligible for a license or certificate, an applicant shall:
1. Meet the qualification criteria contained in A.R.S. Title 32, Chapter 36, Article 2 and these rules;
 2. Achieve a passing score on the applicable examination required by R4-46-204(D), unless exempted under A.R.S. § 32-3626;
 3. Pay all required application and examination fees;
 4. Pay the biennial federal registry fee; and
 5. Comply with the requirements of A.R.S. § 32-3611.
- C. In addition to the requirements listed ~~above~~ in subsection (B), an applicant for licensure shall demonstrate 2,000 hours of experience earned in not less than 18 months.
- D. An applicant shall meet all requirements for a license or certificate within one year of filing the application or the applicant's file will be closed and the applicant shall reapply, meeting the requirements of R4-46-202(B). The Board shall notify an applicant whose application has been closed by certified mail or personal service at the applicant's last known address of record. Notice is complete upon deposit in the U.S. mail or by service as permitted under the Arizona Rules of Civil Procedure.

R4-46-203. Procedures for Processing Applications

- A. To comply with A.R.S. Title 41, Chapter 6, Article 7.1, the Board establishes the following time-frames for ~~all licenses and certificates~~ processing license and certificate applications, including renewal applications:
1. The Board shall notify the applicant within 45 days of receipt of the application that it is either complete or incomplete. If the application is incomplete, the notice shall specify what information is missing.
 2. The Board shall not substantively review an application until the applicant has fully complied with the requirements of R4-46-202. The Board shall render a final decision not later than 45 days after the applicant successfully completes all requirements of R4-46-202.
 3. Although the applicant may have up to one year to comply with requirements of R4-46-202, the overall time-frame for Board action is 90 days, 45 days for administrative completeness review and 45 days for substantive review.
- B. If the Board denies a license, the Board shall send the applicant written notice explaining:
1. The reason for denial, with citations to supporting statutes or rules;
 2. The applicant's right to seek a hearing to challenge the denial; and
 3. The time periods for appealing the denial.

R4-46-204. Appraiser Examinations

- A. The Board shall not ~~schedule~~ allow an applicant ~~for~~ to schedule an examination until the applicant has completed all of the prerequisite education requirements.
- B. If the test provider does not allow for a test on demand, an applicant shall file an application to take an examination at least 45 days ~~prior to~~ before the examination date.
- C. Rescheduling; excused absence; forfeiture
1. Except as provided in subsections (C)(2) and (3), the Board shall not provide an applicant scheduled for an examination date with a later examination date unless the applicant files a new application and pays a reexamination fee.
 2. The Board may grant an excused absence from a scheduled examination if the applicant provides evidence satisfactory to the Board that the absence was the direct result of an emergency situation or condition which that was beyond the applicant's control and which that could not have been reasonably foreseen by the applicant. An applicant shall promptly make a request for an excused absence in writing and support the request with documentation verifying the reason for the absence. ~~A The Board shall deny a request for an excused absence received more than 15 days after the examination date will be denied unless the applicant was unable to file a timely request due to the same circumstances that prevented the applicant from taking the examination.~~
 3. An applicant may request that the ~~applicants~~ applicant's examination date be rescheduled if the request is made at least 15 days before the originally scheduled examination date.
- D. Subject Matter. ~~Each~~ An applicant shall take an examination for the applicable classification of license or certificate that covers the subject matter set forth in the National Uniform Examination Content Outline, dated November 4, 1993, which is incorporated by reference and on file with the Board and the Office of the Secretary of State. ~~This incorporation by reference contains no future additions or amendments. A copy of the outline may be obtained from the Board or the~~ The Appraisal Foundation, in the real property appraiser examination for the applicable classification endorsed by the Appraiser Qualifications Board.
- E. Reexamination. An applicant for a license or certificate who fails to pass an examination or fails to appear for a scheduled examination may schedule another examination by filing a new application and paying the reexamination fee.

R4-46-206. Hearing on Denial of a License or Certificate

Pursuant to A.R.S. § 41-1065, A.R.S. § 41-1092.03, any applicant denied a license or certificate by the Board may file a written request for hearing, within 30 days after issuance of the notice of denial. Any hearing shall be conducted under the formal

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hearing procedures prescribed in Article 3 of these rules; A.R.S. Title 41, Chapter 6, Article 10; and 2 A.A.C. 19.

R4-46-207. Renewal of a License or Certificate

- A. ~~No~~ Not later than 30 days before expiration of an ~~Appraiser's~~ appraiser's license or certificate, an ~~Appraiser~~ appraiser seeking to renew the license or certificate shall submit a completed application accompanied by the ~~appropriate~~ required renewal application fees. Once the application has been filed, fees are ~~non-refundable~~ nonrefundable, unless A.R.S. § 41-1077 is applicable. To be eligible for a renewal of a license or certificate, an applicant shall:
1. Meet the requirements of A.R.S. Title 32, Chapter 36, and these rules;
 2. Meet the continuing education requirements set forth ~~in the Appraiser Qualification Criteria in The Real Property Appraiser Qualification Criteria and Interpretations of the Criteria adopted February 16, 1994, effective January 1, 1998. All Interpretations and Supplementary Information as of January 1, 2002, and Appendix I, Criteria Revisions effective January 1, 2003, which is~~ incorporated by reference in R4-46-201(A); except:
 - a. The Board shall not grant credit toward the classroom hour requirement unless the length of the educational offering is at least three hours.
 - b. The American Council on Education's Program on Noncollegiate Sponsored Instruction (ACE/Credit Program) is not an approved organization for distance education course reviews, and
 - c. A renewal applicant shall not obtain more than 75% of required continuing education through distance education; and
 3. Pay the renewal and biennial federal registry fees.
- B. ~~In addition to the requirements in subsection (A), effective October 1, 2000, a~~ A renewal applicant shall demonstrate completion of a minimum of 14 hours of course work ~~in USPAP consisting of two 7-hour National USPAP Update Courses, or their equivalent, approved through the AQB Course Approval Program, within four years prior to before~~ expiration of the license or certificate. ~~Course~~ A course used to satisfy this requirement cannot be used to satisfy the continuing education requirements of in subsection (A)(2) unless the course was completed within ~~the two years prior to before~~ the expiration of the license or certificate. Each appraiser shall successfully complete the 7-hour National USPAP Update Course, or its equivalent, approved through the AQB Course Approval Program, at least every two years. A renewal applicant shall not substitute the 15-hour National USPAP Course, or its equivalent, approved through the AQB Course Approval Program, for the 7-hour National USPAP Update Course, or its equivalent, approved through the AQB Course Approval Program.
- C. If the last day for filing falls on a Saturday, Sunday, or legal holiday, ~~the Appraiser~~ an appraiser may file the renewal form on the next business day.

R4-46-208. Renewal of an Expired License or Certificate

- A. An ~~Appraiser~~ appraiser may renew a license or certificate ~~which that~~ has expired within 90 days of expiration. If the last day falls on a Saturday, Sunday, or legal holiday, the ~~Appraiser~~ appraiser may file a renewal on the next business day.
- B. To apply for renewal of an expired license within the ~~90-day~~ 90-day period, an ~~Appraiser~~ appraiser shall comply with the requirements of R4-46-207 ~~and submit the delinquent renewal fee prescribed by R4-46-207 and submit the delinquent renewal fee prescribed by R4-46-106. Once an application for renewal of an expired license or certificate has been filed, fees are non-refundable. nonrefundable, unless A.R.S. § 41-1077 is applicable.~~
- C. An ~~Appraiser~~ appraiser who fails to seek renewal within the time prescribed by this rule shall re-apply, ~~meeting and meet~~ the requirements of R4-46-202(B).

NOTICE OF FINAL RULEMAKING

TITLE 7. EDUCATION

CHAPTER 2. STATE BOARD OF EDUCATION

[R05-161]

PREAMBLE

1. Sections Affected

R7-2-612
R7-2-613

Rulemaking Action

Amend
Amend

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

Authorizing statute: A.R.S. § 15-203(A)

Implementing statutes: A.R.S. §15-203(A)(14); A.R.S. §15-206 through §15-207; A.R.S. §15-191.01; and A.R.S. §15-1251

Notices of Final Rulemaking

3. The effective date of the rules:

June 26, 2005

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

Notice of Rulemaking Docket Opening: 9 A.A.R. 3351, July 25, 2003

Notice of Proposed Rulemaking: 9 A.A.R. 5512, December 26, 2003

Notice of Supplemental Proposed Rulemaking: 10 A.A.R. 1618, April 23, 2004

Notice of Supplemental Proposed Rulemaking: 10 A.A.R. 3950, October 1, 2004

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

Name: Vince Yanez, Executive Director, Arizona State Board of Education

Address: 1535 W. Jefferson
Phoenix, AZ 85007

Telephone: (602) 542-5057

Fax: (602) 542-3046

6. An explanation of the rule, including the agency's reason for initiating the rule:

The State Board of Education is initiating the creation of an Early Childhood Education Certificate and an Early Childhood Education Endorsement for Arizona teachers to provide improved professional development and teacher preparation programs for educators who will be providing services in the early years, primarily, preschool and kindergarten programs. The Board recognizes that early childhood, the years between birth and age eight, are an important and unique period in a child's life. Recent research and national reports suggest early experiences and education are of critical importance for a child's cognitive, social, emotional and educational success and well being. New research finds that young children's learning and development clearly depends on the educational qualifications of their teachers.

Under the current teacher certification system in Arizona, all teachers teaching public school kindergarten and primary grades must have an elementary teaching certificate, but they are not required to have more than one course in child development nor training in early childhood education as part of that preparation. More importantly, teachers of preschool children may obtain an early childhood special education certificate but the certification requirements to build a foundation in child development does not provide specific guidance as to hours of coursework critical to building the foundation of knowledge in teaching young children with and without special needs. Furthermore, the practicum requirement for this certificate does not require a beginning teacher to obtain experience in teaching all ages of children birth to eight.

Current teacher certification standards were developed prior to the extensive availability of, and demand for, early childhood education programs. These proposed rules will strengthen Arizona's teacher quality in the area of early childhood education, improve the quality of early childhood programs, and influence teacher preparation programs in the state. Most importantly, the proposed rules will assist Arizona's youngest children to start school ready to learn.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

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:

The rule will not diminish a previous grant of authority of a political subdivision of this state.

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

The rules as proposed are not expected to have a significant economic impact. A minimal impact may occur after July 1, 2009 for members of the teaching profession who are providing preschool and kindergarten education in public schools in Arizona. For these teachers, the adoption of the new Early Childhood Education Certificate and Early Childhood Education Endorsement will institute an additional certification/endorsement requirement and the associated fees will be assessed. The economic impact is negated, however, with the inclusion of a "grandfathering" provision for teachers certified prior to July 1, 2006 with preschool or kindergarten teaching experience. An economic impact will really only occur for individuals wishing to change careers or levels of teaching instruction which often require additional certifications and/or endorsements. It is anticipated that the possible minimal individual costs will be out-weighed by the positive effects on students in public early childhood education programs. Certification and endorsements in the area of early childhood education will provide more specialized professional development in this critical stage of learning and brain development, leading to higher quality early childhood education programs.

Notices of Final Rulemaking

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

The changes made between the Proposed Rule and the Notice of Final Rulemaking, including two Supplemental Rulemaking notices, include:

The Proposed Rules provided an implementation requirement by the 2009-2010 school year and the Final Rules provide an exact date of July 1, 2009.

The Proposed Rules required an early childhood certificate or endorsement for individuals teaching in public school infant/toddler, preschool and kindergarten programs, however the Final Rules clarify that these requirements apply to "early childhood education programs" and provide a definition of such programs.

The Proposed Rules required an early childhood certificate or endorsement for all individuals teaching in public school infant/toddler, preschool and kindergarten programs. The Final Rules provide an exception to the traditional endorsement requirements for teachers certified in elementary education or special education prior to July 1, 2006. Teachers certified in elementary education or special education prior to July 1, 2006 who have at least three years early childhood teaching experience in the preceding 10 years and who have passed the early childhood subject knowledge portion of the Arizona Educator Proficiency Assessment will also be eligible to receive an Early Childhood Education Endorsement.

The Proposed Rules provided for both the award of an Early Childhood Education Certificate and Endorsement if an individual holds current National Board Certification in Early Childhood, however the Final Rules provide for eligibility for an Early Childhood Education Certificate only as the endorsement is not necessary if an individual qualifies for the full certificate.

The Proposed Rules required eight practicum hours with flexibility in the ages served and the Final Rules require a minimum of eight practicum, internship or student teaching hours and delineate that these hours must include at least four semester hours of supervised experience in a birth – preschool setting, and at least four semester hours of supervised experience in a kindergarten – grade 3 setting.

The Proposed Rules allowed for verified teaching experience in either a school-based education program or a DHS licensed child care center-based program to substitute for the required practicum to obtain an Early Childhood Education Certificate or Endorsement. The Final Rules include teaching experience in entities regulated by either tribal authorities or the military to substitute as well.

The Final Rules also contain additional technical and conforming changes, including incorporating by reference the K-12 Academic Standards and the Early Childhood Education Standards. Specific technical changes include the following: In R7-2-612 (I) (1) and R7-2-612 (J) (1), the term "will" was changed to "shall." In R7-2-612 (I) (2), four lines above subsection (I) (3), the word "conflict" was changed to "conflicts." In R7-2-612 (I) (4) (b) (ii) (2) (b), the period at the end of the last sentence was replaced with a semicolon and the word "or," and in R7-2-613 (L) (3) (a) and R7-2-613 (L) (3) (b) (ii) (2), the period at the end of each subsection was replaced with a semicolon.

11. A summary of the comments made regarding the rule and the agency response to them:

The following comments were made to the proposed and supplemental rules:

Comment: Clarity is needed in identifying what programs must have teachers with an Early Childhood Education Certificate of Endorsement.

Response: The term "early childhood education programs" has been defined and used consistently throughout the rules.

Comment: The rules should "grandfather" existing K-3 certified teachers and provide them an exemption to this new certification/endorsement requirement.

Response: The final rules provide an alternative path to receive an early childhood education endorsement for teachers certified in elementary education or special education prior to July 1, 2006, recognizing their early childhood education teaching experience.

Comment: The practicum hours required to obtain an Early Childhood Education Certificate should provide for experience in both a birth-preschool setting and a kindergarten-grade 3 setting.

Response: This recommendation was included in the Final Rules.

Comment: The rules should "grandfather" existing preschool teachers and provide them an exemption to this new certification/endorsement requirement.

Response: This recommendation was not included in the Final Rules. It was determined that preschool is a critical time in early childhood education. Individuals providing this instruction are not currently certificated and they should be when providing instruction in an "early childhood education program" as defined by these Rules.

Comment: Professional development activities should be able to be substituted for required coursework to obtain an Early Childhood Education Certificate.

Notices of Final Rulemaking

Response: This recommendation was not included in the Final Rules. Establishing criteria to approve professional development activities and approving such activities for initial certification is beyond the capacity of current Board and Department of Education resources.

Comment: The Supplemental Proposed Rules provide that student teaching may occur in either a school-based education program or Department of Health Services licensed center-based programs. This inadvertently excludes tribal regulating agencies that control child care within the tribe or nation.

Response: This recommendation has been included in the Final Rules. The Final Rules also include entities regulated by the military in order to encompass all regulated environments where individuals may gain early childhood teaching experience.

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

No

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

K-12 Academic Standards and Early Childhood Education Standards referenced in R7-2-612(I)(2)

14. Was this rule previously made as an emergency rule?

No.

15. The full text of the rules follows:

TITLE 7. EDUCATION

CHAPTER 2. STATE BOARD OF EDUCATION

ARTICLE 6. CERTIFICATION

Section

R7-2-612. Other Teaching Certificates

R7-2-613. Endorsements

ARTICLE 6. CERTIFICATION

R7-2-612. Other Teaching Certificates

- A. No change
- B. No change
- C. No change
- D. No change
- E. No change
- F. No change
- G. No change
- H. No change

I. Provisional Early Childhood Education Certificate - birth through age eight

1. By July 1, 2009, either a provisional or a standard early childhood education certificate shall be required for individuals teaching in public school early childhood education programs, except as provided in R7-2-610 or in R7-2-613(L). For individuals teaching in grades 1 - 3, this certificate is optional, but recommended.
2. For the purposes of this rule, public school early childhood education programs are defined as education programs provided by local education agencies, including their sub-grantees and contracted providers, for children birth through age 8 for the purpose of providing academically and developmentally appropriate learning opportunities that are standards-based with defined curriculum and comprehensive in content to include all appropriate developmental and academic areas as defined by the Arizona Early Childhood Education Standards or the Arizona K-12 Academic Standards approved by the Board. The Arizona Early Childhood Education Standards: Arizona Department of Education, 1535 West Jefferson, Phoenix, AZ 85007, were adopted by the State Board of Education in June 2003 and the Arizona K-12 Academic Standards: Arizona Department of Education, 1535 West Jefferson, Phoenix, AZ 85007, were adopted by the State Board of Education as follows: Arts, April 1997; Comprehensive Health/PE, April 1997; Foreign and Native Language, April 1997; Mathematics, March 2003; Reading, March 2003; Science, May 2004; Social Studies, March 2000; Technology, September 2000; Workplace Skills, March 1997; and Writing, June 2004, are incorporated by reference and are on file with the Arizona Department of Education. This incorporation by reference contains no further editions or amendments. Copies of the incorporated material are available for review at Arizona Department of Education, 1535 West Jefferson, Phoenix, AZ 85007 or on the Arizona Department of Education web site at www.ade.az.gov/standards. Public school early childhood education programs include, but are not limited

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to, half day and full day kindergarten programs, Early Childhood Block Grant programs pursuant to A.R.S. §15-1251, Family Literacy Programs for preschool children pursuant to A.R.S. §15-191.01, and public school-administered early childhood education programs funded in whole or part with federal funds, such as the Head Start or Even Start programs, provided nothing in these rules conflicts with the terms of the federal grant. Extended day child care programs provided by local educational agencies are not considered early childhood education programs for purposes of this rule unless the program meets the definition of a public school early childhood education program set forth above.

3. This certificate is valid for two years and is not renewable.
 4. The requirements are:
 - a. A Bachelor's degree; and
 - b. One of the following:
 - i. Completion of a teacher preparation program in early childhood education from an accredited institution or a teacher preparation program approved by the Board; or
 - ii. Early childhood education coursework and practicum experience which teaches the knowledge and skills described in R7-2-602 and includes both of the following:
 - (1) 37 semester hours of early childhood education courses to include all of the following areas of study:
 - (a) foundations of early childhood education;
 - (b) child guidance and classroom management;
 - (c) characteristics and quality practices for typical and atypical behaviors of young children;
 - (d) child growth and development, including health, safety and nutrition;
 - (e) child, family, cultural and community relationships;
 - (f) developmentally appropriate instructional methodologies for teaching language, math, science, social studies and the arts;
 - (g) early language and literacy development;
 - (h) assessing, monitoring and reporting progress of young children; and
 - (2) A minimum of 8 semester hours of practicum, including:
 - (a) A minimum of 4 semester hours in supervised field experience, practicum, internship or student teaching setting serving children birth – preschool. One year of full-time verified teaching experience with children in birth – preschool may substitute for this student teaching experience. This verification may come from a school -based education program or center-based program licensed by the Department of Health Services or regulated by tribal or military authorities; and
 - (b) A minimum of 4 semester hours in a supervised student teaching setting serving children in kindergarten - grade 3. One year of full-time verified teaching experience with children in kindergarten – grade 3 in an accredited school may substitute for this student teaching experience; or
 - iii. A valid early childhood education certificate from another state.
 - c. A valid Fingerprint Clearance Card issued by Arizona DPS; and
 - d. A passing score on the professional knowledge portion of the Arizona Educator Proficiency Assessment once that portion of the AEPA is adopted by the Board; and
 - e. A passing score on the early childhood subject knowledge portion of the Arizona Educator Proficiency Assessment once that portion of the AEPA is adopted by the Board.
- J. Standard Early Childhood Education Certificate - birth through age eight**
1. By July 1, 2009, either a provisional or a standard early childhood education certificate shall be required for individuals teaching in public school early childhood education programs, except as provided in R7-2-610 or in R7-2-613(L). For individuals teaching in grades 1 - 3, this certificate is optional, but recommended.
 2. This certificate is valid for six years.
 3. The requirements are:
 - a. Qualification for the Provisional Early Childhood Education Certificate, except as provided in R7-2-612(J)(4); and
 - b. Two years of verified teaching experience with children birth through age eight or grade three in a school-based education program or center-based program licensed by the Department of Health Services or regulated by tribal or military authorities.
 4. An individual may also qualify for a standard Early Childhood Education Certificate if the individual:
 - a. Holds current National Board Certification in Early Childhood; and
 - b. Holds a valid fingerprint Clearance Card issued by DPS.

R7-2-613. Endorsements

- A. No change
- B. No change
- C. No change
- D. No change

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

L. Early Childhood Education Endorsement – birth through age eight

1. An early childhood endorsement is optional, but recommended for individuals teaching in public school early childhood education programs who are not otherwise certified in early childhood education. When combined with an Arizona elementary education teaching certificate or an Arizona special education teaching certificate, it may be used in lieu of a standard early childhood education certificate as described in R7-2-612(I).
2. An endorsement shall be automatically renewed with the certificate on which it is posted.
3. The requirements are:
 - a. A valid Arizona elementary education teaching certificate as provided in R7-2-608 or a valid Arizona special education teaching certificate as provided in R7-2-610;
 - b. Early childhood education coursework and practicum experience which includes both of the following:
 - i. 21 semester hours of early childhood education courses to include all of the following areas of study:
 - (1) foundations of early childhood education;
 - (2) child guidance and classroom management;
 - (3) characteristics and quality practices for typical and atypical behaviors of young children;
 - (4) child growth and development, including health, safety and nutrition;
 - (5) child, family, cultural and community relationships;
 - (6) developmentally appropriate instructional methodologies for teaching language, math, science, social studies and the arts;
 - (7) early language and literacy development;
 - (8) assessing, monitoring and reporting progress of young children; and
 - ii. A minimum of 8 semester hours of practicum including:
 - (1) A minimum of 4 semester hours in a supervised field experience, practicum, internship or student teaching setting serving children birth – preschool. One year of full-time verified teaching experience with children in birth – preschool may substitute for this student teaching experience. This verification may come from a school -based education program or center-based program licensed by the Department of Health Services or regulated by tribal or military authorities; and
 - (2) A minimum of 4 semester hours in a supervised student teaching setting serving children in kindergarten - grade 3. One year of full-time verified teaching experience with children in kindergarten – grade 3 in an accredited school may substitute for this student teaching experience;
 - c. A valid Fingerprint Clearance Card issued by Arizona DPS; and
 - d. A passing score on the early childhood subject knowledge portion of the Arizona Educator Proficiency Assessment once that portion of the AEPA is adopted by the Board.
4. Teachers with a valid Arizona elementary education certificate or Arizona special education certificate as of July 1, 2006 meet the requirements of this Section with evidence of the following:
 - a. A minimum of three years infant/toddler, preschool or kindergarten - grade 3 classroom teaching experience within 10 years prior to July 1, 2009, and
 - b. A passing score on the early childhood subject knowledge portion of the Arizona Educator Proficiency Assessment once that portion of the AEPA is adopted by the Board.

L.M. Middle Grade Endorsement -- grades 5 - 9

1. No change
2. No change

M.N. Drivers Education Endorsement

1. No change
2. No change

N.O. Cooperative Education Endorsement -- grades K - 12

1. No change
2. No change

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
HEALTH CARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED

[R05-169]

PREAMBLE

1. Sections Affected

R9-27-101
R9-27-201
R9-27-202
R9-27-203
R9-27-204
R9-27-205
R9-27-206
R9-27-207
R9-27-208
R9-27-209
R9-27-210

Rulemaking Action

Amend
Repeal
Amend
Amend
Amend
Repeal
Repeal
Repeal
Repeal
Repeal
Amend

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

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

Implementing statute: A.R.S. § 36-2912(I)(5)

3. The effective date of the rules:

May 3, 2005

The rules are effective on filing with the Office of the Secretary of State as allowed under A.R.S. § 41-1032(A)(1) and (A)(4). These rules provide a public benefit and there is no penalty associated with a violation of the rules. In addition, these rules help to preserve the public health of Arizona citizens. In Arizona, 96% of all businesses are small businesses with 50 or less employees. Only 30% of these small employers offer health care coverage to their employees. Healthcare Group provides health care coverage to this consumer market, which currently totals more than 13,000 members in the state. Changes to the scope of services rules will allow Healthcare Group to provide health care coverage to more employees of small businesses. The rules do not contain a penalty for violations.

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

Notice of Rulemaking Docket Opening: 10 A.A.R. 4489, November 5, 2004

Notice of Proposed Rulemaking: 10 A.A.R. 5166, December 27, 2004

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

Name: Jane McVay
Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4135
Fax: (602) 253-9115
E-mail: AHCCCSRules@ahcccs.state.az.us

6. An explanation of the rule, including the agency's reason for initiating the rule:

In 1988, the Arizona Legislature created the Healthcare Group Program to offer health insurance to a segment of the health insurance market, small businesses, that the Legislature felt were not adequately served by commercial insurers. Healthcare Group was created as a division within the Administration to provide affordable and accessible health care benefit plans for Arizona small businesses with 50 or fewer employees. In Arizona 96% of all businesses are small businesses. Only 30% of Arizona small employers provide health care coverage to their employees. Many of these employees are low-wage earners whose income is on the verge of eligibility for AHCCCS coverage. Legislation was enacted in 2004, which allows Healthcare Group to offer health care coverage plans to employees of political subdivisions in the state, in addition to small businesses. As of March 3, 2005, 13,246 persons subscribe to health care coverage

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through Healthcare Group. Fifteen individual members who are eligible for the federal health care tax credit under 26 U.S.C. 35 also have Healthcare Group coverage. A total of 4,660 employers and 3 political subdivisions offer Healthcare Group coverage.

Typically, commercial insurers "rate" small groups; that is, the premium for the group is based on the health histories of the individual members. As a result, the premiums for the employee with a history of illness and the other members of the group are often prohibitively expensive. Under A.R.S. § 36-2912, the Healthcare Group Program was designed to offer health insurance to small groups without "rating" prospective members based on individual histories. In effect, the risk is spread over all participants in the program equally rather than being assigned to the individual employer group.

The Healthcare Group Program consists of contracts between the Health Care Group Administration (HCGA) and small employers that wish to offer, as an employment benefit, health coverage for the employers, employees, and their dependents. These contracts are known as Group Service Agreements or GSA's. HCGA has responsibility for the design of those contracts and for determining the eligibility of employer groups and covered persons. HCGA also establishes premium rates sufficient to cover the risk and collects those payments from the employer. Essentially, the HCG Program consists of a series of voluntary contracts between the agency and small employers, between the agency and HMO-style managed care entities, and potentially between the agency and providers and administrative entities. Under A.R.S. § 41-1015(A)(15), matters relating to state contracts are exempt from the requirements of formal rulemaking. AHCCCS is required to establish rules for the Healthcare Group Program under A.R.S. § 36-2912(I)(5). The only specific rulemaking requirement in A.R.S. § 36-2912(G) is for AHCCCS to adopt rules to allow a business to continue Healthcare Group coverage when the number of employees exceeds 50. Aside from this requirement, rulemaking authority for the Healthcare Group Program is permissive. The statute gives AHCCCS permissive authority to establish rules to allow withholding of payments to a contractor for failing to comply with the contract or with adopted rules. The agency's objective is to use the rules as a means by which interested employers or employees can obtain basic information regarding the program but to refer them to the actual contracts for details.

Currently, the HCG Program offers three different options to participating employers, employees, and their dependents. In general terms, these options vary based on the level of copayments, coinsurance, and deductibles, and to some extent on the scope of covered services (that is, some of the options are more comprehensive than others). Although HCG does not consider the health history of individuals in setting premiums, each of the options has a different premium schedule that takes into consideration the age, sex, and location of the member, as well as the option selected. Within the same employer group, individual employees can select from the available options. HCG does not prescribe any level of employer participation in the financial cost – they may cover the cost themselves, share the cost with the employees, or simply allow payroll deduction for the employee with the employee carrying the full cost.

In general, participation in Healthcare Group is limited to employers of fewer than 50 persons. Under the current statute, the employer must not have offered group health insurance during the 180-day period prior to HCG coverage. This limitation was designed to provide reasonable assurances to the commercial health insurance industry that the market consisted of the uninsured, thereby, minimizing the loss of commercial carriers to Healthcare Group. As of State Fiscal Year 2004, the program is funded by the premiums paid by the participating employers. Participation, on both the employer level and the individual employee level, is voluntary.

With respect to the actual delivery of services, HCG currently assigns employer groups to a managed care entity ("health plans") under contract with HCG, or where choice is available, allows the employer to select from HCG-contracted managed care entities. The contracts between HCGA and the health plan define the network of providers from whom service is received, and assign responsibility for medical management and payment of claims consistent with the terms of the health plan contract and the contract between HCG and the employer. These health plans are "at risk;" that is, the agency pays the health plan on a per member per month basis and, in return, the health plan is obligated to cover the costs of all medical care covered under the GSA regardless of the actual cost of those services. Essentially, they operate like Health Maintenance Organizations.

At the outset of the HCG Program, the agency exercised its discretion to administer the Program in a fashion similar to the other health programs administered by the agency. At the time, all of the participating health plans also participated in the other AHCCCS programs, thus the uniformity offered the advantage of simplified administration for both the agency and its contracted health plans. During the past few years and legislative sessions, there has been a recognition that the HCG Program can more effectively meet the needs of small business through greater program flexibility. For instance, recent statutory changes permit the agency to contract directly with providers in the absence of a willing contractor and with third parties to assist with the administration of the program. This enables the Program to offer preferred provider networks ("PPO"), in addition to the closed network of the HMO-style product offered through the health plans. Under the PPO model, the agency manages the risk itself and will adjust premiums, if necessary, through contract amendments to cover the claims experience associated with the PPO product.

Of particular importance are proposed modifications to the rules that define the scope of services offered by the Program. By statute, the agency has the discretion to establish the scope of services under the GSA's. However, in some instances, the current rules restrict the program from offering services that many employer groups are willing to pay for (for instance, dental and mental health coverage). It is also possible that the current rules could be interpreted to require the coverage of certain services that are perceived as of little value to employer groups or are offered under terms that make the fiscally sound premiums excessive from the employer group's perspective. These proposed rules

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set forth the basic terms of coverage without unduly restricting or mandating services. As noted in the rules, the details of coverage are reflected in the terms of the Group Service Agreement and are described in the member handbooks that are available to prospective members and provided to all active members. In effect, these rules advise the public of the Healthcare Group program, but permit the agency the flexibility to tailor health insurance benefit options to the needs of different segments of the target market.

The Administration is updating the Healthcare Group rules on program-related definitions and the scope of services to conform them to current practice and state statutes, and to make them more clear, concise, and understandable. The Group Service Agreement that an employer group signs with Healthcare Group contains many provisions pertaining to the scope of Healthcare Group services. The rules will also allow Healthcare Group to have more flexibility in the types of services and plans provided. Healthcare Group is offering a greater number of affordable health care coverage plans to provide health care coverage to an increasing number of employees and families. This will help to reduce the substantial number of uninsured Arizona citizens. In addition, this will allow employees throughout the state who meet the eligibility criteria to obtain affordable health care coverage. These health care benefit plans provide an additional option for many employees and their families to obtain affordable health care coverage.

New provisions are added to conform to provisions in Chapter 332, Laws 2004, Second Regular Session, regarding creditable coverage for an employee who is eligible for Healthcare Group coverage due to receipt of a federal health coverage tax credit under 26 U.S.C. 35. The definition of experimental services is amended to delineate the criteria for experimental services.

Health care coverage is defined to provide a distinction between this coverage and other types of coverage, such as Medicare Supplemental insurance, accident insurance, and similar types of coverage. The rules also contain a definition of member handbook and evidence of coverage, the written description of services and rights and responsibilities given to each employee. Provisions regarding pre-existing conditions are revised to include adopted children, children placed for adoption, and certain eligible employees who have twelve months of creditable coverage or 18 months for a late enrollee. Late enrollee pre-existing condition provisions are revised to conform to state statutes. These rules also detail the procedures for receiving out-of-network coverage for emergency medical and ambulance services, the notification requirements, and the terms of financial liability. The rules also include a listing of services that are excluded from coverage in the HCG Plan.

7. **A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

AHCCCS did not review any studies relating to the rules.

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:**

AHCCCS believes that the overall impacts of the rules on small businesses and consumers are beneficial, however, consumers may have an additional financial burden due to use of out-of-network emergency services. The availability of affordable health care coverage to employees through Healthcare Group to individuals who do not currently have health care coverage and do not meet the AHCCCS eligibility requirements, will have a positive economic impact on the state. Small businesses provide health care coverage to only about 30 percent of Arizona's citizens. Many Arizona businesses and employees are unable to find affordable health care coverage. More than 1,000,000 persons currently receive health care services under all the AHCCCS programs. The availability of additional health care coverage options through Healthcare Group provides an option for uninsured persons to obtain affordable health care coverage. The availability of more Healthcare Group plans benefits employees and businesses. Expansion of health care coverage will benefit consumers, particularly in rural areas, who have limited health care coverage choices. AHCCCS believes that for the limited coverage benefits options, the cost of the premium will be lower and more affordable. However, in each case, the employee will have the option of a comprehensive benefit that although higher priced, is still affordable for many low-income workers. AHCCCS believes that the new health care benefit options will be price competitive and attractive to employees at each income level. The multiple plan options afford the employee a choice of health plan network and benefit options based on their health care needs. The cost of Healthcare Group coverage is comparable to the stated average premium offerings of many commercial plans.

Health care coverage is currently provided by managed care entities who contract with Healthcare Group. Healthcare Group plans to continue to invite commercial insurers to provide health care coverage to Arizonans, so the approval of these rules is not anticipated to have a negative impact on commercial insurance businesses. The statutes require that employers must have a "bare period" of 180 days with no health care coverage in order to be eligible to enroll in Healthcare Group plans. This means that when these employees enroll with a Healthcare Group plan, business is not being taken away from a commercial insurance company. Finally, Healthcare Group is not competing with commercial insurers to insure the same employees because many of them work part-time or in high-risk businesses for which commercial insurers are not interested in providing health care coverage.

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Availability of affordable health care coverage through Healthcare Group provides an important option for employed persons who meet the eligibility requirements to obtain health care coverage. Many uninsured employees wait until they have an illness or emergency and "spend down" to become eligible for AHCCCS coverage. The increase to more than 1,000,000 Arizonans receiving health care coverage through AHCCCS has created a substantial medical and financial liability for the state. The rate of growth of Arizona's uninsured population far exceeds the rate of growth of the state general fund. The result will be a structural deficit in the future with inadequate money in the state general fund to pay health care costs for an increasing AHCCCS membership. For these reasons, these rules will have a positive economic impact on small business, consumers, and the state.

The purpose of the changes to R9-27-204 regarding notification by emergency providers to health plans is to clarify in rule the current practice. This will reduce problems associated with inconsistent application of claims denied for late notification, as well as the member responsibility to pay for non-covered services. Acute care hospitals are well aware of their responsibility to notify the health plan within 48 hours. Historically, emergency care providers have complied with these standards. The reason this requirement is necessary is to avoid hospitals delaying notification and not allowing the health plans to manage the patient's care by transferring care (when medically appropriate) to a network provider that will reduce the problem of out-of-network coverage for individuals that choose the PPO option.

A member or provider may appeal any decision or adverse action taken by the health plan for denial of all or a part of the claim under 9 A.A.C. 34. This process must be completed within a specified period of time. If the denial is upheld, there is no economic impact. If the appeal is upheld, the medical cost is part of the health plan medical cost risk, or the cost may be covered by reinsurance if it meets the criteria.

In regard to the formulary available to consumers, each health plan maintains a formulary. Each formulary has a minimum of 2 different medications in each therapeutic class. Currently, our health plans may authorize FDA-approved medications for off-label use in both an ambulatory or an inpatient setting.

Employees receive services from providers under contract with their health plan. The contract specifies the terms of reimbursement and requires the provider to accept payment from the health plan as payment in full. In the case of emergency services, however, the member may go to a provider for emergency out-of-network services, which may be an uncontracted provider. In this instance, the health plan has no means to require the provider to accept the payment from the health plan as payment in full. Under the terms of the current contracts with employers, the health plan is obligated to pay 80% of billed charges for these services. If the provider is unwilling to accept this as payment in full, the member may have a residual financial responsibility amounting to a 20% copayment. In this situation, the employee may have an additional burden. If AHCCCS contracts with a larger network of providers for emergency services, the health care premium costs might be higher.

This rulemaking will have a minimal economic impact on AHCCCS and the Secretary of State for costs associated with the rulemaking. In summary, AHCCCS believes that the rules provide additional health care options to uninsured persons in the state and have beneficial impacts that outweigh any costs that may be associated with out-of-network emergency services.

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

R9-27-101	<ul style="list-style-type: none"> • Deleted the definitions of disability and substantial gainful activity from this Section and moved them into R9-27-303, Healthcare Group rulemaking, Article 3. • In definition of "employee member" struck citation of "Section 35 of the Internal Revenue Code of 1986" and inserted "26 U.S.C. 35". • In definition of "enrollment" deleted "HCG provides the eligible employee and dependent with written notification of the effective date of coverage." • Struck location of definition of "experimental services in R9-22-101 and amended the definition in R9-27-101(B), as follows: "Experimental services means services that are associated with treatment or diagnostic evaluation and that are not generally and widely accepted as a standard of care in the practice of medicine in the United States unless: The weight of evidence in peer-reviewed articles in medical journals published in the United States supports the safety and effectiveness of the service, or In the absence of such articles, for services that are rarely used, novel, or relatively unknown in the general professional medical community, the weight of opinions from specialists who provide the service attests to the safety and effectiveness of the service." • In definition of "Full-time employee" after "employee" inserted "or a self-employed person." Deleted language that employment is expected to continue for at least 5 months. • In definition of "HCGA" inserted "or Healthcare Group Administration." • In definition of "health care coverage" deleted a hospital "and" medical service corporation policy, inserted "or." Deleted "individuals," inserted "persons." • In definition of "medically necessary," deleted "by the HCG Plan Medical Director," inserted "HCG Plan or HCGA Medical Director." • In definition of "member handbook and evidence of coverage" clarified that HCGA provides the handbook. • In definition of "network" deleted "health" plans. • Revised definition of "network provider" as follows: "Network provider means a provider who has a subcontract with the member's HCG Plan and renders covered services to a member." • Revised definition of "political subdivision" as follows: "Political subdivision means the state of Arizona or a county, city, town, or school district within the state, or entity whose employees are eligible for hospitalization and medical care under Arizona Revised Statutes, Title 38, Chapter 4, Article 4." • Revised definition of "prior authorization" as follows: "Prior authorization means the process by which the Healthcare Group Administration or the HCG Plan informs a provider that it has made a preliminary determination that the requested service is medically necessary, appropriate, and is a covered service. Prior authorization is not a guarantee of payment." • In definition of "qualifying event" after "situation" inserted "as described in the GSA."
R9-27-202	<ul style="list-style-type: none"> • Deleted "Not all medically necessary services are covered services."
R9-27-203	<ul style="list-style-type: none"> • In subsection (A)(3), revised as follows: "Services that require prior authorization for which the member does not obtain prior authorization." • In subsection (A)(5) struck "reasonably." • Revised subsection (A)(6) as follows: "Pregnancy termination, except when required by law to be covered." • Revised subsection (A)(8) as follows: "Services that HCGA, through its Medical Director, deems are not medically necessary." • Revised subsection (A)(11) as follows: "Experimental services; and" • In subsection (A)(12), revised as follows: "Medications not approved by the FDA." (See item 7.) • In subsection (B)(2) after "medically necessary" deleted: "as determined by the HCG Plan Medical Director, or designee."

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R9-27-204	<ul style="list-style-type: none"> • In subsection (A)(1), struck "the nearest medical facility capable of providing necessary emergency services. Inserted "a medical facility." • Revised last sentence in subsection (A)(2) as follows: "Failure to provide timely notice constitutes cause for denial of payment unless the member or provider shows good cause." • Revised subsection (B) as follows: "Emergency ambulance services required to transport a member to a medical facility that provides emergency services are covered if the provider notifies the HCG Plan within 10 working days from the day that the member presents for emergency ambulance service." In the last sentence, after "payment" inserted "unless the provider shows good cause." • Struck subsection (C), inserted the following: "The financial liability of HCG for coverage for out-of-network emergency services may be limited under the terms of the GSA. Members receiving out-of-network emergency services may be financially liable to an out-of-network provider to the extent charges by the provider exceed the financial liability established in the GSA." • Deleted former subsection (D): "Payment for out-of-state inpatient and outpatient hospital services, including emergency services shall be made in accordance with A.A.C. R9-22-703(E)."
R9-27-210	<ul style="list-style-type: none"> • In subsection (A), after "A.R.S. § 36-2912" inserted "and the GSA." • Revised subsection (B)(1) as follows: "An employee eligible under R9-27-302(A)(1) who meets the aggregate periods of creditable coverage as calculated under A.R.S. § 36-2912 of 12 months or 18 months in the case of a late enrollee." This change is required to make the rule consistent with A.R.S. § 36-2912(R)(1) and COBRA. • Deleted subsections (D)(1) and (D)(2) as follows (See item 11): "1. For 12 months if the member enrolls within 30 days of the designated enrollment time-frame, or 2. For 18 months if the member enrolls 31 or more days after the designated time-frame for enrollment."
General	<ul style="list-style-type: none"> • AHCCCS made the rules more clear, concise, and understandable by making grammatical and structural changes throughout the rules.
General	<ul style="list-style-type: none"> • AHCCCS made grammatical and stylistic changes at the suggestion of the Governor's Regulatory Review Council staff.

11. A summary of the comments made regarding the rule and the agency response to them:

Comments were submitted that did not relate to this rulemaking and are not discussed here. Comments regarding the location of the definitions of disability and substantial gainful activity are contained in the Notice of Final Rulemaking for the Healthcare Group rules for Article 3. The summary of the comments submitted that relate to provisions contained in this rulemaking and the agency response to them, are as follows:

#	Subsection	Comment	Recommendation
1.	R9-27-101	Definition of emergency medical services in R9-27-101 does not conform with definition of emergency medical services in 42 U.S.C. 1396u-2, which does not include the "sudden onset" requirement. It also refers to "serious dysfunction of any bodily organ or part." Arizona Center for Disability Law	Disagree. Although the "sudden onset" provision does not appear in federal statute, "sudden onset" is found in the implementing federal regulation, 42 CFR 440.255. Moreover, these federal provisions apply to the Medicaid program and not to health care coverage offered by Healthcare Group.
2.	R9-27-101	Definition of inpatient hospital services is "services received at a hospital that result in an inpatient admission."Redraft language to state that inpatient hospital services are services provided to a patient who is admitted to a hospital for medical care or treatment. Arizona Center for Disability Law	Agree. Redrafted as follows: "Inpatient hospital services means services provided to a member who is admitted to a hospital, for medical care and treatment."

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3.	R9-27-101	<p>Definition of qualifying event fails to describe the eligible qualifying events for enrollment outside of a designated open enrollment period. To ensure members know their rights, these distinctions should be in rule rather than the GSA.</p> <p>Arizona Center for Disability Law</p>	<p>Disagree Qualifying events are listed in A.R.S. § 36-2912(AA)(9)(a) and are also in the GSA and in the member handbook. Pursuant to A.R.S. § 41-1005(A)(15), terms of state contracts are not required to be in rules.</p>
4.	R9-27-203 (A)(9)(a)	<p>Excludes coverage for injuries resulting from participation in a riot. The rule is very broad. Recommends removal or amending to limit application to injuries incurred as a result of participation in a riot when the person is convicted on related charges.</p> <p>Arizona Center for Disability Law</p>	<p>Disagree. This restriction is commonly found in commercial health insurance policies.</p>
5.	R9-27-203(A)(9)(b)	<p>Exclusion for injuries incurred as a result of committing or attempting to commit a felony is very broad. Recommended exclusion be amended or removed to clarify that it is limited to injuries incurred as a result of committing or attempting to commit a felony or assault when person is convicted.</p> <p>Arizona Center for Disability Law</p>	<p>Disagree. This restriction is commonly found in commercial health insurance policies.</p>
6.	R9-27-203(A)(9)(c), (d)	<p>Exclusions for committing intentional acts of self-inflicted injury or attempting suicide deprive coverage for person suffering from mental illness and blame person for consequences of the disease. Recommends exclusion from rule.</p> <p>Arizona Center for Disability Law</p>	<p>Disagree. This restriction is commonly found in commercial health insurance policies.</p>
7.	R9-27-203(A)(12)	<p>Exclusion of medications not approved by the FDA for the purpose prescribed will result in high unpaid medical bills. Off-label prescription use is reimbursable under Medicaid, Medicare, and other private insurance plans.</p> <p>Arizona Center for Disability Law</p>	<p>Partially Agree. Healthcare Group is not required to meet the same requirements for prescriptions as Medicare and Medicaid. Language is modified as follows: "Medications not approved by the FDA." Each health plan maintains a formulary. Each formulary has a minimum of 2 different medications in each therapeutic class. Currently, our health plans may authorize FDA-approved medications for off-label use in both an ambulatory and an inpatient setting.</p>
8.	R9-27-204(A)	<p>Citation in R9-27-204(A) should read 42 U.S.C. 1396u-2.</p> <p>Arizona Center for Disability Law</p>	<p>Agree. Agree with citation change.</p>
9.	R9-27-204(A)(1)	<p>R9-27-204(A)(1) provides coverage outside of the HCG plan network if the member presents for emergency medical services at the nearest medical facility capable of providing necessary emergency services. This will result in high unpaid medical bills. Recommends removal.</p> <p>Arizona Center for Disability Law</p>	<p>Agree. Language modified to remove requirement for member to go to the nearest emergency medical facility. If the provider is not within the HCG network, the member may be responsible for a portion of the unpaid medical expense as identified in the terms of the GSA and the member handbook.</p>

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10.	R9-27-204(A)(2), R9-27-204(B)	Emergency medical services are not covered unless the member or provider notifies the HCG Plan no later than 48 hours from the day the member presented for the service. Language struck from R9-27-209(B)(3) is omitted: "If a member is incapacitated, the provider is responsible for notifying the HCG Plan no later than 48 hours after the member is capable of verifying coverage under HCGA." Recommends this inclusion and adding a general provision permitting untimely notice for other good cause. Recommends adding an exception for timely notice for notification of emergency ambulance service. Arizona Center for Disability Law	Partially agree. Language modified to allow notification by members or providers no later than 48 hours (10 working days for ambulance service providers) and allows member or provider to show good cause. The 10 working day requirement reflects the requirements of the current rule (see R9-27-204(B)). EMS transportation providers are given additional time because it is often necessary to obtain that information from the member and in recognition of the fact that the information is not always available at the time of transport. The requirement was developed in consultation with representative providers of ambulance services.
11.	R9-27-210(D),	Language in R9-27-210(D) on late enrollee pre-existing condition timeframes appears to be inconsistent with the language in A.R.S. § 36-2912(AA)(9). A.R.S. § 36-2912 (AA)(9) requires a minimum 31day period after the minimum thirty-one day initial enrollment period. R9-27-210 permits only 30 days after the enrollment period. Recommends R9-27-210 conform to the statute. Arizona Center for Disability Law	Agree. Language in R9-22-210(D) is changed: "An HCG Plan shall exclude coverage for a pre-existing condition for a late enrollee according to A.R.S. § 36-2912." The statute adequately explains coverage exclusions for pre-existing conditions for late enrollees. It is not necessary to duplicate statutory language in rules.

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:

None

14. Was this rule previously made as an emergency rule?

No.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

**CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
HEALTH CARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED**

ARTICLE 1. DEFINITIONS

Section

R9-27-101. Location of Definitions

ARTICLE 2. SCOPE OF SERVICES

Section

R9-27-201. ~~Scope of Services~~ Repealed

R9-27-202. Covered Services

R9-27-203. Exclusions and Limitations

R9-27-204. ~~Out-of-service Area Coverage~~ Network Coverage of Emergency Medical Services

R9-27-205. ~~Outpatient Health Services~~ Repealed

R9-27-206. ~~Laboratory, Radiology, and Medical Imaging Services~~ Repealed

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- R9-27-207. Pharmaceutical Services Repealed
- R9-27-208. Inpatient Hospital Services Repealed
- R9-27-209. Emergency Medical Services Repealed
- R9-27-210. Pre-existing Conditions

ARTICLE 1. DEFINITIONS

R9-27-101. Location of Definitions

A. Location of definitions. Definitions applicable to this Chapter are found in the following:

Definition	Section or Citation
<u>"Accountable health plan"</u>	<u>A.R.S. § 20-2301</u>
"ADHS"	R9-27-101
"AHCCCS"	R9-27-101
"Administrative law judge"	A.R.S. § 41-1092
"Adverse action"	R9-27-101
"Administrative review"	R9-27-101
"Ambulance"	A.R.S. § 36-2201
"Certification"	29 U.S.C. 1181
"Clean claim"	A.R.S. § 36-2904
<u>"COBRA continuation provisions"</u>	<u>A.R.S. § 36-2912</u>
"Coinsurance"	R9-27-101
"Complainant"	R9-27-101
"Copayment"	R9-27-101
"Covered services"	R9-27-101
"Creditable coverage"	A.R.S. § 36-2912
"Date of notice"	R9-27-101
"Day"	R9-27-101
"Deductible"	R9-27-101
"Dependent"	R9-27-101
<u>"Disability"</u>	<u>R9-27-303</u>
"Durable medical equipment" or "DME"	R9-27-101
<u>"Effective date of coverage"</u>	<u>R9-27-101</u>
"Eligible employee"	A.R.S. § 36-2912
"Emergency ambulance service"	R9-27-101
"Emergency medical services"	R9-27-101
"Employer group"	R9-27-101
"Employee member"	R9-27-101
"Enrollment"	R9-27-101
"Experimental services"	R9-22-101 <u>R9-27-101</u>
"FDA"	<u>R9-27-101</u>
"Full-time employee"	R9-27-101
"Grievance"	R9-27-101
"Group Service Agreement" or "GSA"	R9-27-101
"Healthcare Group Administration" or "HCGA"	R9-27-101
"HCG"	R9-27-101
<u>"HCGA" or "Healthcare Group Administration"</u>	<u>R9-27-101</u>
<u>"HCG benefit plan"</u>	<u>R9-27-101</u>
"HCG Plan"	R9-27-101
<u>"Health care coverage"</u>	<u>R9-27-101</u>
"Health care practitioner"	R9-27-101
"Hearing"	R9-27-101
"Hospital"	R9-27-101
"Inpatient hospital services"	R9-27-101
"Late enrollee"	A.R.S. § 36-2912
"Life threatening"	R9-27-101
"Medical record"	R9-27-101
"Medical services"	A.R.S. § 36-401
"Medically necessary"	R9-27-101
"Member"	R9-27-101

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"Member handbook and evidence of coverage" or <u>"member handbook"</u>	R9-27-101
<u>"Network"</u>	<u>R9-27-101</u>
<u>"Network provider"</u>	<u>R9-27-101</u>
"Non-contracting provider"	R9-27-101
"Office of Administrative Hearings" or OAH	A.R.S. § 41-1092
"Outpatient service"	R9-27-101
"Party"	R9-27-101
"Pharmaceutical service"	R9-27-101
"Physician service"	R9-27-101
"Political subdivision"	R9-27-101
"Pre-existing condition"	A.R.S. § 36-2912
"Pre-existing condition exclusion"	A.R.S. § 36-2912
"Premium"	R9-27-101
"Pre-payment"	R9-27-101
<u>"Prescription"</u>	<u>R9-27-101</u>
<u>"Primary care practitioner"</u>	<u>R9-27-101</u>
<u>"Primary care provider"</u>	<u>R9-27-101</u>
"Prior authorization"	R9-27-101
<u>"Qualifying event"</u>	<u>R9-27-101</u>
<u>"Quality management"</u>	<u>R9-27-101</u>
"Referral"	R9-27-101
<u>"Renewal date"</u>	<u>R9-27-101</u>
<u>"Respondent"</u>	<u>R9-27-101</u>
"Scope of services"	R9-27-101
"Service area"	R9-27-101
"Spouse"	R9-27-101
"Subcontract"	R9-27-101
<u>"Substantial gainful activity"</u>	<u>R9-27-303</u>
<u>"Utilization control"</u>	<u>R9-27-101</u>
<u>"Utilization review"</u>	<u>R9-27-101</u>
"Waiting period"	A.R.S. § 36-2912

B. Definitions. In addition to the definitions contained in A.R.S. Title 36, Chapter 29, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

- "ADHS" means the Arizona Department of Health Services, the state agency mandated to serve the public health needs of all Arizona residents.
- "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 an eligible member.
- "Adverse action" means any action under this Chapter, including adverse eligibility actions, for which a party may file a grievance or request a hearing under A.R.S. § 41-1092 et seq. under 9 A.A.C. 27, Article 6.
- "Administrative review" means that portion of the grievance process beginning with the filing of a grievance with the Administration or its contractor and concluding with the issuance of a final decision by the Administration or its contractor that advises the party of formal hearing rights under A.R.S. § 41-1092 et seq.
- "Coinsurance" means a predetermined amount a member agrees to pay to a provider for covered services. A coinsurance payment is a percentage of the fee schedule rate for the services.
- ~~"Complainant" means an applicant, member, person, or entity filing a grievance or request for hearing.~~
- "Copayment" means a monetary amount specified by the HCGA that a member or dependent pays directly to a provider at the time a covered service is rendered.
- "Covered services" means the health and medical services described in 9 A.A.C. 27, Article 2, the GSA, and the member handbook.
- ~~"Date of notice" means the date on a notice of action.~~
- "Day" means a calendar day unless otherwise specified in the text.
- "Deductible" means a fixed annual dollar amount a member agrees to pay for certain covered services before the HCG plan agrees to pay.
- "Dependent" means the eligible spouse and children of an employee member under 9 A.A.C. 27, Article 3.
- "Durable Medical Equipment" or "DME" means durable items or appliances, as determined by the HCG Plan to be a medically necessary item or supply and a benefit under the Employer's GSA. The DME is:
 - ~~Able to withstand repeated use;~~
 - ~~Designed to serve a medical purpose;~~

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Generally not useful to a person in the absence of a medical condition, illness, or injury;
Not customarily found in a physician's office;
Is not disposable; and
Is needed for functional rather than cosmetic reasons.

"Effective date of coverage" means the date on which an employee can receive HCG coverage.

"Emergency ambulance service" means: transportation by a ground or an air ambulance company for a member requiring emergency medical services in which the emergency medical services are provided by a person certified by ADHS to provide the services before, during, or after the member is transported by a ground or an air ambulance company.

~~Transportation by an ambulance or air ambulance company for a member requiring emergency medical services. Emergency medical services that are provided by a person certified by the ADHS to provide the services before, during, or after a member is transported by an ambulance or air ambulance company.~~

"Emergency medical services" means medical services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could reasonably be expected to result in:

Placing a patient's health in serious jeopardy,
Serious impairment to bodily functions, or
Serious dysfunction of any bodily organ.

~~"Employer group" means the aggregate enrollment of an employer group or business with a HCG Plan for covered services; a group or a self-employed person who meets the criteria specified in R9-27-301.~~

"Employee member" means an enrolled employee of an employer group, a person who is self-employed, or a person who is eligible for a federal health coverage tax credit under 26 U.S.C. 35. A self-employed person shall meet the criteria specified in A.A.C. R9-27-301.

~~"Enrollment" means the process by in which an applicant applies for coverage under an employer group contracted with HCGA; eligible employee and dependents, if any, are qualified to receive HCG services by selecting an HCG benefit plan and completing and submitting all necessary documentation specified by HCGA under R9-27-302; and the HCG Plan receiving the full required premium no later than the date specified in the GSA.~~

~~"Experimental services" means services that are associated with treatment or diagnostic evaluation and that are not generally and widely accepted as a standard of care in the practice of medicine in the United States unless:~~

~~The weight of evidence in peer-related articles in medical journals published in the United States supports the safety and effectiveness of the service; or~~

~~In the absence of such articles, for services that are rarely used, novel, or relatively unknown in the general professional medical community, the weight of opinions from specialists who provide the service attests to the safety and effectiveness of the service.~~

"FDA" means the U.S. Food and Drug Administration.

"Full-time employee" means an employee or a self-employed person who works at least 20 hours per week, and expects to continue employment for at least five months following enrollment.

"Grievance" means a complaint that initiates an administrative review that does not involve a hearing under A.R.S. § 41-1092 et seq. A party may request a hearing under A.R.S. § 41-1092 et seq. after an administrative review.

"GSA" means Group Service Agreement, a contract between an employer group and HCGA, or between HCGA and a person eligible for the federal health coverage tax credit.

~~"Healthcare Group Administration" or "HCGA" means the section within AHCCCS that directs, determines eligibility, and regulates the continuous development and operation of the HCG Program.~~

"HCG" means Healthcare Group of Arizona, the registered name of the Healthcare Group Program, a prepaid medical coverage product marketed by the HCGA to small uninsured businesses and political subdivisions within the state.

"HCGA" or "Healthcare Group Administration" means the section within AHCCCS that directs, determines eligibility, and regulates the continuous development and operation of the HCG Program.

"HCG benefit plan" means the scope of health care and prescription benefit coverage that a member selects on enrollment or renewal.

~~"HCG Plan" means a Healthcare Group prepaid health plan health plan offered by HCGA or by an entity that is currently under contract with the HCGA to provide covered or administrative services to a member of an employer group members.~~

"Health care coverage" means a hospital or medical service corporation policy or certificate, a health care services organization contract, a multiple-employer welfare arrangement, or any other arrangement under which health services or health benefits are provided to two or more persons. Health care coverage does not include the following:

1. Accident only, dental only, vision only, disability income only or long-term care only insurance, fixed or hospital indemnity coverage, limited benefit coverage, specified disease coverage, credit coverage, or

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Taft-Hartley trusts:

2. Coverage that is issued as a supplement to liability insurance;
3. Medicare supplemental insurance;
4. Workers' compensation insurance; or
5. Automobile medical payment insurance.

"Health care practitioner" means a person who is licensed or certified under Arizona law to deliver health care services.

Physician;
Physician assistant;
Nurse practitioner; or
Other person who is licensed or certified under Arizona law to deliver health care services.

"Hearing" means an administrative hearing under Title 41, Chapter 6, Article 10.

"Hospital" means a health care institution licensed as a hospital by the ADHS under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is determined by AHC-CCS to meet the requirements for certification under Title XVIII of the Social Security Act, as amended.

"Inpatient hospital services" means a medically necessary service that requires an inpatient stay in services provided to an acute-care hospital; member who is admitted to a hospital for medical care and treatment. An inpatient hospital service is provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.

"Life threatening" means any condition for which a delay in obtaining pre-authorization or traveling to an approved medical facility would have a severe adverse effect on a patient's condition.

"Medical record" means a single, complete record kept at the site of a member's primary care provider that documents the medical services received by a member, including inpatient discharge summary, outpatient care, and emergency care.

"Medically necessary" means covered services provided determined by the HCG Plan or HCGA Medical Director, and a physician or other licensed health care practitioner within the scope of the physician's or other health care practitioner's practice under state law to:

Prevent disease, disability, and other adverse health condition or its progression; or
Prolong life.

"Member" means an employee member or a dependent who is enrolled with an HCG Plan.

"Member handbook and evidence of coverage" or "member handbook" means the written description that HCGA provides for each member on enrollment, of the rights and responsibilities of members of HCG, as well as a list of covered services, limitations, exclusions, coinsurance, copayments, and deductibles that apply to the member's choice of coverage.

"Network" means the providers who have subcontracts with HCG Plans in which members are enrolled.

"Network provider" means a provider who has a subcontract with the member's HCG Plan and renders covered services to a member.

"Noncontracting provider" means a provider who renders covered services to a member but who does not have a subcontract with the member's HCG Plan.

"Outpatient service" means a medically necessary service that may be provided in any setting on an outpatient basis that does not require an overnight stay in an inpatient hospital. An outpatient service is provided by or under the direction of a physician or other health care practitioner, upon referral from a member's primary care provider.

"Party" means a person or entity by or against whom a grievance or request for hearing is brought.

"Pharmaceutical service" means a medically necessary medication prescribed by a physician, a practitioner, or a dentist upon referral by a primary care provider and dispensed under 9 A.A.C. 27, Article 2.

"Physician service" means a service provided within the scope of practice of medicine or osteopathy as defined by state law, by, or under the direction of a person licensed under state law to practice medicine or osteopathy.

"Political subdivision" means the state of Arizona; or a county, a city, a town, or a school district within the state; or entity whose employees are eligible for hospitalization and medical care under Arizona Revised Statutes, Title 38, Chapter 4, Article 4.

"Premium" means the monthly pre-payment amount submitted due to HCGA by the employer group.

"Pre-payment" means submission of the employer group's full premium payment at least 30 days in advance of the effective date of coverage under the GSA, under 9 A.A.C. 27, Article 3.

"Prescription" means an order for covered services for a member that is signed or transmitted by a provider licensed under applicable state law to prescribe or order the service.

"Primary care practitioner" means a physician assistant or a registered nurse practitioner who is certified and practicing in an appropriate affiliation with a physician, as authorized by law.

"Primary care provider" means a member's primary care physician or a primary care practitioner.

"Prior authorization" means the process by which the HCG Plan authorizes, in advance, the delivery of a covered ser-

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vice. Administration or the HCG Plan informs a provider that it has made a preliminary determination that the requested service is medically necessary, appropriate, and is a covered service. Prior authorization is not a guarantee of payment.

"Qualifying event" means a situation as described in the GSA that enables a person to enroll outside a designated open enrollment period or to obtain continuation coverage, if applicable.

"Quality management" means a methodology used by professional health personnel to assess the degree of conformance to desired medical standards and practices and to implement activities designed to continuously improve and maintain quality service and care, and which is performed through a formal program with involvement of multiple organizational components and committees.

"Referral" means the process by which a primary care provider directs a member to another appropriate provider or resource for diagnosis or treatment.

"Renewal date" means the annual anniversary date for an employer group, which occurs one year from the date that the GSA for the employer group is effective.

"Respondent" means a party responsible for the adverse action that is the subject of a grievance or request for hearing.

"Scope of services" means the covered, limited, and excluded services listed in 9 A.A.C. 27, Article 2, the GSA, and the member handbook.

"Service area" means the geographic area designated by HCGA where each HCG Plan shall provide covered health care benefits to members directly or through subcontracts.

"Spouse" means a husband or a wife of an HCG member who has entered into a marriage recognized as valid by Arizona.

"Subcontract" means an agreement entered into by HCGA or an HCG Plan with any of the following:

A provider of health care services who agrees to furnish covered services to members,

A marketing organization, or

Any other organization to serve the needs of the HCG Plan or HCGA.

"Utilization control" means an overall accountability program encompassing quality management and utilization review.

"Utilization review" means a methodology used by professional health personnel to assess the medical indications, appropriateness, and efficiency of care provided.

ARTICLE 2. SCOPE OF SERVICES

R9-27-201. Scope of Services Repealed

- ~~A. HCGA shall provide a list of covered services to each HCG Health Plan. Each HCG Plan shall provide, either directly or through subcontracts, a list of the covered services specified in this Article.~~
- ~~B. Provision of covered services. The HCG Plans shall ensure that covered services are provided by, or under the direction of, a primary care provider.~~
- ~~C. Scope of covered services. An HCG Plan shall not further delineate, expand, or limit the list of covered services beyond the standard covered services under this Article, or GSA.~~

R9-27-202. Covered Services

Covered services. Subject to the exclusions and limitations specified in these rules this Article, and the GSA, and the member handbook, and subject to coinsurance, copayments, and deductible requirements, an HCG Plan shall cover the following services: services specified under the GSA.

1. Outpatient services;
2. Laboratory, radiology, and medical imaging services;
3. Prescription drugs;
4. Inpatient hospital services;
5. Emergency medical services under R9-27-209 in and out of the service area;
6. Emergency ambulance services;
7. Maternity care;
8. Cornea transplants;
9. Kidney transplants;
10. Durable medical equipment, orthotics, and prostheses as specified in the GSA; and
11. Other services as agreed under the GSA.

R9-27-203. Exclusions and Limitations

- ~~A. Excluded medical services. Any medical service not specifically provided for in this Article is not a covered medical service.~~
- ~~B.A. Excluded services. An HCG Plan shall not cover the following:~~

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1. Services or items furnished solely for cosmetic purposes except for breast reconstruction performed by an HCG Plan following a mastectomy, and services or items provided to reconstruct or improve personal appearance after an illness or injury as specified in the GSA;
2. Services or items requiring prior authorization for which prior authorization has not been obtained;
3. Services or items furnished gratuitously or for which charges are not usually made;
4. Hearing aids, eye examinations for prescriptive lenses, prescriptive lenses and surgery for the correction of myopia;
5. Long-term care services, including nursing services;
6. Private or special duty nursing services, provided in a hospital unless medically necessary and prior authorized by the HCG Plan Medical Director;
7. Care for health conditions that are required by state or local law to be treated in a public facility;
8. Care for military service disabilities treatable through governmental facilities if the member is legally entitled to treatment and the facilities are reasonably available;
9. Gastric stapling or diversion for weight loss;
10. Reports, evaluations, or physical examinations not required for health reasons including employment, insurance, or governmental licenses, sports, and court-ordered forensic or custodial evaluations;
11. Treatment of temporomandibular joint dysfunction, unless treatment is prior authorized and determined medically necessary by the HCG Plan Medical Director or designee;
12. Pregnancy termination under A.R.S. § 35-196.02;
13. Medical and hospital care and costs for the child of a dependent, unless the child is otherwise eligible under the GSA;
14. Nonmedical ancillary services including vocational rehabilitation, employment counseling, psychological counseling and training, and physical therapy for learning disabilities;
15. Treatment of gender dysphoria including gender reassignment surgeries and reversal of voluntarily induced infertility (sterilization);
16. Services not deemed medically necessary by the HCG Plan Medical Director, or the responsible primary care provider;
17. Routine foot care;
18. Blood products, blood derivatives, synthetic blood, including artificial and genetic derivatives and coagulation factors and the associated charges for the administrative costs which are separately billed;
19. Organ transplants except as specified in R9-27-202;
20. Bone marrow transplants including autologous, allogeneic-related, and allogeneic-unrelated;
21. Mental health services;
22. Acupuncture;
23. Dental services;
24. Transportation other than emergency ambulance services;
25. Psychotherapeutic drugs;
26. Charges for injuries incurred as the result of:
 - a. Participating in a riot;
 - b. Committing, or attempting to commit a felony or assault;
 - c. Committing intentional acts of self-inflicted injuries; or
 - d. Attempting suicide.
27. Infertility testing, in vitro fertilization and all other fertilization treatments;
28. Allergy testing and hyposensitization treatment;
29. Experimental services as determined by the HCGA, or services provided primarily for the purpose of research;
30. Alternative medicine;
31. Chiropractic services;
32. Osteopathic manipulation therapy; and
33. Other services under the GSA:
 1. Excluded services as specified in the GSA and the member handbook;
 2. Services not covered in the member's choice of HCG benefit options;
 3. Services that require prior authorization for which the member does not obtain prior authorization;
 4. Care for a health condition for which a state or local law requires the member to be treated in a public facility;
 5. Care for military service disabilities treatable through governmental facilities if the member is legally entitled to treatment and the facilities are available;
 6. Pregnancy termination, except when required by law to be covered;
 7. Treatment of gender dysphoria including gender reassignment surgeries and reversal of voluntarily induced infertility (sterilization);
 8. Services that HCGA, through its Medical Director, deems not to be medically necessary;
 9. Charges for injuries incurred as the result of:
 - a. Participating in a riot,

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- b. Committing or attempting to commit a felony or assault,
- c. Committing intentional acts of self-inflicted injury, or
- d. Attempting suicide.

- 10. Infertility testing, in-vitro fertilization, and all other fertilization treatments;
- 11. Experimental services; and
- 12. Medications not approved by the FDA.

~~C.B.~~ Limitations. When providing covered services, the HCG Plan shall adhere to the coverage limitations in this Article, the GSA, and the following:

- 1. Inpatient hospital accommodations are limited to no more than a semi-private rate, except when a patient must be isolated for medical reasons; are covered as specified in the GSA and the member handbook.
- 2. Alternative levels of care instead of hospitalization are covered if cost-effective and medically necessary, as determined by the HCG Plan Medical Director, or designee.
- 3. Dialysis is limited to services not covered by Title XVIII, of the Social Security Act, as amended.
- 4. Hospice services are limited to the terms in the GSA.
- 5. Home infusion therapy is limited to the terms in the GSA.
- 6. Home Health Care is limited to the terms in the GSA.

R9-27-204. Out-of-service Area Coverage Network Coverage of Emergency Medical Services

~~Out-of-service area coverage.~~ As specified in R9-27-209, a member is entitled to only emergency services when outside the member's HCG Plan service area. The Administration shall not cover services outside the United States.

A. Emergency medical services provided outside the HCG Plan's network are covered, based on the prudent layperson standard under 42 U.S.C. 1396u-2, if:

- 1. The member presents for emergency medical services at a medical facility; and
- 2. The member or provider notifies the HCG Plan no later than 48 hours from the day that the member presents for the emergency service. Failure to provide timely notice constitutes cause for denial of payment unless the member or provider shows good cause.

B. Emergency ambulance services required to transport a member to a medical facility that provides emergency services are covered if the provider notifies the HCG Plan within 10 working days from the day that the member presents for emergency ambulance service. Failure to provide notice within 10 working days constitutes cause for denial of payment unless the provider shows good cause.

C. The financial liability of HCG for coverage for out-of-network emergency services may be limited under the terms of the GSA. Members receiving out-of-network emergency services may be financially liable to an out-of-network provider to the extent charges by the provider exceed the financial liability established in the GSA.

R9-27-205. Outpatient Health Services Repealed

~~Outpatient services.~~ The HCG Plan shall provide the following covered services if medically necessary:

- 1. ~~Ambulatory surgery and anesthesiology services not specifically excluded;~~
- 2. ~~Physician's services;~~
- 3. ~~Pharmaceutical services and prescribed drugs to the extent authorized in this Article and under the GSA;~~
- 4. ~~Laboratory services;~~
- 5. ~~Radiology and medical imaging services;~~
- 6. ~~Services of other health care practitioners when supervised by a physician;~~
- 7. ~~Nursing services provided in an outpatient health care facility;~~
- 8. ~~The use of emergency, examining, or treatment rooms when required for the provision of physician services;~~
- 9. ~~Specialty care physician services referred by a primary care provider or health plan;~~
- 10. ~~Physical examinations, periodic health examinations, health assessments, physical evaluations, or diagnostic work-ups that include treatments or procedures to:~~
 - a. ~~Determine risk of disease;~~
 - b. ~~Provide early detection of disease;~~
 - c. ~~Detect the presence of injury or disease at any stage;~~
 - d. ~~Establish a treatment plan for injury or disease at any stage;~~
 - e. ~~Evaluate the results or progress of a treatment plan or treatment decision; or~~
 - f. ~~Establish the presence and characteristics of a physical disability that may be the result of disease or injury.~~
- 11. ~~Short-term rehabilitation is provided as specified in the GSA, if in the judgment of the HCG Plan Medical Director or designee, the treatment can be expected to result in the significant improvement of a member's condition.~~

R9-27-206. Laboratory, Radiology, and Medical Imaging Services Repealed

~~A. Coverage of medically necessary laboratory, radiology, and medical imaging services. Medically necessary laboratory, radiology, and medical imaging services shall be provided by a licensed or certified health care provider as prescribed by the member's primary care provider. These services shall be provided through the HCG Plan in a hospital, a clinic, a physician's office or other health facility.~~

- B.** Satisfaction of applicable license and certification requirements. A clinical laboratory, radiology, or medical imaging service provider must satisfy all applicable state and federal license and certification requirements and shall provide only services that are within the categories stated in the provider's license or certification.

R9-27-207. Pharmaceutical Services Repealed

- A.** Provision of pharmaceutical services. The HCG Plan shall ensure that pharmaceutical services are available to members during customary business hours. The services shall be located within reasonable travel distance as determined by the HCGA within the HCG Plan's service area.
- B.** Limitations. The HCG Plan shall adhere to the following limitations when providing a pharmaceutical service:
1. Drugs personally dispensed by a physician or a dentist are not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
 2. Prescription drugs are prescribed up to a 30-day supply unless the HCG Plan determines a longer supply is more cost-effective.
 3. Members are eligible for immunosuppressant drugs only as part of the post-operative treatment for a covered kidney or cornea transplant authorized by an HCG Plan as specified in R9-27-202.
 4. Over-the-counter drugs are not covered.

R9-27-208. Inpatient Hospital Services Repealed

- A.** Inpatient hospital services. The HCG Plan shall provide the following inpatient hospital covered services if medically necessary:
1. Routine services, including:
 - a. Hospital accommodations;
 - b. Specialty units;
 - c. Nursing services necessary and appropriate for a member's medical condition;
 - d. Dietary services;
 - e. Medical supplies, appliances, and equipment furnished to hospital inpatients, billed as part of routine services, and included in the daily room and board charge;
 2. Ancillary services, including:
 - 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 as specified in the GSA;
 - g. Pharmaceutical services and prescribed drugs;
 - h. Respiratory therapy;
 - i. Maternity services;
 - j. Nursery and related services;
 - k. Chemotherapy; and
 - l. Dialysis as limited in this Article.
- B.** Limitations. The HCG Plan shall adhere to the following coverage limitations when providing inpatient hospital services:
1. Inpatient hospital accommodations are limited to no more than a semi-private rate, except when a patient must be isolated for medical reasons.
 2. Dialysis is limited to services not covered by Title XVIII, of the Social Security Act, as amended.
 3. Alternative levels of care instead of hospitalization are covered if cost-effective and medically necessary as determined by the HCG Plan Medical Director, or designee.

R9-27-209. Emergency Medical Services Repealed

- A.** Emergency medical services provided within the HCG Plan's service area.
1. Emergency medical services shall be provided to a member 24 hours-a-day, seven-days-a-week based on the prudent layperson standard under 42 U.S.C. 1396u-2.
 2. The member or provider shall notify the HCG Plan no later than 24 hours after the initiation of treatment.
 3. If a member is incapacitated, the provider is responsible for notifying the HCG Plan no later than 24 hours after the member is capable of verifying coverage under the HCGA. Failure to provide timely notice constitutes cause for denial of payment.
- B.** Emergency medical services provided outside the HCG Plan's service area.
1. Emergency medical services provided outside the HCG Plan's service area is based on the prudent layperson standard under 42 U.S.C. 1396u-2.
 2. The member or provider shall notify the HCG Plan no later than 48 hours after the initiation of treatment.
 3. If a member is incapacitated, the provider is responsible for notifying the HCG Plan no later than 48 hours after the member is capable of verifying coverage under the HCGA. Failure to provide timely notice constitutes cause for

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denial of payment.

C. Ambulance services.

1. Within the HCG Plan's service area. A member is entitled to emergency ambulance services within the HCG Plan's service area. The provider shall notify the HCG Plan within 10 working days after providing emergency ambulance service to the member. Failure to provide notice within 10 working days constitutes cause for denial of payment.
2. Outside the HCG Plan's service area. A member is entitled to ambulance services outside the HCG Plan's service area to transport the member to the nearest medical facility capable of providing necessary emergency services. The provider shall notify the HCG Plan within 10 working days after providing emergency ambulance service to the member. Failure to provide notice within 10 working days constitutes cause for denial of payment.

R9-27-210. Pre-existing Conditions

- A. Pre-existing conditions exclusions. Subject to subsection (B), an HCG Plan shall not cover any services related to a pre-existing condition as specified in A.R.S. § 36-2912 and the GSA.
- B. ~~Failure to impose a pre-existing condition exclusion.~~ Pre-existing conditions coverage. An HCG Plan shall ~~not impose a pre-existing condition exclusion against an eligible employee who meets the following standards:~~ cover pre-existing conditions for the following:
 1. Newborns from the time of birth, adopted children, and children placed for adoption, if enrolled within the time-frames ~~under R9-27-308; set forth in the GSA;~~
 2. Eligible employees who meet the portability requirements of A.R.S. § 20-2308:
 - a. ~~A person who had continuous coverage for a one-year period and during that year had no breaks in coverage totaling more than 31 days; and~~
 - b. ~~A person's prior coverage ended within 63 days before the date of enrollment.~~
 2. An employee eligible under R9-27-302(A)(1) who meets the aggregate periods of creditable coverage as calculated under A.R.S. § 36-2912 of 12 months or 18 months in the case of a late enrollee.
- C. Credit for prior health coverage. An HCG Plan shall apply a credit toward meeting the 12 month pre-existing condition exclusion of one month for each month of continuous coverage that an eligible employee had under another HCG Plan or accountable health plan under A.R.S. § 36-2912. Upon request, a contracted health plan or an accountable health plan that provided continuous coverage to an individual a person shall disclose the coverage provided.
- D. Late enrollee pre-existing conditions time-frames. An HCG Plan shall exclude coverage for a ~~preexisting~~ pre-existing condition for a late enrollee ~~under~~ according to A.R.S. § 36-2912.
 1. ~~For 12 months if the member enrolls within 30 days of the designated enrollment time frame, or~~
 2. ~~For 18 months if the member enrolls 31 or more days after the designated time frame for enrollment.~~

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

**CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
HEALTH CARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED**

[R05-171]

PREAMBLE

1. Sections Affected

- R9-27-301
- R9-27-302
- R9-27-303
- R9-27-305
- R9-27-306
- R9-27-307
- R9-27-307
- R9-27-308
- R9-27-309
- R9-27-310
- R9-27-310

Rulemaking Action

- Amend
- Amend
- Amend
- Repeal
- Repeal
- Repeal
- Repeal
- New Section
- Repeal
- Repeal
- Repeal
- New Section

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

- Authorizing statute: A.R.S. § 36-2903.01(F)
- Implementing statute: A.R.S. § 36-2912(I)(5)

3. The effective date of the rules:

May 3, 2005

The rules are effective on filing with the Office of the Secretary of State as allowed under A.R.S. § 41-1032(A)(1) and (A)(4). These rules provide a public benefit and there is no penalty associated with a violation of the rules. In addition, these rules help to preserve the public health of Arizona citizens. In Arizona, 96% of all businesses are small businesses with 50 or less employees. Only 30% of these small employers offer health care coverage to their employees. Healthcare Group provides health care coverage to this consumer market, which currently totals more than 13,000 members in the state. Changes to the eligibility and enrollment rules will allow Healthcare Group to offer health care coverage to more employees of small businesses. The rules do not contain a penalty for rule violations.

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

Notice of Rulemaking Docket Opening: 10 A.A.R. 4489, November 5, 2004

Notice of Proposed Rulemaking: 10 A.A.R. 5177, December 27, 2004

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

Name: Jane McVay
Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4135
Fax: (602) 253-9115
E-mail: AHCCCSRules@ahcccs.state.az.us

6. An explanation of the rule, including the agency's reason for initiating the rule:

In 1988, the Arizona Legislature created the Healthcare Group Program to offer health insurance to a segment of the health insurance market, small businesses, that the Legislature felt were not adequately served by commercial insurers. Healthcare Group was created as a division within the Administration to provide affordable and accessible health care benefit plans for Arizona small businesses with 50 or fewer employees. In Arizona 96% of all businesses are small businesses. Only 30% of Arizona's small employers offer health care coverage to their employees. Many of these employees are low-wage earners, whose income is on the verge of eligibility for AHCCCS coverage. Legislation was enacted in 2004, which allows Healthcare Group to offer health care benefit plans to employees of political subdivisions in the state, in addition to small businesses. As of March 3, 2005, 13,246 persons subscribe to health care coverage through Healthcare Group. Fifteen individual members who are eligible for the federal health care tax credit under 26 U.S.C. 35 also have Healthcare Group coverage. A total of 4,660 employers and 3 political subdivisions offer Healthcare Group coverage.

Typically, commercial insurers "rate" small groups; that is, the premium for the group is based on the health histories of the individual members. As a result, the premiums for the employee with a history of illness and the other members of the group are often prohibitively expensive. Under A.R.S. § 36-2912, the Healthcare Group Program was designed to offer health insurance to small groups without "rating" prospective members based on individual histories. In effect, the risk is spread over all participants in the program equally rather than being assigned to the individual employer group.

The Healthcare Group Program consists of contracts between the Health Care Group Administration and small employers that wish to offer, as an employment benefit, health coverage for employees and their dependents. These contracts are known as Group Service Agreements or GSA's. HCGA has responsibility for the design of those contracts and for determining the eligibility of employer groups and covered persons. HCGA also establishes premium rates sufficient to cover the risk and collects those payments from the employer. Essentially, the HCG program consists of a series of voluntary contracts between the agency and small employers, between the agency and HMO-style managed care entities, and potentially between the agency and providers and administrative entities. Under A.R.S. § 41-1015(A)(15), matters relating to state contracts are exempt from the requirements of formal rulemaking. AHCCCS is required to establish rules for the Healthcare Group Program under A.R.S. § 36-2912(I)(5). The only specific rulemaking requirement in A.R.S. § 36-2912(G) is for AHCCCS to adopt rules to allow a business to continue Healthcare Group coverage when the number of employees exceeds 50. Aside from this requirement, rulemaking authority for the Healthcare Group Program is permissive. The statute gives AHCCCS permissive authority to establish rules to allow withholding of payments to a contractor for failing to comply with the contract or with adopted rules. The agency's objective is to use the rules as a means by which interested employers or employees can obtain basic information regarding the program but to refer them to the actual contracts for details.

Currently, the HCG Program offers three different options to participating employers, employees, and their dependents. In general terms, these options vary based on the level of copayments, coinsurance, and deductibles, and to some extent on the scope of covered services (that is, some of the options are more comprehensive than others). Although HCG does not consider the health history of individuals in setting premiums, each of the options has a dif-

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ferent premium schedule that takes into consideration the age, sex, and location of the member, as well as the option selected. Within the same employer group, individual employees can select from the available options. HCG does not prescribe any level of employer participation in the financial cost – they may cover the cost themselves, share the cost with the employees, or simply allow payroll deduction for the employee with the employee carrying the full cost.

In general, participation in Healthcare Group is limited to employers of fewer than 50 persons. Under the current statute, the employer must not have offered group health insurance during the 180-day period prior to HCG coverage. This limitation was designed to provide reasonable assurances to the commercial health insurance industry that the market consisted of the uninsured, thereby minimizing the loss of commercial carriers to Healthcare Group. As of State Fiscal Year 2004, the program is funded by the premiums paid by the participating employers. Participation, on both the employer level and the individual employee level, is voluntary.

With respect to the actual delivery of services, HCG currently assigns employer groups to a managed care entity (“health plan”) under contract with HCG, or where choice is available, allows the employer to select from HCG-contracted managed care entities. The contracts between the HCG Administration and the health plan define the network of providers from whom service is received and assign responsibility for medical management and payment of claims consistent with the terms of the health plan contract and the contract between HCG and the employer. These health plans are “at risk;” that is, the agency pays the health plan on a per member per month basis and, in return, the health plan is obligated to cover the costs of all medical care covered under the GSA regardless of the actual cost of those services. Essentially, they operate like Health Maintenance Organizations.

At the outset of the HCG Program, the agency exercised its discretion to administer the Program in a fashion similar to the other health programs administered by the agency. At the time, all of the participating health plans also participated in the other AHCCCS programs, thus the uniformity offered the advantage of simplified administration for both the agency and its contracted health plans. During the past few years and legislative sessions, there has been a recognition that the HCG Program can more effectively meet the needs of small business through greater program flexibility. For instance, recent statutory changes permit the agency to contract directly with providers in the absence of a willing contractor and with third parties to assist with the administration of the program. This enables the Program to offer preferred provider networks (“PPO”), in addition to the closed network of the HMO-style product offered through the health plans. Under the PPO model, the agency manages the risk itself and will adjust premiums, if necessary, through contract amendments to cover the claims experience associated with the PPO product.

Healthcare Group acts as the benefits administrator and performs eligibility and enrollment, marketing/sales, premium collection, contract management, and exercises financial oversight over the managed care organization as the administrative arm of the program. Healthcare Group management establishes the benefit options, sets medical policy, sets premium pricing and capitation that is paid to managed care contractors, and provides member/employer customer service. HCG does not currently pay claims, but will pay claims through the Third Party Administrator as soon as the PPO health plan option is offered to employers. The HCG Administration has responsibility for the design of the contracts and for determining the eligibility of employer groups and covered persons. HCG also establishes premium rates sufficient to cover the risk and collects those payments from the employer.

There are three different Healthcare Group plans that are designed to meet varying health needs, income levels, and lifestyles. All three current benefit plans are delivered via managed care health plan networks. These three Managed Care Organizations and a Third Party Administrator are under contract to Healthcare Group. In July 2005, Healthcare Group plans to introduce a statewide PPO health care product through the Third Party Administrator. Managed care health plans are not geographically exclusive. AHCCCS expects to have two or more statewide health plan contractors in the near future. The PPO option will be statewide as well.

The rules revise and clarify the enrollment and eligibility criteria for employees, dependents, and employer groups, state how Healthcare Group members may continue coverage through COBRA, delineate when members may enroll in an HCG benefit plan, and the circumstances under which a member's coverage can be terminated. AHCCCS is updating the existing Healthcare Group rules on eligibility and enrollment to make them consistent with current practices and statutory changes, and to make them clear, concise, and understandable. The rulemaking contains changes to conform to recent statutory changes enacted in Chapter 332, Laws 2004, Second Regular Session, including the requirement that the Administration is not allowed to enroll an employer group sooner than 180 days after the date that the employer's health insurance coverage under an accountable health plan is discontinued. These rules conform to this law authorizing persons who are unemployed and eligible for a federal health coverage tax credit to be eligible for Healthcare Group coverage.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

AHCCCS did not review any study relating to the rules.

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:

AHCCCS anticipates that the Healthcare Group eligibility rules will have a positive impact on consumers and small businesses. The mission of Healthcare Group is to provide affordable health care coverage to employees in small businesses in the state in order to reduce the number of Arizona citizens without health care coverage. Healthcare Group will offer more health care services and health care plans to employees of small businesses in the state. AHCCCS and employee members who have health care coverage through HCG Plans will benefit from the additional clarity of the rules. In addition, availability of affordable health care coverage to those uninsured and to an expanding market, including political subdivision employees, may also provide financial savings to the state and improve the health of Arizona citizens.

The rules may have a beneficial impact on private and public employment. The rule benefits these employees by offering additional health care coverage options. In Arizona 96% of all businesses are small businesses with 50 or fewer full-time employees. Less than 30% of these employers offer health care coverage to their employees due to the prohibitive cost.

A.R.S. § 36-2912(G) requires AHCCCS to adopt rules to allow a business that offers Healthcare Group coverage to continue coverage if the business grows to include more than 50 employees. After initial enrollment in HCG, employers who add additional qualified employees during the initial enrollment year or subsequent continuous reenrollment period shall not lose eligibility for HCG. The rule changes in R9-27-301(A)(2) and R9-27-301(E) are consistent with the statute. As long as an employer meets this criteria, an employer will not be impacted by the number of employees added.

AHCCCS believes that for the limited coverage benefits options, the cost of the premium will be lower and more affordable. However, in each case, the employee will have the option of a comprehensive benefit that although higher priced is still affordable for many low-income workers. AHCCCS believes that the new health care benefit options will be price-competitive and attractive to employees at each income level. The multiple plan options afford the employee a choice of health plan network and benefit options based on their health care needs. The cost of Healthcare Group coverage is comparable to the stated average premium offerings of many commercial plans. In some of our age/sex adjusted premium groupings, Healthcare Group plans are a little higher in cost. In some Healthcare Group age/sex groupings, Healthcare Group plans are priced lower than other commercial plans. The major difference is that Healthcare Group rates as a community (age/sex band pricing), and commercial health plans underwrite the group based on their medical cost experience. The advertised average premium for commercial health plans is often not the offered price to many groups. In addition, year-to-year commercial small group pricing increases are much higher on an average rate than HCG premium increases have been.

The economic impact of the rules on consumers and small business is beneficial. Availability of health care coverage through Healthcare Group allows individuals in many small companies to obtain affordable health care coverage. Without this coverage, some employees would not have affordable health care coverage, or in the event of illness would need to "spend down" to qualify for health care coverage through AHCCCS. Currently, AHCCCS provides health care coverage to more than 1,000,000 Arizona residents, including adults and children. AHCCCS currently receives a state appropriation that constitutes a substantial, growing portion of the state budget. The rate of growth of AHCCCS' uninsured population far exceeds the rate of growth of the state general fund. The availability of health care benefit plans through Healthcare Group to individuals who do not currently have health care coverage has a beneficial economic, small business, and consumer impact. Many of these employees are low-wage earners, who do not meet the eligibility requirements for AHCCCS coverage.

Because persons eligible for Healthcare Group health care coverage are not enrolled in other commercial health care coverage plans due to the 180-day bare period requirement, this rule does not negatively impact commercial insurers. For this reason, it is unlikely that employers will switch or drop their existing health care coverage from commercial carriers to benefit plans offered by Healthcare Group. It is anticipated that the rule will not impact commercial health insurance companies. This rule allows Healthcare Group to offer employees more flexible and diverse health care coverage plans to a growing market of individuals who need affordable health care coverage.

The availability of health care coverage through Healthcare Group is beneficial because nearly 30% of the employees who have Healthcare Group coverage would qualify by income and family size if they applied for AHCCCS. The state will incur a savings of state and federal monies provided to AHCCCS because these employees select private health care coverage.

AHCCCS does not believe that the limited coverage benefit options will push low-income employees to apply for AHCCCS Medicaid/Kids Care coverage in lieu of paying reasonable employer-sponsored premiums. The 80% employee participation rule protects HCG from selecting only certain employees. The limited benefit options make it easier for these employees to choose benefits that meet their current needs and not pay for benefits they do not want.

This rulemaking will have a minimal economic impact on AHCCCS and the Secretary of State for costs associated with the rulemaking. In summary, AHCCCS believes that the economic impact of these rules is beneficial to consumers and small businesses. Employees who may otherwise be uninsured will have an additional option for health care coverage. This benefit far outweighs any costs associated with the rules.

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

R9-27-301	<ul style="list-style-type: none"> • In subsection (A)(1), language was revised to clarify the eligibility requirements for an employer group to obtain HCGA health care coverage. • In subsection (B), language is amended to read: "The 180-day enrollment restriction does not apply to an employer group if the employer's accountable health plan discontinues offering the health plan of which the employer is a member." • In subsection (D)(4), language is amended to read: "Individual coverage or health care coverage through another employer." • In subsection (D)(3), struck: "subsection (I)"
R9-27-302	<ul style="list-style-type: none"> • In subsection (A)(1), struck "Section 35 of the Internal Revenue Code of 1986," inserted "26 USC 35." • In subsection (A)(2), struck "Be on an employer's payroll," inserted "Be employed" • In subsection (A)(2)(b), struck "Expects to continue employment by the employer group for at least five months following enrollment." Inserted "Meet other requirements as specified in the GSA." • In subsection (C), revised language as follows: "After completion of the actions in subsection (B), HCGA shall send written notification of the effective date of coverage to the eligible employee and dependent." • In subsection (E), language amended as follows: "An employee member and dependent who are entitled to continuation coverage under COBRA continuation provisions after termination of employment may retain HCG coverage until the benefit expires or the continuation coverage ends, or the premium is not paid by the employee, whichever is earlier."
R9-27-303	<ul style="list-style-type: none"> • Moved definitions of "disability and "substantial gainful activity" from the Healthcare Group rule package for Articles 1 and 2, Chapter 27, published in the <u>Arizona Administrative Register</u> on December 27, 2004, to R9-27-303. Revised definition of "disability" as follows: 'Disability' means the inability to do any substantial gainful activity by reason of any impairment or combination of impairments that HCGA through the HCG Medical Director expects to be permanent and continuous. The impairment must result from anatomical, physiological or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. Medical evidence consisting of signs, symptoms, and laboratory findings, not only the member's statement of symptoms, establishes an impairment." • In (A)(3), after the first reference to "child" inserted "as specified in subsection (A)(2)."
R9-27-307	<ul style="list-style-type: none"> • In (A), after "may" inserted "select an HCG benefit plan," deleted "but not limited to." • In (B), amended as follows: "HCGA shall establish the effective date of coverage for an employer group or an employee member under an HCG benefit plan and shall provide written notice of the effective date of coverage to the employee member and the employer group."
R9-27-309	<ul style="list-style-type: none"> • Struck "(A)(6). Retirement."
R9-27-310	<ul style="list-style-type: none"> • Revised headings and language regarding termination of HCG coverage, denial of enrollment, and exclusion from eligibility and enrollment to make provisions more clear, concise, and understandable.
General	<ul style="list-style-type: none"> • AHCCCS made the rules more clear, concise, and understandable by making grammatical and structural changes throughout the rules.
General	<ul style="list-style-type: none"> • AHCCCS made grammatical and stylistic changes at the suggestion of the Governor's Regulatory Review Council staff.

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11. A summary of the comments made regarding the rule and the agency response to them:

Comments were received regarding other Healthcare Group rules that were not contained in Article 3 of these rules. These comments are not shown in the following table. A summary of the comments submitted that are relevant to the Sections contained in this Healthcare Group rulemaking and the agency response are as follows:

#	Subsection	Comment	Recommendation
1.	R9-27-307	<p>Definition of qualifying event fails to describe the eligible qualifying events for enrollment outside of a designated open enrollment period. To ensure members know their rights, these distinctions should be in rule rather than the GSA.</p> <p>Arizona Center for Disability Law</p>	<p>Disagree</p> <p>Qualifying events are listed in A.R.S. § 36-2912(AA)(9)(a), the GSA, and in the member handbook that HCGA provides to members. Under A.R.S. § 41-1005(A)(15), matters relating to state contracts are exempt from the requirements of formal rulemaking. Thus, rulemaking regarding this program is permitted but not mandatory. AHC-CCS is required to establish rules for the Healthcare Group Program under A.R.S. § 36-2912(I)(5). The agency's objective is to use the published rule as a means by which interested employers or employees can obtain basic information regarding the program but to refer them to the actual contract for details. The details of coverage are in the GSA and the member handbook and evidence of coverage that are available to prospective members and provided to all active members.</p>

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2.	R9-27-303	<p>Definition of "substantial gainful activity" should be located in R9-27-303 and is only appropriate in context of R9-27-303.</p> <p>Arizona Center for Disability Law</p>	<p>Agree. Definition is moved to R9-27-303. <u>The Arizona Rulemaking Manual</u> states that definitions applicable only to a specific Article or Section should appear at the beginning of that Article or Section.</p>
3.	R9-27-301, R9-27-309(A)	<p>The current limitation in R9-27-301 (D)(1) states that if group health care coverage is provided through a spouse or another employer, an employee who elects not to participate in an HCG plan will not be counted for the required percentages. This penalizes an employee who has coverage through a domestic partner, who will be counted in determining the minimum number of employees. Recommends amending R9-27-309(A) or the relevant provisions of the GSA to allow an employee who initially opts out because the person has health care coverage through a domestic partner, and later loses coverage, to be eligible to enroll in HCG on termination of coverage.</p> <p>Arizona Center for Disability Law</p>	<p>Disagree. Although there is no statutory definition of dependent, the rule defines dependent in R9-27-101 to mean the eligible spouse and child of the employee member. In accordance with A.R.S. § 36-2912(D)(1), employees with other existing health care coverage who elect not to receive Healthcare Group coverage are not considered when determining the required enrollment percentages if coverage is provided through a spouse, parent, legal guardian, or through individual coverage, or another employer. Persons who have individual coverage or coverage through a domestic partner's employer would not be counted in the enrollment percentages.</p>

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4.	R9-27-303(A) (3)	Under R9-27-303(A)(3), an unmarried child of any age with a disability that existed before the child's 19th birthday may enroll as a dependent of the employee member, but presumably this includes a dependent who is a natural or adopted child or a stepchild. This provision is unclear whether the coverage includes an adult who does not meet the criteria, for whom the employee member was the legal guardian before the individual's 19th birthday (a grandmother or other related or unrelated legal guardian). Recommends retaining current language in R9-27-303(A)(3). Arizona Center for Disability Law	Partially Agree. Statute does not define dependent. Definition of dependent in the rule only includes the spouse and children of the employee member. R9-27-303(A)(3) was revised to clarify that an unmarried child includes a dependent who is a natural or an adopted child or stepchild.
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<p>5.</p>	<p>R9-27-303(A)(3)</p>	<p>The current rule language makes an adult dependent child of an employee member eligible to enroll in an HCG plan if the person is currently incapable of self-sustaining support due to a disability existing prior to the 19th birthday. Proposed rule may require person to be incapable of engaging in substantial gainful activity prior to the 19th birthday. Rule doesn't have requirement that person was incapable of self-sustaining support before the 19th birthday. Recommends that language is clarified so that a person may be eligible for covered services due to progression of a disabling condition or disease. Arizona Center for Disability Law</p>	<p>Disagree. The current rule has never been interpreted or applied as suggested. Under the existing rule, a disability rendering the child incapable of self-sustaining support must exist prior to the child's 19th birthday. The commenter's interpretation is unreasonable and contrary to the statutory intent to limit coverage to dependents. For example, if a child's disability progresses to the point that he or she can no longer work at 45, it would lead to an unreasonable result to characterize the adult child as a "dependent." The adult may have been living independently and been a productive member of the workforce for 25 years prior to the disability rendering the adult incapable of work even though the disability practice existed prior to the person's 19th birthday. The amendment does not represent a change in policy or practice; it is, at most, a clarification.</p>
<p>6.</p>	<p>R9-27-303</p>	<p>Definition of "substantial gainful activity" does not incorporate all the requirements in federal regulations. Recommends incorporating the federal exclusions and limitations. Arizona Center for Disability Law</p>	<p>Disagree. AHCCCS is not bound by the SSI regulations on substantial gainful activity and does not intend to adopt the federal exclusions and limitations.</p>

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7.	R9-27-310	<p>The terms "employee member," "member," "dependent," and "persons insured through the employee member" appear to be used interchangeably and inconsistently, which is confusing. In subsections (A) and (B), AHCCCS is dealing with termination of a dependent, which will terminate the dependent's coverage, and termination of an employee member, which will result in immediate termination of the employee member and all persons insured through the employee member. In subsection (E), this language is unclear: "Coverage for all persons, who are not hospitalized on the effective date of termination and are insured through the employee shall terminate at midnight on the effective date of termination of the employee member's coverage." Recommends clarifying this language.</p> <p>Arizona Center for Disability Law</p>	<p>Agree. Language throughout this Section has been revised and refers to termination of a member, which is defined to mean the member or the dependent. Language in subsection (C) is revised to provide that coverage for all members, except a hospitalized member, shall terminate on the effective date of the termination of the member's coverage.</p>
8.	R9-27-310 (E)	<p>Clarify who is responsible for paying the premium for the hospitalized member to continue coverage.</p> <p>Arizona Center for Disability Law</p>	<p>Agree. This refers to continuation coverage through COBRA. Language was reworded to state that for coverage of a hospitalized member to continue under this Article, HCGA shall continue to receive timely paid premiums. The employee is responsible for paying the premium for continuation coverage under R9-27-302(E).</p>
9.	R9-27-310(A)(1)	<p>This provision allows HCGA or an HCG plan to terminate a member based on fraud or misrepresentation when applying for coverage. Standard applied in determining whether a member has committed fraud or misrepresentation is unclear. Recommends use of clear and convincing evidence of fraud or intentional misrepresentation when applying for coverage.</p> <p>Arizona Center for Disability Law</p>	<p>Agree. Language revised as follows: "Clear and convincing evidence of fraud or misrepresentation material to enrollment or factors that impact the premium when the member applies for coverage or obtains services."</p>

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10.	R9-22-310(B)	<p>An HCG plan may terminate a member's coverage at midnight on the last day of the month that written notice of termination of coverage is mailed. There is no minimum notice period before termination. R9-27-405 requires 30 days written notice before terminating a member.</p> <p>Arizona Center for Disability Law</p>	<p>Agree. Rule revised to require a 10 day written notice before termination in R9-27-310(A) and a 30 day written notice before termination in R9-27-310(B).</p>
11.	R9-27-310(D)	<p>HCGA has the authority to exclude, as ineligible to enroll, an employer group, employee member, or a dependent whose prior health care coverage is terminated by an HCG Plan or other accountable health plan under subsection (D)(1) for repeated and unreasonable demands for unnecessary medical services. This may exclude a dependent covered under another parent's insurance who was terminated for misrepresentation in applying for coverage. Recommends subsection (D)(1) require clear and convincing evidence.</p> <p>Arizona Center for Disability Law</p>	<p>Partially agree. R9-27-310(D) applies only to coverage terminated by an HCG plan. "Accountable health plan" deleted in subsection (D. Subsections (A)(1), (D)(1) revised as follows: "Clear and convincing evidence of fraud or misrepresentation material to enrollment or factors that impact the premium when the member applies for coverage or obtains services."</p>
12.	R9-27-310(E)(4)	<p>This provision may exclude a person whose coverage was terminated because the employer didn't pay the premium. Employers may have had difficulty paying for other health plans. Recommends deleting exclusion or limiting to employer groups previously terminated from HCG participation due to failure to pay a financial obligation.</p> <p>Arizona Center for Disability Law</p>	<p>Agree. Language in subsection (D) was revised to limit the exclusion to a person whose prior health care coverage was previously terminated by an HCG Plan.</p>

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13.	R9-27-302	<p>Recommends rewording (E) as follows: "Employee members of HCG and their dependents who are entitled to continuation coverage under COBRA continuation provisions after the employee member's termination of employment may retain HCG coverage until the benefit expires or the premium is not paid by the employee member, whichever is earlier. The employee member shall pay the premium to the employer group, which shall pay the premium to HCGA." Arizona Center for Disability Law</p>	<p>Partially agree. Language changed as follows: "An employee member and dependent who are entitled to continuation coverage under COBRA continuation provisions after termination of employment, may retain HCG coverage until the benefit expires or the continuation coverage ends, or the premium is not paid by the employee, whichever is earlier." The last sentence is deleted because it is unnecessary.</p>
14.	R9-27-302(C)	<p>Language should be reworded to state that HCGA shall send the employee member and dependent the effective date of coverage.</p>	<p>Agree.</p>

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<p>15.</p>	<p>General Comment</p>	<p>Healthcare Group Program's intent is to provide affordable health coverage to Arizona small businesses. Proposed rules appear to restrict eligibility, reduce benefits, and increase uncovered medical expenses for the member. Arizona Center for Disability Law</p>	<p>Disagree. AHCCCS does not believe that the rules will restrict eligibility. Most health plans have excluded services. Healthcare Group plans are similar to other plans in terms of excluded services. Members will know which services are excluded in the Member Handbook and Evidence of Coverage. Some services are excluded in order to keep plan premiums affordable to as many employees as possible. Eligibility requirements have been relaxed as Healthcare Group is trying to expand the program. Benefits will be expanded in the future to include mental health, dental and vision. Healthcare Group needs to limit benefits as all commercial plans do to control premium costs. Health plans available through Healthcare Group are not an entitlement program and no longer receive a subsidy. These plans must be self-sufficient on the premiums collected.</p>
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16.	R9-27-303(A)((3)	Rules don't specify factors the HCG medical director should use in determining the onset of disability. Concerned that without guidelines, determinations of medical director will be arbitrary, capricious, and inconsistent.	Disagree. Language revised as follows: "An unmarried child of any age with a disability that existed before the child's 19th birthday, as determined by HCGA through its Medical Director." HCGA through its Medical Director will determine whether a qualifying disability exists and the date of onset. This determination calls for professional judgment and is fact specific. "Disability" is defined in R9-27-303(B) and requires that an anatomical, physiological or psychological abnormality must be established through medically acceptable clinical and diagnostic techniques evidenced in the member's medical record. To the extent that the HCG Medical Director makes a factual determination, that determination is subject to administrative and judicial review to ensure against arbitrary decisions.
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17.	General Comment	<p>AHCCCS proposes to repeal many eligibility and enrollment rules in Article 3. It is unclear why AHCCCS feels it's preferable to remove duplicated provisions from rules and incorporate them into contracts.</p> <p>Arizona Center for Disability Law</p>	<p>Disagree. Provisions contained in contracts should not be duplicated in administrative rules. Under A.R.S. § 41-1005(A)(15), matters relating to state contracts are exempt from the requirements of formal rulemaking. Thus, rulemaking regarding this program is permitted but not mandatory. The agency's objective is to use the published rule as a means by which interested employers or employees can obtain basic information regarding the program but to refer them to the actual contract for details. The details of coverage are in the GSA and the member handbook and evidence of coverage that are available to prospective members and provided to all active members.</p>
18.	R9-27-303	<p>Definition of disability is only appropriate in context of R9-27-303.</p>	<p>Agree. Definition of disability is moved from R9-27-101 to R9-27-303. <u>The Arizona Rulemaking Manual</u> states that definitions applicable only to a specific Article or Section should appear at the beginning of that Article or Section.</p>

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19.	R9-27-303	Definition of "disability" in rule differs from and is more restrictive than the SSI definition because impairments must be permanent and continuous. SSI definition also contains other criteria. Recommends conforming rule's definition of disability with the SSI definition.	Disagree. The agency is not bound by the SSI definition of disability as this is not an SSI-related program. The agency believes that the language adds clarification without adding the complexity of the SSI definition.
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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:

None

14. Was this rule previously made as an emergency rule?

No.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

**CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
HEALTH CARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED**

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

Section

- R9-27-301. Eligibility Criteria for Employer Groups
- R9-27-302. Eligibility and Enrollment Criteria for Employee Members Employees
- R9-27-303. Eligibility Criteria for Dependents
- R9-27-305. Health History Form Repealed
- R9-27-306. Effective Date of Coverage Repealed
- R9-27-307. Open Enrollment of Employee Members Enrollment; Effective Date of Coverage
- R9-27-308. Enrollment of Newborns Repealed
- R9-27-309. Enrollment of Newly Eligible Employee and Dependent Due to Loss of Own Coverage Repealed
- R9-27-310. Denial and Termination of Enrollment Termination of HCG Coverage; Denial of Enrollment; Exclusion from Eligibility and Enrollment

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-27-301. Eligibility Criteria for Employer Groups

A. Criteria for employer groups.

- ~~1. An employer group shall conduct business:~~
 - ~~a. Within Arizona for at least 60 days before making application to be an employer group eligible for HCG coverage; and~~
 - ~~b. Within a county which has an HCG Plan.~~
- 1. The eligibility requirements for an employer group to obtain health care coverage through an HCG Plan are as follows:
 - a. The employer group shall conduct business for at least 60 days within Arizona before applying to HCGA; and
 - b. The employer group shall conduct business in a county with an established HCG Plan.
- 2. The HCGA shall determine eligibility for an employer group and its employees through documentation of one or more of the following: An employer group shall have a minimum of one and a maximum of 50 eligible full-time employees on the effective date of the first GSA with HCGA.

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- a. Participation in state unemployment insurance;
 - b. Participation in state worker's compensation;
 - c. Personal tax return with schedule C, SE, or SEZ; or
 - d. Other verifiable proof that the applicant is conducting a business in Arizona.
- B.** Amount of eligible employees and enrollment. Other than the state of Arizona and political subdivisions of the state, an employer group shall have a minimum of one and a maximum of 50 eligible employees at the effective date of the first GSA with HCGA. Acceptable proof of the number of eligible employees may include canceled checks, bookkeeping records, and personnel records.
- B.** Employer group's prior health care coverage. HCGA shall not enroll an employer group in Healthcare Group sooner than 180 days after the date that the employer's health care coverage under an accountable health plan is discontinued. An employer group's enrollment in Healthcare Group is effective on the first day of the month after the 180-day period. The 180-day enrollment restriction does not apply to an employer group if the employer's accountable health plan discontinues offering the health plan of which the employer is a member.
- C.** Required enrollment of a ~~particular number~~ minimum percentage of eligible employees. Other than state employees and employees of political subdivisions of the state, employers with one to 50 eligible full-time employees may contract with HCGA if the employer group:
- 1. Has five or fewer eligible full-time employees and enrolls 100% percent of these employees in an HCG Plan, or
 - 2. Has six or more eligible full-time employees and enrolls at least 80% percent of these employees in an HCG Plan.
- D.** HCGA does not include employees who work less than 20 hours per week when determining participation requirements.
- E.D.** ~~Employees Full-time employees~~ Employees Full-time employees with proof of other insurance: health care coverage. ~~Employees Full-time employees~~ Employees Full-time employees with proof of existing health care coverage who elect not to participate in an HCG Plan shall not be considered when determining the required percentage of the required number of enrollees, specified in subsection (C), if the health care coverage is: one of the following:
- 1. Group coverage offered provided through a spouse, a parent, or a legal guardian; or
 - 2. ~~Coverage available from a government-subsidized health care program.~~ Medical assistance provided by a government-subsidized health care program;
 - 3. Medical assistance provided under A.R.S. § 36-2982; or
 - 4. Individual coverage or health care coverage through another employer.
- F.E.** Post-enrollment changes in group size. Changes in group size that occur during the term of the GSA or during any renewal periods shall do not affect eligibility.
- G.F.** Review and verification of eligibility ~~determinations~~ determination. The HCGA may conduct random reviews of an eligibility ~~determinations~~ determination of an employer group and its employees.
- R9-27-302. Eligibility and Enrollment Criteria for Employee Members Employees**
- A.** Residence. An employee member shall reside, work, or reside and work in Arizona and in a county with an HCG Plan.
- B.** Eligible employer group. An employee member shall be employed by an eligible employer group specified in R9-27-301.
- C.** Days of consecutive employment. An employee member shall have been employed at least 60 consecutive days before the effective date of coverage.
- D.** Hours of employment per week. A member working for an employer group or a self-employed person shall work at least 20 hours per week, with anticipated employment of at least five months following enrollment.
- A.** Eligibility criteria for employees. An eligible employee shall:
- 1. Be eligible for a federal health coverage tax credit under 26 U.S.C. 35 as specified in A.R.S. § 36-2912 (AA)(4)(d); or
 - 2. Be employed or self-employed by an eligible employer group specified in R9-27-301 for a period of at least 60 calendar days before the effective date of coverage and:
 - a. Work at least 20 hours per week for the employer group; and
 - b. Meet other requirements as specified in the GSA.
- B.** Enrollment criteria for eligible employees. An eligible employee and dependent may receive HCG coverage if all of the following occur:
- 1. The eligible employee selects an HCG benefit plan;
 - 2. The eligible employee completes and submits all necessary documentation specified by HCGA including the employee enrollment information and health history forms; and
 - 3. HCGA receives the full required premium no later than the date specified in the GSA.
- C.** After completion of the actions in subsection (B), HCGA shall send written notification of the effective date of coverage to the eligible employee and dependent.
- E.D.** Eligibility for ~~government-subsidized~~ government-subsidized health care programs. The HCGA shall provide written information to members who may be eligible for a ~~government-subsidized~~ government-subsidized health care program.
- E.** Continuation Coverage. An employee member and dependent who are entitled to continuation coverage under COBRA continuation provisions after termination of employment may retain HCG coverage until the benefit expires, the continuation coverage ends, or the premium is not paid by the employee, whichever is earlier.

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R9-27-303. Eligibility Criteria for Dependents

- A.** Eligible dependents. An eligible dependent of an employee member shall reside in Arizona, in a county with an HCG Plan and includes:
1. A legal spouse;
 2. Unmarried children less than the age of 19 or less than the age of 24 if the child is a full-time student, and is:
 - a. A natural child,
 - b. An adopted child; or a child who is placed for adoption,
 - c. A step-child, or
 - d. A child for whom the employee member is a legal guardian.
 3. ~~A child~~ An unmarried child, as specified in subsection (A)(2), of any age with a disability that existed incapable of self-sustaining support by reason of mental or physical disability existing before the child's 19th birthday, as determined by the HCG plan medical director or designee. HCGA through its Medical Director.
- B.** ~~Limitations. A grandchild of an employee member shall be eligible to receive covered services only if the grandchild meets the eligibility requirements in subsection (A)(2)(b), (c), and (d) or (A)(3).~~
- B.** For the purposes of this Section:
1. "Disability" means the inability to do any substantial gainful activity by reason of any impairment or combination of impairments that HCGA through the HCG Medical Director expects to be permanent and continuous. The impairment must result from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. Medical evidence consisting of signs, symptoms, and laboratory findings, not only the member's statement of symptoms, establishes an impairment.
 2. "Substantial gainful activity" means work that:
 - a. Involves doing significant and productive physical or mental duties, and
 - b. Is done or intended for pay or profit.

R9-27-305. Health History Form Repealed

~~Completion of a health history form. An eligible employee and dependents shall complete the HCG health history form before enrollment. An eligible employee or a dependent shall not be denied enrollment as a result of conditions described on the health history form. Pre-existing conditions limit the benefits available to a member as specified in R9-27-210. Failure to provide complete and accurate information on the health history form is cause for immediate termination from the HCG Plan.~~

R9-27-306. Effective Date of Coverage Repealed

- ~~**A.** Payment in advance of effective date. Employer groups shall submit payment 30 days in advance of the effective date of coverage. If the Administration receives the full premium payment on or before the 15th day of the month, enrollment will begin on the first day of the next month. If the Administration receives the full premium payment after the 15th day of the month, coverage begins on the first day of the second month. No retroactive coverage is available.~~
- ~~**B.** Other effective date options. For other effective date options, an employer group shall complete and submit the enrollment documents and initial premium payment by the time frames specified in the GSA.~~

R9-27-307. Open Enrollment of Employee Members Enrollment; Effective Date of Coverage

- ~~**A.** Open enrollment. Enrollment of an employee member shall occur only during one of the following open enrollment periods:~~
1. ~~Thirty days following the effective date of the GSA for a newly enrolled employer group;~~
 2. ~~A 31-day period to start 60 days from the date of employment for a new employee in an enrolled employer group, or a 31-day period after the completion of an employer's waiting period on eligibility for health care coverage, whichever period is greater; or~~
 3. ~~A 31-day period to begin 105 days before and conclude at least 75 days before the employer group's renewal date, as determined by the HCGA.~~
- ~~**B.** New dependent enrollment. Enrollment of new dependents shall occur:~~
1. ~~Within the 31-day period following the addition of a new dependent defined in R9-27-303(A), or~~
 2. ~~Under R9-27-308 if the dependent is a newborn.~~
- ~~**A.** Enrollment. A member who meets the eligibility requirements may select an HCG benefit plan under the terms and during the periods specified in the GSA, including the following situations:~~
1. ~~When an employer member signs the GSA;~~
 2. ~~When a qualifying event occurs as prescribed in the GSA;~~
 3. ~~When the open enrollment period occurs as specified in the GSA; or~~
 4. ~~When the existing health care coverage for an eligible employee or any dependent terminates.~~
- ~~**B.** Effective date of coverage. The HCGA shall establish the effective date of coverage for an employer group or an employee member under an HCG benefit plan and shall provide written notice of the effective date of coverage to the employee member and the employer group.~~

R9-27-308. Enrollment of Newborns Repealed

Newborn enrollment. A newborn shall be enrolled 30 days following the birth to be eligible for coverage. Upon enrollment, the newborn's premium is due to the HCGA 30 days following the birth for coverage retroactive to the first day of the month in which the birth occurred.

R9-27-309. Enrollment of Newly Eligible Employee and Dependent Due to Loss of Own Coverage Repealed

A. Enrollment of newly eligible employee due to loss of own coverage. An eligible employee who had health care coverage through a spouse, is eligible to enroll as a member within 30 days of the loss of coverage, if that loss of separate health care coverage is due to:

1. Death of the eligible employee's spouse;
2. Divorce;
3. Termination of employment of the eligible employee's spouse;
4. Legal separation;
5. Reduction in hours of employment.

B. Enrollment of newly eligible dependent due to loss of own coverage. An eligible dependent, who had individual or family health care coverage separate from the member's coverage is eligible to enroll as a dependent member within 30 days of the loss of coverage, if that loss of separate health care coverage is due to:

1. Death;
2. Divorce;
3. Termination of employment;
4. Legal separation;
5. Reduction in hours of employment, or
6. Retirement.

R9-27-310. Denial and Termination of Enrollment Termination of HCG Coverage; Denial of Enrollment; Exclusion from Eligibility and Enrollment

A. Denial of enrollment. An employer group, an employee, or a dependent who fails to meet the requirements of this Article shall be denied enrollment.

B. Termination of enrollment. Termination of enrollment and coverage for an employer group, an employee member, or a dependent shall occur on the last day of the month that:

1. The employer group loses eligibility;
2. The employee member loses eligibility; or
3. The dependent loses eligibility.

C. Exclusion from enrollment. The HCGA may exclude an employer group or an employee member from enrollment who has committed fraud or misrepresentation while enrolled with another HCG Plan or health benefits carrier.

A. Termination of a member's coverage within 10 days. The HCGA or HCG Plan may terminate a member's coverage effective 10 days from the date the HCGA or HCG Plan mails a written notice of termination of coverage to the member's last known address, for any of the following reasons:

1. Clear and convincing evidence of fraud or misrepresentation material to enrollment or factors listed in A.R.S. § 36-2912(P) that impact the premium when the member applies for coverage or obtains services;
2. Committing or threatening to commit violence toward employees or agents of HCGA, an HCG Plan, network providers, or out-of-network providers.

B. Termination with 30-day written notice. The HCGA or an HCG plan may terminate a member's coverage effective 30 days from the date the HCGA or HCG Plan mails a written notice of termination of coverage to the member's last known address for any of the following reasons:

1. Repeated and unreasonable demands for unnecessary medical services;
2. Failure to pay any copayment, coinsurance, or deductible;
3. Violating a material provision of the member handbook;
4. Terminating employment;
5. Change in age or other status of the member that is required for eligibility under R9-27-302;
6. Changes to the eligibility criteria for a dependent under R9-27-303;
7. Failure of the member's employer to pay the premium; or
8. Loss of the participating health plan with which the employer group is enrolled, if there is no other participating health plan available to serve the employer group.

C. Effective date of termination of hospitalized member. Subject to continuation coverage as described in R9-27-302 (E), on the effective date of termination of coverage, the HCG Plan has no further obligation to provide services and benefits to a member whose coverage terminates, except that a member who is an inpatient on the effective date of termination shall continue to have coverage until the HCG Plan Medical Director or designee determines that care in the hospital is no longer medically necessary for the condition for which the member was admitted to the hospital. Coverage for all members, except a hospitalized member, shall terminate on the effective date of the termination of the employee member's coverage. For coverage of a hospitalized member to continue under this Article, HCGA shall continue to receive timely

paid premiums.

- D.** Exclusion from eligibility and enrollment. The HCGA may exclude, as ineligible to enroll or re-enroll, an employer group, an employee member, or a dependent whose prior health care coverage has been terminated by an HCG Plan for any of the following reasons:
1. Clear and convincing evidence of fraud or misrepresentation material to enrollment or factors listed in A.R.S. § 36-2912(P) that impact the premium when the member applies for coverage or obtains services;
 2. Committing or threatening to commit violence toward employees or agents of HCGA, an HCG Plan, network providers, or out-of-network providers;
 3. Repeated and unreasonable demands for unnecessary medical services;
 4. Failure to pay any copayment, coinsurance, or deductible; or
 5. Violating a material provision of the member handbook.