

NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by first submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication. Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for making, amending, or repealing any rule. (A.R.S. §§ 41-1013 and 41-1022)

NOTICE OF PROPOSED RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 16. ARIZONA MEDICAL BOARD

[R05-164]

PREAMBLE

1. Sections Affected

R4-16-101
R4-16-401
R4-16-401
R4-16-402
R4-16-402
R4-16-403

Rulemaking Action

New Section
Repeal
Amend
Re-number
Amend
Re-number

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. § 32-1404(D)

Implementing statute: A.R.S. § 32-1456(B) and (D)

3. A list of all previous notices appearing in the *Register* addressing the proposed rule:

Notice of Rulemaking Docket Opening: 11 A.A.R. 2037, May 27, 2005

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

Name: George R. Pavia, Rules/Policy Analyst

Address: 9545 E. Doubletree Ranch Rd.
Scottsdale, AZ 85258-5514

Telephone: (480) 551-2769

Fax: (480) 551-2828

E-mail: gpavia@azmdboard.org

Please visit the board web site to track progress of this rule and any other agency rulemaking matters at www.azmdboard.org.

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

In this rulemaking the Board takes the following actions:

- a. To move Article 4's single definition under R4-16-401 into lead Chapter 16 Section R4-16-101 for definitions applicable to the entire Chapter;
- b. To renumber remaining Article 4 Sections as R-4-16-401 and R4-16-402 for efficiency after moving the definition to Article 1;
- c. To update the incorporation by reference of the Commission on Accreditation of Allied Health Education Program's "Standards and Guidelines for an Accredited Educational Program for the Medical Assistant" to reflect the 2003 published standards that expand a medical assistant's duty competencies; and
- d. To make other lexical, stylistic, or syntactical changes that reflect current publication standards of the Governor's Regulatory Review Council and the Secretary of State.

Notices of Proposed Rulemaking

This rulemaking arises from a promised action in a Five-Year Rule Review (F-05-0502) approved by the Governor's Regulatory Review Council on May 3, 2005.

6. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on or 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 will not rely on any study in this rulemaking.

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

Not applicable

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

The material incorporated by reference effectively expands a medical assistant's medical office functionality providing for increased duty competency in the following areas:

- a. Medical transcription;
- b. Specimen collection;
- c. Patient care test screening and follow-up;
- d. Knowledge of federal and state healthcare regulations; and
- e. Application of quality control methods.

It is assumed that the additional medical assistant competencies will not cause increase in training time or financial burden. The benefit is that the medical assistant becomes more versatile in a busy medical office setting to free higher cost professionals from tasks that may now be performed more cost effectively by a medical assistant. The result to the consumer is preservation of primary healthcare services at the lowest possible overhead cost.

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

An interested person may communicate with the agency official in item #4 concerning the economic impact statement.

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

No oral proceeding is scheduled for this rulemaking. A person may make a request for an oral proceeding by notifying the agency official in item #4. If no oral proceeding is requested, the public record for this rulemaking will close at 4:30 p.m. on July 1, 2005.

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

Not applicable

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

None

13. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 16. ARIZONA MEDICAL BOARD

ARTICLE 1. GENERAL PROVISIONS

Section

R4-16-101. ~~Renumbered~~ Definitions

ARTICLE 4. MEDICAL ASSISTANTS

Section

~~R4-16-401. Definitions Repealed~~

~~R4-16-402. R4-16-401. Medical Assistant Training Requirements~~

~~R4-16-403. R4-16-402. Authorized Procedures for Medical Assistants~~

ARTICLE 1. GENERAL PROVISIONS

R4-16-101. Renumbered Definitions

Unless context otherwise requires, definitions prescribed under A.R.S. § 32-1401 and the following apply to this Chapter:

“Approved medical assistant training program” means:

An accredited program by one of the following:

The Commission on Accreditation of Allied Health Education Programs (CAAHEP);

The Accrediting Bureau of Health Education Schools (ABHES); or

A medical assisting program accredited by any accrediting agency recognized by the U.S. Department of Education; or

A training program designed and offered by a licensed allopathic physician, that meets or exceeds any of the prescribed accrediting programs, and verifies the entry-level competencies of a medical assistant prescribed under R4-16-402(A).

ARTICLE 4. MEDICAL ASSISTANTS

R4-16-401. Definitions Repealed

For the purposes of A.R.S. Title 32, Chapter 13 and of this Chapter, unless the context otherwise requires:

~~“Approved medical assistant training program” means a program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP), the Accrediting Bureau of Health Education Schools (ABHES), a medical assisting program accredited by any accrediting agency recognized by the United States Department of Education, or a training program designed and offered by a licensed allopathic physician, that meets or exceeds any of these three accrediting programs, and verifies the entry level competencies of a medical assistant referenced in R4-16-303.~~

R4-16-402. R4-16-401. Medical Assistant Training Requirements

A. ~~The~~ A supervising physician or physician assistant shall ensure that a medical assistant satisfies one of the following training requirements ~~prior to the medical assistant’s employment before employing the medical assistant:~~

1. Completion of an approved medical assistant training program.
2. Completion of an unapproved medical assistant training program and passage of the medical assistant examination administered by either the American Association of Medical Assistants or the American Medical Technologists.

B. This ~~rule Section~~ Section does not apply to any person who:

1. ~~Prior to the effective date of these rules completed an unapproved medical assistant training program and was employed as a medical assistant since completion of the program.~~
2. ~~Prior to the effective date of these rules was directly supervised by the same physician, group of physicians, or physician assistant for at least 2000 hours.~~
3. ~~Completes a medical services training program of the Armed Forces of the United States.~~

1. Before February 2, 2000:

- a. Completed an unapproved medical assistant training program and was employed as a medical assistant after program completion; or
- b. Was directly supervised by the same physician, physician group, or physician assistant for a minimum of 2000 hours; or

2. Completes a U.S. armed forces medical services training program.

R4-16-403. R4-16-402. Authorized Procedures for Medical Assistants

A. A medical assistant may perform, under the direct supervision of a physician or a physician assistant, the medical procedures listed in the ~~April 1999~~ 2003 revised edition, Commission on Accreditation of Allied Health Education Program’s, “Standards and Guidelines for an Accredited Educational Program for the Medical Assistant, Section ~~(2)(A)(5)(a through e)~~ (III)(C)(3)(a through c).” The address is 35 East Wacker Drive, Suite 1970, Chicago, Illinois 60601. This material is incorporated by reference, does not include any later amendments or editions of the incorporated matter, ~~and is on file with the Office of the Secretary of State and may be obtained from the publisher at www.caahep.org or the Arizona Medical Board at 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258, www.azmdboard.org.~~

B. No change

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ADMINISTRATION

[R05-181]

PREAMBLE

1. Sections Affected

Rulemaking Action

R9-22-101	Amend
R9-22-105	Repeal
R9-22-501	Amend
R9-22-502	Amend
R9-22-503	New Section
R9-22-504	Amend
R9-22-505	Repeal
R9-22-507	Repeal
R9-22-508	Amend
R9-22-509	Amend
R9-22-510	Repeal
R9-22-511	Repeal
R9-22-512	Amend
R9-22-513	Repeal
R9-22-514	Repeal
R9-22-518	Amend
R9-22-521	Amend
R9-22-522	Amend
R9-22-524	Repeal

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. §§ 36-2903 and 36-2903.01

Implementing statutes: A.R.S. §§ 36-2903, 36-2903.02, 36-2907, and 36-2910

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening: 11 A.A.R. 414, January 14, 2005

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

Name: Mariaelena Ugarte
Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4232
Fax: (602) 253-9115
E-mail: AHCCCSRules@ahcccs.state.az.us

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

The proposed rule has been written to comply with the regulatory requirement of updating and maintaining rules every five years, as required by the Governor's Regulatory Review Council. Various provisions were removed from rule because they were found to be only necessary in contract. In addition, the proposed rule was amended for clarity.

6. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on or 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:

No studies were required or reviewed.

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

Not applicable

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

AHCCCS anticipates no impact.

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

Name: Mariaelena Ugarte
Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4232
Fax: (602) 256-6756
E-mail: AHCCCSRules@ahcccs.state.az.us

Proposed rule language will be available on the AHCCCS web site www.ahcccs.state.az.us the week of May 9, 2005. Please send written comments to the address in this item by 5:00 p.m., June 29, 2005. E-mail comments will be accepted.

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

Date: June 29, 2005
Time: 2:00 p.m.
Location: AHCCCS
701 E. Jefferson
Phoenix, AZ 85034
Gold Room
Nature: Public Hearing

Date: June 29, 2005
Time: 2:00 p.m.
Location: ALTCS: Arizona Long-term Care System
110 S. Church, Suite 1360
Tucson, AZ 85701
Nature: Public Hearing

Date: June 29, 2005
Time: 2:00 p.m.
Location: ALTCS: Arizona Long-term Care System
3480 E. Route 66
Flagstaff, AZ 86004
Nature: Public Hearing

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

None

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

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

**CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ADMINISTRATION**

ARTICLE 1. DEFINITIONS

Section

R9-22-101. Location of Definitions

R9-22-105. ~~General Provisions and Standards Related Definitions~~ Repealed

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Section

R9-22-501. ~~Pre-existing Conditions~~ General Provisions and Standards Related Definitions

R9-22-502. ~~Availability and Accessibility of Service~~ Pre-existing Conditions

R9-22-503. ~~Repealed~~ Provider Requirements

R9-22-504. Marketing; Prohibition against Inducements; Misrepresentations; Discrimination; Sanctions

R9-22-505. ~~Approval of Advertisements and Marketing Materials~~ Repealed

R9-22-507. ~~Member Record~~ Repealed

R9-22-508. Limitation of Benefit Coverage for Illness or Injury due to Catastrophe

R9-22-509. Transition and Coordination of Member Care

R9-22-510. ~~Transfer of Members~~ Repealed

R9-22-511. ~~Fraud or Abuse~~ Repealed

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

R9-22-513. ~~Discrimination Prohibition~~ Repealed

R9-22-514. ~~Equal Opportunity~~ Repealed

R9-22-518. Information to Enrolled Members

R9-22-521. Program Compliance Audits

R9-22-522. Quality Management/Utilization Management (QM/UM) Requirements

R9-22-524. ~~Continuity of Care~~ Repealed

ARTICLE 1. DEFINITIONS

R9-22-101. Location of Definitions

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

Definition	Section or Citation
"Accommodation"	R9-22-107
"Act"	R9-22-114
"Active case"	R9-22-109
"ADHS"	R9-22-112
"Administration"	A.R.S. § 36-2901
"Administrative law judge"	R9-22-108
"Administrative review"	R9-22-108
"Advanced Life Support" or "ALS"	R9-25-101
"Adverse action"	R9-22-114
"Affiliated corporate organization"	R9-22-106
"Aged"	42 U.S.C. 1382c(a)(1)(A) and R9-22-115
"Aggregate"	R9-22-107
"AHCCCS"	R9-22-101
"AHCCCS inpatient hospital day or days of care"	R9-22-107
"AHCCCS registered provider"	R9-22-101
"Ambulance"	A.R.S. § 36-2201
"Ancillary department"	R9-22-107
"Annual assessment period"	R9-22-109
"Annual assessment period report"	R9-22-109
"Annual enrollment choice"	R9-22-117
"Appellant"	R9-22-114
"Applicant"	R9-22-101

Notices of Proposed Rulemaking

“Application”	R9-22-101
“Assignment”	R9-22-101
“Attending physician”	R9-22-101
“Authorized representative”	R9-22-114
“Auto-assignment algorithm”	R9-22-117
“Baby Arizona”	R9-22-114
“Basic Life Support” or “BLS”	R9-25-101
“Behavior management services”	R9-22-112
“Behavioral health evaluation”	R9-22-112
“Behavioral health medical practitioner”	R9-22-112
“Behavioral health professional”	R9-20-101
“Behavioral health service”	R9-22-112
“Behavioral health technician”	R9-20-101
“Behavior management services”	R9-22-112
“BHS”	R9-22-114
“Billed charges”	R9-22-107
“Blind”	R9-22-115
“Board-eligible for psychiatry”	R9-22-112
“Burial plot”	R9-22-114
“Capital costs”	R9-22-107
“Capped fee-for-service”	R9-22-101
“Caretaker relative”	R9-22-114
“Case”	R9-22-109
“Case record”	R9-22-109
“Case review”	R9-22-109
“Cash assistance”	R9-22-114
“Categorically-eligible”	R9-22-101
“Certified psychiatric nurse practitioner”	R9-22-112
“Clean claim”	A.R.S. § 36-2904
“Clinical supervision”	R9-22-112
“CMDP”	R9-22-117
“CMS”	R9-22-101
“Complainant”	R9-22-108
“Continuous stay”	R9-22-101
“Contract”	R9-22-101
“Contractor”	A.R.S. § 36-2901
“Copayment”	R9-22-107
“Corrective action plan”	R9-22-109
“Cost-to-charge ratio”	R9-22-107
“Covered charges”	R9-22-107
“Covered services”	R9-22-102
“CPT”	R9-22-107
“CRS”	R9-22-114
“Cryotherapy”	R9-22-120
“Date of eligibility posting”	R9-22-107
“Date of notice”	R9-22-108
“Day”	R9-22-101
“DCSE”	R9-22-114
“De novo hearing”	42 CFR 431.201
“Dentures”	R9-22-102
“Department”	A.R.S. § 36-2901
“Dependent child”	A.R.S. § 46-101
“DES”	R9-22-101
“Diagnostic services”	R9-22-102
“Director”	R9-22-101
“Disabled”	R9-22-115
“Discussions”	R9-22-106
“Disenrollment”	R9-22-117
“District”	R9-22-109
“DME”	R9-22-102
“DRI inflation factor”	R9-22-107
“E.P.S.D.T. services”	42 CFR 441 Subpart B
“Eligible person”	A.R.S. § 36-2901
“Emergency medical condition”	42 U.S.C. 1396b(v)(3)

Notices of Proposed Rulemaking

“Emergency medical services”	R9-22-102
“Emergency services costs”	A.R.S. § 36-2903.07
“Encounter”	R9-22-107
“Enrollment”	R9-22-117
“Enumeration”	R9-22-101
“Equity”	R9-22-101
“Experimental services”	R9-22-101
“Error”	R9-22-109
“FAA”	R9-22-114
“Facility”	R9-22-101
“Factor”	42 CFR 447.10
“FBR”	R9-22-101
“Fee-For-Service” or “FFS”	R9-28-101
“FESP”	R9-22-101
“Finding”	R9-22-109
“First-party liability”	R9-22-110
“Foster care maintenance payment”	42 U.S.C. 675(4)(A)
“Federal poverty level” (“FPL”)	A.R.S. § 1-215
“FQHC”	R9-22-101
“Grievance”	R9-22-108
“GSA”	R9-22-101
“Health care practitioner”	R9-22-112
“Hearing”	R9-22-108
“Hearing aid”	R9-22-102
“Home health services”	R9-22-102
“Homebound”	R9-22-114
“Hospital”	R9-22-101
“Intermediate Care Facility for the Mentally Retarded” or “ICF-MR”	42 CFR 483 Subpart I
“ICU”	R9-22-107
“IHS”	R9-22-117
“IMD”	42 CFR 435.1009 and R9-22-112
“Income”	R9-22-114
“Inmate of a public institution”	42 CFR 435.1009
“Interested party”	R9-22-106
“LEEP”	R9-22-120
“Level I trauma center”	R9-22-2101
“License” or “licensure”	R9-22-101
“Mailing date”	R9-22-114
“Management evaluation review”	R9-22-109
“Medical education costs”	R9-22-107
“Medical expense deduction”	R9-22-114
“Medical record”	R9-22-101
“Medical review”	R9-22-107
“Medical services”	A.R.S. § 36-401
“Medical supplies”	R9-22-102
“Medical support”	R9-22-114
“Medically necessary”	R9-22-101
“Medicare claim”	R9-22-107
“Medicare HMO”	R9-22-101
“Member”	A.R.S. § 36-2901
“Mental disorder”	A.R.S. § 36-501
“New hospital”	R9-22-107
“Nursing facility” or “NF”	42 U.S.C. 1396r(a)
“NICU”	R9-22-107
“Noncontracting provider”	A.R.S. § 36-2901
“Nonparent caretaker relative”	R9-22-114
“Notice of Findings”	R9-22-109
“OAH”	R9-22-108
“Occupational therapy”	R9-22-102
“Offeror”	R9-22-106
“Ownership interest”	42 CFR 455.101
“Operating costs”	R9-22-107
“Outlier”	R9-22-107

Notices of Proposed Rulemaking

“Outpatient hospital service”	R9-22-107
“Ownership change”	R9-22-107
“Partial Care”	R9-22-112
“Party”	R9-22-108
“Peer group”	R9-22-107
“Performance measures”	R9-22-109
“Pharmaceutical service”	R9-22-102
“Physical therapy”	R9-22-102
“Physician”	R9-22-102
“Prior period coverage” or “PPC”	R9-22-107
“Post-stabilization care services”	42 CFR 422.113
“Practitioner”	R9-22-102
“Pre-enrollment process”	R9-22-114
“Preponderance of evidence”	R9-22-109
“Prescription”	R9-22-102
“Primary care provider (PCP)”	R9-22-102
“Primary care provider services”	R9-22-102
“Prior authorization”	R9-22-102
“Private duty nursing services”	R9-22-102
“Proposal”	R9-22-106
“Prospective rates”	R9-22-107
“Prospective rate year”	R9-22-107
“Psychiatrist”	R9-22-112
“Psychologist”	R9-22-112
“Psychosocial rehabilitation services”	R9-22-112
“Qualified alien”	A.R.S. § 36-2903.03
“Quality management”	R9-22-105 <u>R9-22-501</u>
“Radiology”	R9-22-102
“Random sample”	R9-22-109
“RBHA”	R9-22-112
“Rebasing”	R9-22-107
“Referral”	R9-22-101
“Rehabilitation services”	R9-22-102
“Reinsurance”	R9-22-107
“Remittance advice”	R9-22-107
“Resources”	R9-22-114
“Respiratory therapy”	R9-22-102
“Respondent”	R9-22-108
“Responsible offeror”	R9-22-106
“Responsive offeror”	R9-22-106
“Review”	R9-22-114
“Review period”	R9-22-109
“RFP”	R9-22-106
“Scope of services”	R9-22-102
“SDAD”	R9-22-107
“Section 1115 Waiver”	A.R.S. § 36-2901
“Service location”	R9-22-101
“Service site”	R9-22-101
“SESP”	R9-22-101
“S.O.B.R.A.”	R9-22-101
“Specialist”	R9-22-102
“Specified relative”	R9-22-114
“Speech therapy”	R9-22-102
“Spendthrift restriction”	R9-22-114
“Spouse”	R9-22-101
“SSA”	42 CFR 1000.10
“SSI”	42 CFR 435.4
“SSN”	R9-22-101
“Stabilize”	42 U.S.C. 1395dd
“Standard of care”	R9-22-101
“Sterilization”	R9-22-102
“Subcontract”	R9-22-101
“Submitted”	A.R.S. § 36-2904
“Summary report”	R9-22-109

Notices of Proposed Rulemaking

“SVES”	R9-22-114
“Third-party”	R9-22-110
“Third-party liability”	R9-22-110
“Tier”	R9-22-107
“Tiered per diem”	R9-22-107
“Title IV-D”	R9-22-114
“Title IV-E”	R9-22-114
“Tolerance level”	R9-22-109
“Trauma and Emergency Services Fund”	A.R.S. § 36-2903.07
“Unrecovered trauma readiness costs”	R9-22-2101
“Utilization management”	R9-22-105 R9-22-501
“WWHP”	R9-22-120

B. General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“AHCCCS” means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

“AHCCCS registered provider” means a provider or noncontracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A); and

Meets license or certification requirements to provide AHCCCS covered services.

“Applicant” means a person who submits or whose authorized representative submits, a written, signed, and dated application for AHCCCS benefits.

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

“Assignment” means enrollment of a member with a contractor by the Administration.

“Attending physician” means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a fee-for-service member.

“Capped fee-for-service” means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific AHCCCS-covered service or equipment provided to a member. A payment is made in accordance with an upper, or capped, limit established by the Director. This capped limit can either be a specific dollar amount or a percentage of billed charges.

“Categorically-eligible” means a person who is eligible under A.R.S. §§ 36-2901(6)(a)(i), (ii), or (iii) and 36-2934.

“CMS” means the Centers for Medicare and Medicaid Services.

“Continuous stay” means the period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

“Contract” means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and this Chapter.

“Day” means a calendar day unless otherwise specified.

“DES” means the Department of Economic Security.

“Director” means the Director of the Administration or the Director’s designee.

“Eligible person” means a person as defined in A.R.S. § 36-2901.

“Enumeration” means the assignment of a specific nine-digit identification number to a person by the Social Security Administration.

“Equity” means the county assessor full cash or market value of a resource minus valid liens, encumbrances, or both.

“Experimental services” means services that are associated with treatment or diagnostic evaluation that meets one or more of the following criteria:

Is not generally and widely accepted as a standard of care in the practice of medicine in the United States;

Does not have evidence of safety and effectiveness documented in peer reviewed articles in medical journals published in the United States; or

Lacks authoritative evidence by the professional medical community of safety and effectiveness because the services are rarely used, novel, or relatively unknown in the professional medical community.

“Facility” means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution, under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related service.

“FBR” means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.

“FESP” means a federal emergency services program covered under R9-22-217, to treat an emergency medical condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

“FQHC” means federally qualified health center.

“GSA” means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with that contractor.

“Hospital” means a health care institution that is licensed as a hospital by the Arizona Department of Health Services

under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.

“License” or “licensure” means a nontransferable authorization that is awarded based on established standards in law, is issued by a state or a county regulatory agency or board, and allows a health care provider to lawfully render a health care service.

“Medical record” means all documents that relate to medical and behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that are kept at the site of the provider.

“Medically necessary” means a covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or their progression, or prolong life.

“Medicare HMO” means a health maintenance organization that has a current contract with Centers for Medicare and Medicaid for participation in the Medicare program under 42 CFR 417(L).

“Referral” means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

“Service location” means a location at which a member obtains a covered health care service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.

“Service site” means a location designated by a contractor as the location at which a member is to receive covered health care services.

“S.O.B.R.A.” means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII).

“Spouse” means a person who has entered into a contract of marriage, recognized as valid by Arizona.

“SSN” means social security number.

“Standard of care” means a medical procedure or process that is accepted as treatment for a specific illness, or injury, medical condition through custom, peer review, or consensus by the professional medical community.

“Subcontract” means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member;

A marketing organization; or

Any other organization or person who agrees to perform any administrative function or service for a contractor specifically related to securing or fulfilling the contractor’s obligation to the Administration under the terms of a contract.

“Tribal Facility” means a facility that is operated by an Indian tribe and that is authorized to provide services under Public Law 93-638, as amended.

R9-22-105. ~~General Provisions and Standards Related Definitions Repealed~~

~~In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:~~

~~“Quality management” means a methodology and activity used by professional health personnel through a formal program involving multiple organizational components and committees to:~~

~~Assess the degree of conformance to desired medical standards and practices and;~~

~~Improve or maintain quality service and care.~~

~~“Utilization management” means a methodology used by professional health personnel that assesses the medical indications, appropriateness, and efficiency of care provided.~~

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-22-501. ~~Pre-existing Conditions~~ General Provisions and Standards Related Definitions

~~**A.** Except as otherwise provided in Article 3 of this Chapter, a contractor shall be responsible for providing the full scope of covered services to each member from the effective date of eligibility until the time of notification of termination, suspension, or transfer of the member’s enrollment. This responsibility includes providing treatment for all of a member’s pre-existing conditions.~~

~~**B.** A contractor or subcontractor shall not adopt or use any procedure to identify individuals who have an existing or anticipated medical or psychiatric condition in order to discourage or exclude the individuals from enrolling in the contractor’s health plan or encourage the individuals to enroll in another health plan.~~

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“Quality management” means a methodology and activity used by professional health personnel through a formal program involving multiple organizational components and committees to: Assess the degree of conformance to desired

medical standards and practices and; Improve or maintain quality service and care.
“Utilization management” means a methodology used by professional health personnel that assesses the medical indications, appropriateness, and efficiency of care provided.

R9-22-502. Availability and Accessibility of Service Pre-existing Conditions

- A.** ~~A contractor shall provide adequate numbers of available and accessible:~~
- ~~1. Institutional facilities;~~
 - ~~2. Service locations;~~
 - ~~3. Service sites; and~~
 - ~~4. Professional, allied, and paramedical personnel for the provision of covered services, including all emergency medical services for 24 hours a day, seven days a week.~~
- B.** ~~A contractor shall minimally provide the following:~~
- ~~1. A ratio of primary care providers to adults and children, as specified in contract;~~
 - ~~2. A designated emergency services facility, providing care 24 hours a day, seven days a week, accessible to members in each contracted service area. One or more physicians and one or more nurses shall be on call or on duty at the facility at all times;~~
 - ~~3. An emergency services system employing at least one physician, registered nurse, physician’s assistant, or nurse practitioner, accessible by telephone 24 hours a day, seven days a week, to members who need information in an emergency, and to providers who need verification of patient membership and treatment authorization;~~
 - ~~4. An emergency services call log or database to track the following information:~~
 - ~~a. Member’s name;~~
 - ~~b. Address and telephone number;~~
 - ~~c. Date and time of call;~~
 - ~~d. Nature of complaint or problem; and~~
 - ~~e. Instructions given to member.~~
 - ~~5. A written procedure for communicating emergency services information to a member’s primary care provider, and other appropriate organizational units;~~
 - ~~6. An appointment standard as specified in contract for the following:~~
 - ~~a. Emergency appointments;~~
 - ~~b. Urgent care appointments; and~~
 - ~~c. Routine care appointments.~~
 - ~~7. Waiting times for members with appointments that do not exceed 45 minutes, except when the provider is unavailable due to an emergency.~~
- C.** ~~A contractor shall have an affiliation with or subcontract with an organization or individual to provide primary care services. The contractor shall agree to provide services under the primary care provider’s guidance and direction.~~
- ~~1. A primary care provider selected by or to whom an enrolled member is assigned shall be responsible for:~~
 - ~~a. Supervising, coordinating, and providing initial and primary care to the member;~~
 - ~~b. Initiating referrals for specialty care;~~
 - ~~c. Maintaining continuity of member care; and~~
 - ~~d. Maintaining an individual medical record for each assigned member.~~
 - ~~2. A primary care provider or specialist providing inpatient services to a member shall have staff privileges in a minimum of one general acute care hospital under subcontract with the contractor, within the service area of the contractor.~~
- A.** Except as otherwise provided in Article 3 of this Chapter, a contractor shall be responsible for providing the full scope of covered services to each member from the effective date of eligibility until the termination or transfer of the member’s enrollment from the contract.
- B.** A contractor or subcontractor shall not adopt or use any procedure to identify persons who have an existing or anticipated medical or psychiatric condition in order to discourage or exclude the persons from enrolling in the contractor’s health plan or encourage the persons to enroll in another health plan.

R9-22-503. Repealed Provider Requirements

A provider shall maintain and make available to a contractor and to the Administration, financial, and medical records for not less than five years from the date of final payment, or for records relating to costs and expenses to which the Administration has taken exception, five years after the date of final disposition or resolution of the exception. The records shall meet the uniform accounting standards as specified by the Administration, and accepted practices for maintenance of medical records, including detailed specification of all patient services delivered, the rationale for delivery, and the service date.

R9-22-504. Marketing; Prohibition against Inducements; Misrepresentations; Discrimination; Sanctions

- A.** A contractor or the contractor’s marketing representative shall not offer or give any form of compensation or reward, or engage in any behavior or activity that may be reasonably construed as coercive, to induce or procure AHCCCS enroll-

ment. Any marketing solicitation offering a benefit, good, or service, in excess of the covered services in Article 2 shall be deemed an inducement.

- B. A marketing representative shall not misrepresent itself, the contracting health plan represented, or the AHCCCS program, through false advertising, false statements, or in any other manner to induce an eligible person or member of another contracting entity to enroll in the represented health plan.
 - 1. The Administration shall deem violations of this subsection to include, but not be limited to, false or misleading claims, inferences, or representations that:
 - a. An eligible person or member will lose benefits under the AHCCCS program or any other health or welfare benefits to which the eligible person or member is legally entitled, if the eligible person or member does not enroll in the represented contracting health plan;
 - b. Marketing representatives are employees of the state or representatives of the Administration, a county, or any health plan other than the health plan with whom they are employed, or by whom they are reimbursed; and
 - c. The represented health plan is recommended or endorsed as superior to its competition by any state or county agency, or any organization, unless the organization has certified its endorsement in writing to the health plan and the Administration.
- C. A marketing representative shall not engage in any marketing or pre-enrollment practice that discriminates against an eligible person or a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.
- D. ~~The If a violation occurs, the~~ Administration shall hold a contractor responsible for the performance of any marketing representative, subcontractor or agent, program, or process under its employ or direction and shall make the contractor subject to the contract sanctions ~~in this Chapter~~.
- E. A contractor shall produce and distribute information materials to each enrolled member or designated representative after receipt of notification of enrollment from the Administration. The information, which shall be approved by the Administration before distribution, shall include:
 - 1. A description of all covered services as specified in contract;
 - 2. An explanation of service limitations and exclusions;
 - 3. An explanation of the procedure for obtaining services, including a notice stating that the program contractor is liable only for those services authorized by an ALTCS member's case manager;
 - 4. An explanation of the procedure for obtaining emergency services;
 - 5. An explanation of the procedure for filing a grievance and appeal; and
 - 6. An explanation of when plan changes may occur as specified in contract.

R9-22-505. ~~Approval of Advertisements and Marketing Materials Repealed~~

- ~~A. A contractor shall submit its proposed advertisements, marketing materials, and paraphernalia for review and approval by the Administration before distributing the materials or implementing the activities.~~
- ~~B. A contractor shall submit all proposed marketing materials in writing to the Administration.~~
- ~~C. The Administration shall review and approve or disapprove all marketing materials. The Administration shall include a statement of objections and recommendations in a notice of disapproval.~~
- ~~D. To minimize the expense of revising advertising or other copy, a contractor may submit the marketing materials in draft form, subject to final approval and filing of a proof or final copy.~~
- ~~E. A contractor shall provide two copies of the proof or final approved copy of marketing materials to the Administration.~~

R9-22-507. ~~Member Record Repealed~~

~~A contractor shall maintain a member service record that contains at least the following for each member:~~

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

R9-22-508. ~~Limitation of Benefit Coverage for Illness or Injury due to Catastrophe~~

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

R9-22-509. ~~Transition and Coordination of Member Care~~

- A. The Administration shall coordinate and implement disenrollment and re-enrollment procedures when a member's change of residency requires a change in contractor.
- B. A contractor shall assist in the transition of members to and from other AHCCCS contractors.
 - 1. Both the receiving and relinquishing contractor shall:
 - a. Coordinate with the other contractor to facilitate and schedule appointments for medically necessary services for

Notices of Proposed Rulemaking

- the transitioned member within the Administration's timelines specified in the contract. A contractor's policies and procedures regarding transition of members are subject to review and approval by the Administration;
- b. Assist in the referral of transitioned members to other community health agencies or county medical assistance programs for medically necessary services not covered by the Administration, as appropriate; and
 - c. Develop policies and procedures to be followed when transitioning members who have significant medical conditions; are receiving ongoing services; or have, at the time of the transition, received prior authorization or approval for undelivered, specific services.
2. The relinquishing contractor shall notify the receiving contractor of relevant information about the member's medical condition and current treatment regimens within the timelines defined in contract;
 3. The relinquishing contractor shall forward medical records and other materials to the receiving contractor. The cost of reproducing and forwarding medical records and other materials shall be borne by the relinquishing contractor;
 4. Within the contract-specified timelines, the receiving contractor shall ensure that the member selects or is assigned to a primary care provider, and provide the member with:
 - a. Information regarding the contractor's providers,
 - b. Emergency numbers, and
 - c. Instructions about how to obtain new services.
- C. A contractor shall not use a county or nonprovider health resource alternative that diminishes the contractor's contractual responsibility or accountability for providing the full scope of covered services. Referrals made to other health agencies by a contractor, primarily to reduce expenditures incurred by the contractor on behalf of its members, may result in the application of sanctions described in this Chapter.
- ~~D. A contractor may transfer a member from a noncontracting provider to a contracting provider's facility as soon as a transfer will not be harmful to the member's health as authorized by the member's primary care provider or the contractor's Medical Director. A member's plan shall pay the cost of transfer.~~

R9-22-510. Transfer of Members Repealed

A contractor shall implement procedures to allow a member to transfer from the primary care provider of record to another primary care provider within the same contracting organization. Criteria for a transfer include, but are not be limited to:

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

R9-22-511. Fraud or Abuse Repealed

~~A contractor, provider, or nonprovider shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse.~~

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

~~A. The Administration, contractors, providers, and noncontracting providers shall safeguard information concerning an applicant, eligible person, or member, which includes the following:~~

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

A. In accordance with all applicable federal and state privacy laws and regulations and as described under 42 CFR 431.305, the Administration, contractors, providers, and noncontracting providers shall limit the release of safeguarded information to persons or agencies for the following purposes:

1. Official purposes directly related to the administration of the AHCCCS program including:
 - a. Establishing eligibility and post-eligibility treatment of income, as applicable;
 - b. Determining the amount of medical assistance;
 - c. Providing services for eligible persons and members;
 - d. Performing evaluations and analysis of AHCCCS operations;
 - e. Filing liens on property as applicable;
 - f. Filing claims on estates, as applicable; and
 - g. Filing, negotiating, and settling medical liens and claims.
2. Law enforcement officials: Information may be released to law enforcement officials without the applicant's, eligible person's, or member's written or verbal consent, for the purpose of conducting or assisting an investigation, prosecu-

- tion, or criminal or civil proceeding related to the administration of the AHCCCS program.
3. The Administration may release safeguarded member information to a review committee in accordance with the provisions of A.R.S. § 36-2917, without the consent of the applicant, eligible person, or member.
- B.** ~~The restriction upon disclosure of information does not apply to:~~
1. ~~Summary data;~~
 2. ~~Statistics;~~
 3. ~~Utilization data; and~~
 4. ~~Other information that does not identify an applicant, eligible person, or member.~~
- B.** The Administration, contractors, providers, and noncontracting providers shall use or disclose safeguarded information only to:
1. An applicant;
 2. An eligible person;
 3. A member;
 4. An unemancipated minor, with written permission of a parent, custodial relative, or designated representative, if:
 - a. An Administration employee, authorized representative, or responsible caseworker is present during the examination of the eligibility record; or
 - b. As outlined in subsection (E) after written notification to the provider, and at a reasonable time and place.
 5. Persons authorized by the eligible person, applicant or member, or
 6. A lawful court order or subpoena accompanied by a HIPAA compliant authorization, or qualified protective court order as defined by HIPAA.
- C.** ~~The Administration, contractors, providers, and nonecontracting providers shall use or disclose information concerning an eligible person, applicant, or member only under the conditions specified in subsection (D), (E), and (F) and only to:~~
1. ~~The person concerned;~~
 2. ~~Individuals authorized by the person concerned, and~~
 3. ~~Persons or agencies for official purposes.~~
- C.** The Administration, contractors, providers, and noncontracting providers shall safeguard identifying information, protected health information, and information obtained in the course of application or redetermination of eligibility concerning an applicant, eligible person, or member, which includes, but is not limited to the following:
1. Name and address;
 2. Social Security number;
 3. Social and economic conditions or circumstances;
 4. Agency evaluation of personal information;
 5. Medical data and services, including diagnosis and history of disease or disability;
 6. State Data Exchange (SDX) tapes, and other types of information received from outside sources for the purpose of verifying income eligibility and amount of medical assistance payments;
 7. Any information received in connection with the identification of legally liable third party resources.
- D.** ~~Safeguarded information shall be viewed by or released to only:~~
1. ~~An applicant;~~
 2. ~~An eligible person;~~
 3. ~~A member; or~~
 4. ~~An unemancipated minor, with written permission of a parent, custodial relative, or designated representative, if:~~
 - a. ~~An Administration employee or its, authorized representative, county eligibility official, or responsible caseworker is present during the examination of the eligibility record; or~~
 - b. ~~As outlined in subsection (E) after written notification to the provider, and at a reasonable time and place.~~
- D.** The restriction upon disclosure of information does not apply to:
1. De-identified information as defined by the HIPAA Privacy Rule;
 2. Disclosures to requestors who have complied with the HIPAA Privacy Rule.
- E.** ~~An eligibility case record, medical record, and any other AHCCCS related confidential and safeguarded information regarding an eligible person, member, applicant, or unemancipated minor shall be released to individuals authorized by the eligible person, member, applicant, or unemancipated minor only under the following conditions:~~
1. ~~Authorization for release of information is obtained from the eligible person, member, applicant, or designated representative;~~
 2. ~~Authorization used for release is a written document, separate from any other document, that specifies the following information:~~
 - a. ~~Information or records, in whole or in part, which are authorized for release;~~
 - b. ~~To whom release is authorized;~~
 - e. ~~The period of time for which the authorization is valid, if limited; and~~
 - d. ~~A dated signature of the adult and mentally competent member, eligible person, applicant, or designated representative. If the eligible person, member, or applicant is a minor, the signature of a parent, custodial relative, or~~

Notices of Proposed Rulemaking

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

- 3- If an appeal or grievance is filed, the eligible person, member, applicant, or designated representative shall be permitted to review and obtain or copy any nonprivileged record necessary for the proper presentation of the case.

E. Providers shall furnish requested records to the Administration and its contractors at no charge.

F. Release of safeguarded information to individuals or agencies for official purposes:

- 1- Official purposes directly related to the administration of the AHCCCS program are:
 - a- Establishing eligibility and post-eligibility treatment of income, as applicable;
 - b- Determining the amount of medical assistance;
 - c- Providing services for eligible persons and members;
 - d- Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the AHCCCS program;
 - e- Performing evaluations and analyses of AHCCCS operations;
 - f- Filing liens on property as applicable;
 - g- Filing claims on estates, as applicable; and
 - h- Filing, negotiating, and settling medical liens and claims.
 - 2- For official purposes related to the administration of the AHCCCS program and only to the extent required in performance of duties, safeguarded information, including case records and medical records, may be disclosed to the following persons without the consent of the applicant, member, or eligible person:
 - a- Employees of the Administration;
 - b- Employees of the U.S. Social Security Administration;
 - c- Employees of the Arizona Department of Economic Security;
 - d- Employees of the Arizona Department of Health Services;
 - e- Employees of the U.S. Department of Health and Human Services;
 - f- Employees of contractors, program contractors, providers, and subcontractors;
 - g- Employees of the Arizona Attorney General's Office; or
 - h- Employees of counties including Boards of Supervisors, AHCCCS-eligibility offices, and the County Attorney, as applicable.
 - 3- Law enforcement officials:
 - a- Information may be released to law enforcement officials without the applicant's, eligible person's, or member's written or verbal consent, for the purpose of an investigation, prosecution, or criminal or civil proceeding relating to the administration of the AHCCCS program.
 - b- Medical record. The Administration and contractors shall release safeguarded information contained in a member's medical record to law enforcement officials without the member's consent only if the member is suspected of fraud or abuse against the AHCCCS program.
 - c- A contractor shall release the medical record or information in the case record or other information developed in case management or utilization management operations without the member's written or verbal consent, for the purpose of an investigation, prosecution, or similar criminal proceeding not in connection with the Administration, only if the law enforcement official requesting the information has statutory authority to obtain the information.
 - 4- The Administration may release safeguarded information including case records and medical records to a review committee in accordance with the provisions of A.R.S. § 36-2917, without the consent of the applicant, eligible person, or member.
 - 5- In accordance with the 1634 Agreement between the State of Arizona and the U.S. Department of Health and Human Services, a recipient of information or records disclosed or used for an official purpose shall comply with the 1634 Agreement, dated October 1, 1982, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
 - 6- Providers shall furnish requested records to the Administration and its contractors at no charge.
- G.** The holder of a medical record of a former applicant, eligible person, or member shall obtain written consent from the former applicant, eligible person, or member before transmitting the medical record to a primary care provider.
- H.** Subcontractors are not required to obtain written consent from an eligible person or member before transmitting the eligible person's or member's medical records to a physician who:
 - 1- Provides a service to the eligible person or member under subcontract with the program contractor;
 - 2- Is retained by the subcontractor to provide services that are infrequently used or are of an unusual nature, and
 - 3- Provides a service under the contract.

R9-22-513. Discrimination Prohibition Repealed

A. A contractor, provider, and nonprovider shall not discriminate against an eligible person or member because of race, color,

creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, or physical or mental disability in accordance with Title VI of the U.S. Civil Rights Act of 1964, 42 U.S.C., Section 2000d, and rules and regulations promulgated according to, or as otherwise provided by law. For the purpose of providing covered service under contract according to A.R.S. Title 36, Ch. 29, discrimination includes, but is not limited to, the following if done on the grounds of the eligible person's or member's race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, or physical or mental disability:

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

~~B.~~ All provisions in this Section shall not apply to an eligible person defined as eligible according to A.R.S. § 36-2901 (4)(d) through (4)(g), who is not required by statute or these rules to obtain health care services at a county-owned and operated facility, if the health care facility is awarded a contract as an AHCCCS provider. A person eligible according to A.R.S. § 36-2901 (4)(b) shall have freedom of choice in selecting membership with an AHCCCS contractor in all instances in which more than one choice of contractor is available. However, an eligible person shall become a member of a county program and receive services in a county facility, if a county is the only AHCCCS contractor for the eligible person in the service area.

~~C.~~ A contractor shall take affirmative action to ensure that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental disability, except where medically indicated.

R9-22-514. Equal Opportunity Repealed

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

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

R9-22-518. Information to Enrolled Members

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

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

~~C.~~ A contractor shall revise and distribute to members a service guide insert describing any change that the contractor proposes to make in services provided or service locations. The insert shall be distributed to all affected members or family units at least 14 days before a planned change. Notification shall be provided as soon as possible when unforeseen circumstances require an immediate change in services, sites or locations.

~~D.~~ A contractor shall submit informational and educational materials for approval by the Administration before distributing the materials to members and families.

R9-22-521. Program Compliance Audits

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

B. A review team may perform any or all of the following procedures:

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

subcontractors providing health care and other services to the health plan. The examination may include, but not be limited to: minutes of medical staff meetings, peer review and quality of care review records, duty rosters of medical personnel, appointment records, written procedures for the internal operation of the health plan, contracts and correspondence with members and with providers of health care services and other services to the plan, and additional documentation deemed necessary by the Administration to review the quality of medical care.

R9-22-522. Quality Management/Utilization Management (QM/UM) Requirements

- A. A contractor shall comply with Quality Management/Utilization Management (QM/UM) requirements specified in this Section and in contract. The contractor shall ensure compliance with QM/UM requirements that are accomplished through delegation or subcontract with another party.
- B. ~~A~~ In addition to any requirements specified in contract, a contractor shall:
1. Submit a written QM/UM plan that includes a description of the systems, methodologies, protocols, and procedures to be used in:
 - a. Monitoring and evaluating the types of services,
 - b. Identifying the numbers and costs of services provided,
 - c. Assessing and improving the quality and appropriateness of care and services,
 - d. Evaluating the outcome of care provided to members, and
 - e. Determining the steps and actions necessary to improve service delivery.
 2. Submit the QM/UM plan on an annual basis within timelines specified in contract. If the QM/UM plan is changed during the year, the contractor shall submit the revised plan before implementation;
 3. Receive approval from the Administration before implementing the initial QM/UM plan;
 4. Ensure that a QM/UM committee operates under the control of the contractor's medical director, and includes representation from medical and executive management personnel. The committee shall:
 - a. Oversee the development, revision and implementation of the QM/UM plan; and
 - b. Ensure and allocate qualified QM/UM personnel and sufficient resources to implement the contractor's QM/UM activities.
 5. Ensure that the QM/UM activities include at least:
 - a. Prior authorization for non-emergency or scheduled hospital admissions;
 - b. Concurrent review of inpatient hospitalization;
 - c. Retrospective review of hospital claims;
 - d. Program and provider audits designed to detect over or under utilization, service delivery effectiveness, and outcome;
 - e. Medical records audits;
 - f. Surveys to determine satisfaction of members;
 - g. Assessment of the adequacy and qualifications of the contractor's provider network;
 - h. Review and analysis of QM/UM data; and
 - i. Other activities necessary to improve the quality of care and the efficient, cost effective delivery and utilization of services.
- C. An eligible person's or member's primary care provider shall maintain medical records that:
1. Are detailed and comprehensive and identify:
 - a. All medically necessary services provided to the member by the contractor and the subcontractors, and
 - b. All emergency services provided by nonproviders for an eligible person or member.
 2. Conform to professional medical standards and practices for documentation of medical diagnostic and treatment data;
 3. Facilitate follow-up treatment; and
 4. Permit professional medical review and medical audit processes.
- D. A subcontractor or its designee shall forward medical records or copies of medical records of all members assigned to the subcontractor or for whom the subcontractor has provided services, within 30 days following termination of a contract between the subcontractor and the contractor.
- E. The Administration shall monitor contractors and their providers to ensure compliance with Administration QM/UM requirements and adherence to the contractor QM/UM plan.
1. A contractor and its providers shall cooperate with the Administration in the performance of its QM/UM monitoring activities; and
 2. A contractor and its providers shall develop and implement mechanisms for correcting deficiencies identified through the Administration's QM/UM monitoring.

R9-22-524. Continuity of Care Repealed

~~A contractor shall establish and maintain a system to ensure continuity of care which shall, at a minimum, include:~~

- ~~1. Referring members who need specialty health care services;~~
- ~~2. Monitoring members with chronic medical conditions;~~

3. Providing hospital discharge planning and coordination including post-discharge care; and
4. Monitoring operation of the system through professional review activities.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R05-178]

PREAMBLE

1. Sections Affected

R9-28-101
R9-28-105
R9-28-501
R9-28-502
R9-28-503
R9-28-504
R9-28-505
R9-28-507
R9-28-510
R9-28-511
R9-28-513
R9-28-514
R9-28-515

Rulemaking Action

Amend
Repeal
New Section
Amend
Repeal

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. §§ 36-2903 and 36-2903.01

Implementing statutes: A.R.S. §§ 36-2903, 36-2903.02, 36-2907, 36-2910, 36-2932, and 36-2938

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening: 11 A.A.R. 414, January 14, 2005

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

Name: Mariaelena Ugarte
Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4232
Fax: (602) 253-9115
E-mail: AHCCCSRules@ahcccs.state.az.us

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

The proposed rule has been written to comply with the regulatory requirement of updating and maintaining rules every five years, as required by the Governor's Regulatory Review Council. Various provisions were removed from rule because they were found to be only necessary in contract. In addition, the proposed rule was amended for clarity.

6. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on or 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:

No studies were required or reviewed.

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

Not applicable

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

AHCCCS anticipates no impact.

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

Name: Mariaelena Ugarte
Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4232
Fax: (602) 256-6756
E-mail: AHCCCSRules@ahcccs.state.az.us

Proposed rule language will be available on the AHCCCS web site www.ahcccs.state.az.us the week of May 9, 2005. Please send written comments to the address in this item by 5:00 p.m., June 29, 2005. E-mail comments will be accepted.

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

Date: June 29, 2005
Time: 2:00 p.m.
Location: AHCCCS
701 E. Jefferson
Phoenix, AZ 85034
Gold Room
Nature: Public Hearing

Date: June 29, 2005
Time: 2:00 p.m.
Location: ALTCS: Arizona Long-term Care System
110 S. Church, Suite 1360
Tucson, AZ 85701
Nature: Public Hearing

Date: June 29, 2005
Time: 2:00 p.m.
Location: ALTCS: Arizona Long-term Care System
3480 E. Route 66
Flagstaff, AZ 86004
Nature: Public Hearing

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

None

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

R9-28-503(A) – 42 CFR 442, as of October 1, 2004
R9-28-503(B) – 42 CFR 483, as of October 1, 2004
R9-28-505 – 42 CFR 482, as of October 1, 2004
R9-28-505 – 42 CFR 456(C), as of October 1, 2004
R9-28-511 – 42 CFR 456, as of October 1, 2004

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

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

ARTICLE 1. DEFINITIONS

Section

R9-28-101. General Definitions

R9-28-105. ~~Program Contractor and Provider Standards Related Definitions~~ Repealed

ARTICLE 5. PROGRAM CONTRACTOR AND PROVIDER STANDARDS

Section

R9-28-501. ~~Reserved Program Contractor and Provider Standards Related Definitions~~

R9-28-502. Long-term Care Provider Requirements

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

R9-28-504. Standards of Participation, Licensure, and Certification for HCBS Providers

R9-28-505. Standards, Licensure, and Certification for Providers of Hospital and Medical Services

R9-28-506. Reserved

R9-28-507. Program Contractor General Requirements

R9-28-509. Reserved

R9-28-510. Case Management

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

R9-28-513. Program Compliance Audits

R9-28-514. Release of Safeguarded Information by the Administration and Contractors

R9-28-515. ~~Discrimination prohibition and equal opportunity~~ Repealed

ARTICLE 1. DEFINITIONS

R9-28-101. General Definitions

A. Location of definitions. Definitions applicable to Chapter 28 are found in the following:

Definition	Section or Citation
"Administration"	A.R.S. § 36-2931
"ADHS"	R9-22-112
"Aggregate"	R9-22-107
"AHCCCS"	R9-22-101
"AHCCCS Registered Provider"	R9-22-101
"Algorithm"	R9-28-104
"ALTCS"	R9-28-101
"ALTCS acute care services"	R9-28-104
"Alternative HCBS setting"	R9-28-101
"Ambulance"	R9-22-102
"Applicant"	R9-22-101
"Bed hold"	R9-28-102
"Behavior intervention"	R9-28-102
"Behavior management services"	R9-20-101
"Behavioral health evaluation"	R9-22-112
"Behavioral health medical practitioner"	R9-22-112
"Behavioral health professional"	R9-20-101
"Behavioral health service"	R9-20-101
"Behavioral health technician"	R9-20-101
"Billed charges"	R9-22-107
"Board-eligible for psychiatry"	R9-22-112
"Capped fee-for-service"	R9-22-101
"Case management plan"	R9-28-101
"Case manager"	R9-28-101
"Case record"	R9-22-101

Notices of Proposed Rulemaking

“Categorically-eligible”	R9-22-101
“Certification”	R9-28-105 R9-28-501
“Certified psychiatric nurse practitioner”	R9-22-112
“CFR”	R9-28-101
“Clean claim”	A.R.S. § 36-2904
“Clinical supervision”	R9-22-112
“CMS”	R9-22-101
“Community Spouse”	R9-28-104
“Contract”	R9-22-101
“Contract year”	R9-28-101
“Contractor”	A.R.S. § 36-2901
“County of fiscal responsibility”	R9-28-107
“Covered services”	R9-28-101
“CPT”	R9-22-107
“CSR D”	R9-28-104
“Day”	R9-22-101
“Department”	A.R.S. § 36-2901
“De novo hearing”	42 CFR 431.201
“Developmental disability”	A.R.S. § 36-551
“Diagnostic services”	R9-22-102
“Director”	R9-22-101
“Disenrollment”	R9-22-117
“DME”	R9-22-102
“EPD”	R9-28-301
“Eligible person”	A.R.S. § 36-2931
“Emergency medical services”	R9-22-102
“Encounter”	R9-22-107
“Enrollment”	R9-22-117
“Estate”	A.R.S. § 14-1201
“Facility”	R9-22-101
“Factor”	R9-22-101
“Fair consideration”	R9-28-104
“FBR”	R9-22-101
“Grievance”	R9-22-108
“GSA”	R9-22-101
“Guardian”	A.R.S. § 14-5311
“HCBS” or “Home and community based services”	A.R.S. §§ 36-2931 and 36-2939
“Health care practitioner”	R9-22-112
“Hearing”	R9-22-108
“Home”	R9-28-101
“Home health services”	R9-22-102
“Hospital”	R9-22-101
“ICF-MR” or “Intermediate care facility for the mentally retarded”	42 CFR 483 Subpart I
“IHS”	R9-28-101
“IMD”	42 CFR 435.1009 and R9-28-111
“Indian”	42 CFR 36.1
“Institutionalized”	R9-28-104
“Interested Party”	R9-28-106
“JCAHO”	R9-28-101
“License” or “licensure”	R9-22-101
“Medical record”	R9-22-101
“Medical services”	R9-22-101
“Medical supplies”	R9-22-102
“Medically eligible”	R9-28-104
“Medically necessary”	R9-22-101
“Member”	A.R.S. § 36-2931
“Mental disorder”	A.R.S. § 36-501
“MMMNA”	R9-28-104
“Nursing facility” or “NF”	42 U.S.C. 1396r(a)
“Noncontracting provider”	A.R.S. § 36-2931
“Occupational therapy”	R9-22-102
“Partial care”	R9-22-112
“PAS”	R9-28-103

Notices of Proposed Rulemaking

“Pharmaceutical service”	R9-22-102
“Physical therapy”	R9-22-102
“Physician”	R9-22-102
“Post-stabilization services”	42 CFR 438.114
“Practitioner”	R9-22-102
“Primary care provider (PCP)”	R9-22-102
“Primary care provider services”	R9-22-102
“Prior authorization”	R9-22-102
“Prior period coverage” or “PPC”	R9-22-107
“Private duty nursing services”	R9-22-102
“Program contractor”	A.R.S. § 36-2931
“Provider”	A.R.S. § 36-2931
“Psychiatrist”	R9-22-112
“Psychologist”	R9-22-112
“Psychosocial rehabilitation”	R9-20-101
“Quality management”	R9-22-105 R9-22-501
“Regional behavioral health authority” or “RBHA”	A.R.S. § 36-3401
“Radiology”	R9-22-102
“Reassessment”	R9-28-103
“Redetermination”	R9-28-104
“Referral”	R9-22-101
“Reinsurance”	R9-22-107
“Representative”	R9-28-104
“Respiratory therapy”	R9-22-102
“Respite care”	R9-28-102
“RFP”	R9-22-106
“Room and board”	R9-28-102
“Scope of services”	R9-28-102
“Section 1115 Waiver”	A.R.S. § 36-2901
“Speech therapy”	R9-22-102
“Spouse”	R9-28-104
“SSA”	42 CFR 1000.10
“SSI”	R9-22-101
“Subcontract”	R9-22-101
“Utilization management”	R9-22-105 R9-22-501
“Ventilator dependent”	R9-28-102

B. General definitions. In addition to definitions contained in A.R.S. §§ 36-551, 36-2901, 36-2931, and 9 A.A.C. 22, Article 1, the following words and phrases have the following meanings unless the context of the Chapter explicitly requires another meaning:

“ALTCS” means the Arizona Long-term Care System as authorized by A.R.S. § 36-2932.

“Alternative HCBS setting” means a living arrangement approved by the Director and licensed or certified by a regulatory agency of the state, where a member may reside and receive HCBS including:

For a person with a developmental disability specified in A.R.S. § 36-551:

- Community residential setting defined in A.R.S. § 36-551;
- Group home defined in A.R.S. § 36-551;
- State-operated group home under A.R.S. § 36-591;
- Group foster home under R6-5-5903;
- Licensed residential facility for a person with traumatic brain injury under A.R.S. § 36-2939;
- Adult therapeutic foster home under 9 A.A.C 20, Articles 1 and 15;
- Level 2 and Level 3 behavioral health agencies under 9 A.A.C. 20, Articles 1, 4, 5, and 6; and
- Rural substance abuse transitional agencies under 9 A.A.C. 20, Articles 1 and 14; and

For a person who is elderly or physically disabled under R9-28-301, and the facility, setting, or institution is registered with AHCCCS:

- Adult foster care homes defined in A.R.S. § 36-401 and as authorized in A.R.S. § 36-2939;
- Assisted living home or assisted living center, units only, under A.R.S. § 36-401, and as authorized in A.R.S. § 36-2939;
- Licensed residential facility for a person with a traumatic brain injury specified in A.R.S. § 36-2939;
- Adult therapeutic foster home under 9 A.A.C. 20, Articles 1 and 15;
- Level II and Level III behavioral health agencies under 9 A.A.C. 20, Articles 1, 4, 5, and 6;
- Rural Substance Abuse Transitional Agencies under 9 A.A.C. 20, Articles 1 and 14; and
- Alzheimer’s treatment assistive living facility demonstration pilot project as specified in Laws 1999, Ch. 313,

Notices of Proposed Rulemaking

§ 35 as amended by Laws 2001, Ch. 140, § 1 and Laws 2003, Ch. 76, § 1.

“Case management plan” means a service plan developed by a case manager that involves the overall management of a member’s care, and the continued monitoring and reassessment of the member’s need for services.

“Case manager” means a person who is either a degreed social worker, a licensed registered nurse, or a person with a minimum of two years of experience in providing case management services to a person who is elderly and physically disabled or has developmental disabilities.

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

“CFR” means Code of Federal Regulations, unless otherwise specified in this Chapter.

“Covered Services” means the health and medical services described in Articles 2 and 11 of this Chapter as being eligible for reimbursement by AHCCCS.

“Fee-For-Service” or “FFS” means a method of payment to registered providers on an amount per service basis.

“Home” means a residential dwelling that is owned, rented, leased, or occupied by a member, at no cost to the member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a:

- Health care institution under A.R.S. § 36-401;
- Residential care institution under A.R.S. § 36-401;
- Community residential setting under A.R.S. § 36-551; or
- Behavioral health service under 9 A.A.C. 20, Articles 1, 4, 5, and 6.

“IHS” means the Indian Health Service.

“JCAHO” means the Joint Commission on Accreditation of Healthcare Organizations.

R9-28-105. ~~Program Contractor and Provider Standards Related Definitions Repealed~~

~~Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:~~

- ~~1. “Certification” means a voluntary process by which a federal or state regulatory entity grants recognition to an individual, facility, or organization which has met certain prerequisite qualifications specified by the regulatory entity and which may assume or use the word “certified” in his, her, or its title or designation to perform prescribed health professional tasks.~~
- ~~2. “Quality management” is defined in 9 A.A.C. 22, Article 1.~~
- ~~3. “Utilization management” is defined in 9 A.A.C. 22, Article 1.~~

ARTICLE 5. PROGRAM CONTRACTOR AND PROVIDER STANDARDS

R9-28-501. Reserved Program Contractor and Provider Standards Related Definitions

Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

1. “Certification” means a voluntary process by which a federal or state regulatory entity grants recognition to a person, facility, or organization which has met certain prerequisite qualifications specified by the regulatory entity and which may assume or use the word “certified” in his, her, or its title or designation to perform prescribed health professional tasks.
2. “Quality management” is defined in 9 A.A.C. 22, Article 1.
3. “Utilization management” is defined in 9 A.A.C. 22, Article 1.

R9-28-502. Long-term Care Provider Requirements

- A.** A provider shall obtain any necessary authorization from the program contractor or the Administration for services provided to an ALTCS-eligible person or member.
- B.** A provider shall maintain and make available to a program contractor and to the Administration, financial, and medical records for not less than five years from the date of final payment, or for records relating to costs and expenses to which the Administration has taken exception, five years after the date of final disposition or resolution of the exception. The records shall meet the uniform accounting standards as specified by the Administration, and accepted practices for maintenance of medical records, including detailed specification of all patient services delivered, the rationale for delivery, and the service date.
- ~~**C.** A provider shall not submit a claim, demand, or otherwise collect payment from an eligible person or member for ALTCS covered services paid to the provider by the Administration or program contractor. A provider shall not bill or attempt to collect payment, directly or through a collection agency, from a person claiming to be ALTCS eligible without first receiving verification from the Administration that the person was ineligible for ALTCS on the date of service, or that services provided were not ALTCS covered services.~~

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

- A.** Nursing facilities that provide services to an eligible person or member shall be Medicare and Medicaid certified and meet

the requirements in 42 CFR 442, ~~September 28, 1995~~ as of October 1, 2004, and 42 CFR 483, ~~September 29, 1995~~ as of October 1, 2004, incorporated by reference and on file with the Administration and the Office of the Secretary of State, and meet the Arizona Department of Health Services' rules for licensure. This incorporation by reference contains no future editions or amendments.

- B. An ICF-MR shall be Medicaid certified and meet the requirements in A.R.S. § 36-2939(B)(1) and 42 CFR 442, Subpart C, ~~November 20, 1992~~ as of October 1, 2004, and 42 CFR 483, ~~September 29, 1995~~ as of October 1, 2004, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
- C. All nursing facilities and ICF-MRs that provide services to an eligible person or member shall be registered as providers with the Administration. To be registered, a provider shall meet the licensure and certification requirements of subsections (A) or (B) and have a current provider agreement with a program contractor.

R9-28-504. Standards of Participation, Licensure, and Certification for HCBS Providers

- A. All noninstitutional long-term care providers shall be registered with the Administration and meet the requirements of the Arizona Department of Health Services' rules for licensure, if applicable.
- B. Additional qualifications:
 - 1. A community residential setting and a group home for ~~an individual~~ a person with developmental disabilities shall be licensed by the appropriate regulatory agency of the state ~~according to under~~ 6 A.A.C. 6;
 - 2. An adult foster care home shall be certified or licensed ~~according to under~~ 9 A.A.C. 10;
 - 3. A home health service agency shall be Medicare-certified and licensed ~~according to under~~ 9 A.A.C. 10;
 - 4. ~~An individual~~ A person providing a homemaker service shall meet the requirements specified in contract;
 - 5. ~~An individual~~ A person providing a personal care service shall meet the requirements specified in contract;
 - 6. An adult day health provider shall be licensed ~~according to under~~ 9 A.A.C. 10;
 - 7. A therapy provider shall meet the following requirements:
 - a. A physical therapy provider shall meet the requirements in 4 A.A.C. 24;
 - b. ~~A speech therapy provider shall be certified by the American Speech, Language, and Hearing Association;~~
 - b. A speech therapist provider shall meet the requirements of all applicable state licenses as described by 9 A.A.C. 16, Article 2.
 - c. An occupational therapy provider shall meet the requirements in 4 A.A.C. 43; and
 - d. A respiratory therapy provider shall meet the requirements in 4 A.A.C. 45;
 - 8. A respite provider shall meet the requirements specified in contract;
 - 9. A hospice provider shall be Medicare-certified and licensed ~~according to under~~ 9 A.A.C. 10;
 - 10. A provider of home delivered meal service shall comply with hygiene requirements in 9 A.A.C. 8;
 - 11. A provider of non-emergency transportation shall be licensed by the Arizona Department of Transportation, Motor Vehicle Division;
 - 12. A provider of emergency transportation shall meet the licensure requirements in 9 A.A.C. 13;
 - 13. A day care provider for the developmentally disabled shall meet the licensure requirements in 6 A.A.C. 6;
 - 14. A habilitation provider shall meet the requirements in A.A.C. R6-6-1523 or the therapy requirements in this Section;
 - 15. Another service provider approved by the director shall meet the requirements specified in a program contractor's contract with the Administration;
 - 16. A behavioral health provider shall have all applicable state licenses or certifications, and meet the service specifications in A.A.C. R9-22-1205;
 - 17. An assisted living home or a residential unit as defined in A.R.S. § 36-401 and as authorized in A.R.S. § 36-2939.

R9-28-505. Standards, Licensure, and Certification for Providers of Hospital and Medical Services

- A. A provider of hospital and medical care services shall be registered with the Administration.
- B. With the exception of an Indian Health Service (IHS) hospital and a Veterans Administration hospital, which must be Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited, a provider of hospital services shall be licensed by the Arizona Department of Health Services, ~~be JCAHO accredited,~~ and meet the requirements in 42 CFR 482, ~~September 9, 1996~~ as of October 1, 2004, and 42 CFR 456(C), ~~September 29, 1978~~ as of October 1, 2004, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation contains no future editions or amendments.

R9-28-506. Reserved

R9-28-507. Program Contractor General Requirements

- A. To participate in the ALTCS program, through a program contractor or directly through the Administration, a provider of ALTCS-covered services shall be registered with the Administration.
- B. ALTCS program contractors shall ensure that providers of service meet the requirements of this Article.
- C. Each ALTCS program contractor shall maintain member service records. These shall include, at a minimum, a case man-

Notices of Proposed Rulemaking

agement plan, medical records, encounter data, grievances, complaints, and service information for each ALTCS member. A program contractor shall ensure that all member service records are retained for five years from the date of final payment. For records relating to costs and expenses to which the Administration has taken exception, member service records are retained for five years after the date of final disposition or resolution of the exception. A program contractor shall provide ALTCS member service records or copies of member service records to the Administration upon request.

- D. An ALTCS program contractor shall produce and distribute information materials to each enrolled ALTCS member or designated representative within 12 business days after receipt of notification of enrollment from the Administration. The information, which shall be approved by the Administration before distribution, shall include:
 - 1. A description of all covered services as specified in contract;
 - 2. An explanation of service limitations and exclusions;
 - 3. An explanation of the procedure for obtaining services, including a notice stating that the program contractor is liable only for those services authorized by an ALTCS member's case manager;
 - 4. An explanation of the procedure for obtaining emergency services;
 - 5. An explanation of the procedure for filing a grievance and appeal; and
 - 6. An explanation of when plan changes may occur as specified in contract.
- ~~E.~~ An ALTCS program contractor shall submit encounter reports on services rendered to each member within 120 days after the month of service, except for services with Medicare coverage, which shall be submitted within 180 days after the month of service.
- F. An ALTCS program contractor or subcontractor shall collect the member's share of cost and report the amount collected as specified in their contract to the program contractor or Administration, if necessary.
- E. A subcontractor shall collect the member's share of cost and report the amount collected as specified in their contract to the program contractor. The program contractor shall report the share of cost collected to the Administration.
- ~~G.~~F. An ALTCS program contractor shall monitor a trust fund account for an institutionalized ALTCS member to verify that expenditures from the member's trust fund account are in compliance with federal regulations.
- ~~H.~~G. A program contractor shall ensure that an institutionalized ALTCS member transferred to an acute facility for services is, whenever possible, returned to the original institution upon completion of acute care.
- ~~I.~~H. A program contractor shall ensure that an institutionalized ALTCS member granted therapeutic leave is returned to the same bed in the original institution upon completion of the therapeutic leave.
- ~~J.~~I. A program contractor shall ensure that services are paid under A.A.C. R9-22-705.
- ~~K.~~J. An EPD A program contractor shall meet the marketing provisions in A.A.C. ~~R9-22-505~~ R9-22-504.

R9-28-509. Reserved

R9-28-510. Case Management

- ~~A.~~ Each eligible person and member shall be assigned a case manager to:
 - 1. Identify,
 - 2. Plan,
 - 3. Coordinate,
 - 4. Monitor, and
 - 5. Reassess the need for and provision of long-term care services.
- A. Each eligible person and member shall be assigned a case manager to identify, plan, coordinate, monitor, and reassess the need for and provision of long-term care services.
- ~~B.~~ The case manager shall:
 - 1. Ensure that appropriate ALTCS placement and services are provided for an eligible person or member within 30 days of notification of enrollment;
 - 2. Complete a case management plan when an eligible person or member is enrolled in ALTCS. The case manager shall re-evaluate and revise the plan when the eligible person or member:
 - a. Transfers to another facility;
 - b. Transfers to a hospital;
 - e. Has a change in the in-home service package, or
 - d. Has a change in the level of care.
 - 3. Specify the services to be received by an eligible person or member, including the:
 - a. Duration;
 - b. Scope of services;
 - e. Units of service;
 - d. Frequency of service delivery;
 - e. Provider of services; and
 - f. Effective time period.
 - 4. Authorize services for an eligible person or member who continues to be financially and medically eligible for ser-

viées;

5. Coordinate with a primary care provider in determining the necessary services for an eligible person or member, including hospital and medical services;
6. Ensure that an eligible person or member participates in the preparation of the eligible person's or member's case management plan;
7. Assist an eligible person or member to maintain or progress toward the highest level of functioning;
8. Monitor receipt of services by an eligible person or member;
9. Initiate a transfer to AHCCCS or other programs, where appropriate, when ALTCS HCBS services are no longer necessary;
10. Submit written justification to the case manager's supervisor to include HCBS in the case management plan, if the services exceed 80% of the institutional cost;
11. Ensure that records are transferred when an eligible person or member is transferred from a facility or provider to a new facility or provider;
12. Perform additional monitoring of an eligible person or member with rehabilitation potential, whose condition is fragile or unstable, whose case management plan is marginally cost effective, or whose use of medical and hospital services is unusual;
13. Revise a case management plan for an eligible person or member according to the terms of the contract; and
14. Arrange behavioral health services if necessary and, if the case manager does not meet the definition of a behavioral health professional according to A.A.C. R9-22-1201, have initial and quarterly consultation and collaboration with a behavioral health professional to review the treatment plan.

B. The case manager shall:

1. Ensure that appropriate ALTCS placement and services are provided for an eligible person or member within 30 days of enrollment;
2. Develop a service plan by:
 - a. Completing a case management plan when an eligible person or member is enrolled in ALTCS and authorize services for an eligible person or member who continues to be financially and medically eligible for services;
 - b. Ensuring that an eligible person or member participates in the preparation of the eligible person or member's case management plan;
 - c. Specifying the services to be received by an eligible person or member, including the duration, scope of services, units of service, frequency of service delivery, provider of services, and effective time period.
 - d. Coordinating with a primary care provider in determining the necessary services for an eligible person or member, including hospital and medical services;
3. Submit a written justification to the case manager's supervisor to include HCBS in the case management plan, if the services exceed 80 percent of the institutional cost;
4. Manage a case management plan by:
 - a. Re-evaluating and revising the case management plan when the eligible person or member transfers to another facility, transfers to a hospital, has a change in the in-home service package, or has a change in the level of care under the terms of the contract,
 - b. Monitoring receipt of services by an eligible person or member;
5. Assist an eligible person or member to maintain or progress toward the highest level of functioning;
6. Ensure that records are transferred when an eligible person or member is transferred from a facility or provider to a new facility or provider;
7. Perform additional monitoring of an eligible person or member with rehabilitation potential, whose condition is fragile or unstable, whose case management plan is marginally cost effective, or whose use of medical and hospital services is unusual;
8. Arrange behavioral health services if necessary. The case manager shall have initial and quarterly consultation and collaboration with a behavioral health professional to review the treatment plan, unless the case manager meets the definition of a behavioral health professional under A.A.C. R9-20-101.

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

C. A program contractor shall submit a service plan and other information upon request to the Administration.

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

A program contractor shall:

1. Comply with all requirements specified in A.A.C. R9-22-522; and
2. Submit a quarterly utilization control report within time lines specified in contract and specified in 42 CFR 456 Subparts C, D, and F, December 1, 1986, October 1, 2004, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

Notices of Proposed Rulemaking

R9-28-513. Program Compliance Audits

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

R9-28-514. Release of Safeguarded Information by the Administration and Contractors

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

R9-28-515. ~~Discrimination prohibition and equal opportunity~~ Repealed

~~The program contractor and provider shall comply with discrimination prohibitions and equal opportunity requirements as set forth in A.A.C. R9-22-513 and R9-22-514.~~

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R05-180]

PREAMBLE

1. Sections Affected

Rulemaking Action

R9-31-101	Amend
R9-31-105	Repeal
R9-31-501	Amend
R9-31-502	Amend
R9-31-504	Amend
R9-31-505	Repeal
R9-31-507	Repeal
R9-31-508	Amend
R9-31-509	Amend
R9-31-510	Repeal
R9-31-511	Repeal
R9-31-512	Amend
R9-31-513	Repeal
R9-31-514	Repeal
R9-31-518	Amend
R9-31-520	Repeal
R9-31-521	Repeal
R9-31-522	Amend
R9-31-523	Repeal
R9-31-524	Repeal
R9-31-1601	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. §§ 36-2903 and 36-2903.01

Implementing statutes: A.R.S. §§ 36-2903, 36-2903.02, 36-2907, 36-2910, 36-2932, and 36-2938

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening: 11 A.A.R. 415, January 14, 2005

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

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4232

Fax: (602) 253-9115
E-mail: AHCCCSRules@ahcccs.state.az.us

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

The proposed rule has been written to comply with the regulatory requirement of updating and maintaining rules every five years, as required by the Governor's Regulatory Review Council. Various provisions were removed from rule because they were found to be only necessary in contract. In addition, the proposed rule was amended for clarity.

6. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on or 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:

No studies were required or reviewed.

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

Not applicable

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

AHCCCS anticipates no impact.

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

Name: Mariaelena Ugarte
Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4232
Fax: (602) 256-6756
E-mail: AHCCCSRules@ahcccs.state.az.us

Proposed rule language will be available on the AHCCCS web site www.ahcccs.state.az.us the week of May 9, 2005. Please send written comments to the address in this item by 5:00 p.m., June 29, 2005. E-mail comments will be accepted.

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

Date: June 29, 2005
Time: 2:00 p.m.
Location: AHCCCS
701 E. Jefferson
Phoenix, AZ 85034
Gold Room
Nature: Public Hearing

Date: June 29, 2005
Time: 2:00 p.m.
Location: ALTCS: Arizona Long-term Care System
110 S. Church, Suite 1360
Tucson, AZ 85701
Nature: Public Hearing

Date: June 29, 2005
Time: 2:00 p.m.

Notices of Proposed Rulemaking

Location: ALTCS: Arizona Long-term Care System
3480 E. Route 66
Flagstaff, AZ 86004

Nature: Public Hearing

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

None

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

R9-31-502 - 42 U.S.C. 1397, August 5, 1997

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

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

ARTICLE 1. DEFINITIONS

Section

R9-31-101. Location of Definitions
R9-31-105. ~~General Provisions and Standards~~ Repealed

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Section

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

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

R9-31-1601. General Requirements

ARTICLE 1. DEFINITIONS

R9-31-101. Location of Definitions

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

Definition	Section or Citation
"ADHS"	R9-31-112
"Administration"	A.R.S. § 36-2901

Notices of Proposed Rulemaking

“Adverse action”	R9-31-108
“Aggregate”	R9-22-107
“AHCCCS”	R9-31-101
“AHCCCS registered provider”	R9-22-101
“Ambulance”	R9-22-102
“Ancillary department”	R9-22-107
“Applicant”	R9-31-101
“Application”	R9-31-101
“Behavior management service”	R9-31-112
“Behavioral health professional”	R9-31-112
“Behavioral health evaluation”	R9-31-112
“Behavioral health medical practitioner”	R9-31-112
“Behavioral health service”	R9-31-112
“Behavioral health technician”	R9-20-101
“Billed charges”	R9-22-107
“Board-eligible for psychiatry”	R9-31-112
“Capital costs”	R9-22-107
“Certified nurse practitioner”	R9-31-102
“Certified psychiatric nurse practitioner”	R9-31-112
“Child”	42 U.S.C. 1397jj
“Chronically ill”	A.R.S. § 36-2983
“Clean claim”	A.R.S. § 36-2904
“Clinical supervision”	R9-31-112
“CMDP”	R9-31-103
“Continuous stay”	R9-22-101
“Contract”	R9-22-101
“Contractor”	A.R.S. § 36-2901
“Contract year”	R9-31-101
“Copayment”	R9-22-107
“Cost avoidance”	R9-31-110
“Cost-to-charge ratio”	R9-22-107
“Covered charges”	R9-31-107
“Covered services”	R9-22-102
“CPT”	R9-22-107
“CRS”	R9-31-103
“Date of eligibility posting”	R9-22-107
“Day”	R9-22-101
“De novo hearing”	42 CFR 431.201
“Dentures”	R9-22-102
“DES”	R9-31-103
“Determination”	R9-31-103
“Diagnostic services”	R9-22-102
“Director”	A.R.S. § 36-2981
“DME”	R9-22-102
“DRI inflation factor”	R9-22-107
“Emergency medical condition”	42 U.S.C. 1396b(v)
“Emergency medical services”	R9-22-102
“Encounter”	R9-22-107
“Enrollment”	R9-31-103
“Experimental services”	R9-22-101
“Facility”	R9-22-101
“Factor”	R9-22-101
“First-party liability”	R9-22-110
“FPL”	A.R.S. § 36-2981
“Grievance”	R9-22-108
“Group Health Plan”	42 U.S.C. 1397jj
“GSA”	R9-22-101
“Head of Household”	R9-31-103
“Health care practitioner”	R9-31-112
“Hearing”	R9-22-108
“Hearing aid”	R9-22-102
“Home health services”	R9-22-102
“Hospital”	R9-22-101
“Household income”	R9-31-103
“ICU”	R9-22-107

Notices of Proposed Rulemaking

“IGA”	R9-31-116
“IHS”	R9-31-116
“IHS” or “Tribal Facility Provider”	R9-31-116
“Information”	R9-31-103
“IMD”	42 CFR 435.1009 and R9-22-112
“Inmate of a public institution”	42 CFR 435.1009
“Inpatient hospital services”	R9-31-101
“License” or “licensure”	R9-22-101
“Medical record”	R9-22-101
“Medical review”	R9-31-107
“Medical services”	R9-22-101
“Medical supplies”	R9-22-101
“Member”	A.R.S. § 36-2981
“Mental disorder”	A.R.S. § 36-501
“Native American”	R9-31-101
“New hospital”	R9-22-107
“NF” or “nursing facility”	42 U.S.C. 1396r(a)
“NICU”	R9-22-107
“Noncontracting provider”	A.R.S. § 36-2981
“Occupational therapy”	R9-22-102
“Offeror”	R9-31-106
“Operating costs”	R9-22-107
“Outlier”	R9-31-107
“Outpatient hospital service”	R9-22-107
“Ownership change”	R9-22-107
“Partial care”	R9-31-112
“Peer group”	R9-22-107
“Pharmaceutical service”	R9-22-102
“Physical therapy”	R9-22-102
“Physician”	A.R.S. § 36-2981
“Post stabilization care services”	42 CFR 438.113
“Practitioner”	R9-22-102
“Pre-existing condition”	R9-31-105
“Prepaid capitated”	A.R.S. § 36-2981
“Prescription”	R9-22-102
“Primary care physician”	A.R.S. § 36-2981
“Primary care practitioner”	A.R.S. § 36-2981
“Primary care provider (PCP)”	R9-22-102
“Primary care provider services”	R9-22-102
“Prior authorization”	R9-22-102
“Private duty nursing services”	R9-22-102
“Program”	A.R.S. § 36-2981
“Proposal”	R9-31-106
“Prospective rates”	R9-22-107
“Provider”	A.R.S. § 36-2931
“PSP” or “Premium Sharing Program”	R9-31-103
“Psychiatrist”	R9-31-112
“Psychologist”	R9-31-112
“Psychosocial rehabilitation”	R9-31-112
“Qualified alien”	A.R.S. § 36-2903.03
“Qualifying plan”	A.R.S. § 36-2981
“Quality management”	R9-22-105
“Radiology services”	R9-22-102
“RBHA”	R9-31-112
“Rebasing”	R9-22-107
“Redetermination”	R9-31-103
“Referral”	R9-22-101
“Rehabilitation services”	R9-22-102
“Reinsurance”	R9-22-107
“Remittance advice”	R9-22-107
“RFP”	R9-31-106
“Respiratory therapy”	R9-22-102
“Respondent”	R9-22-108
“Scope of services”	R9-22-102

Notices of Proposed Rulemaking

“SDAD”	R9-22-107
“Seriously ill”	R9-31-101
“Service location”	R9-22-101
“Service site”	R9-22-101
“SMI” or “Seriously mentally ill”	A.R.S. § 36-550
“Specialist”	R9-22-102
“Speech therapy”	R9-22-102
“Spouse”	R9-31-103
“SSI-MAO”	R9-31-103
“Stabilize”	42 U.S.C. 1395dd
“Standard of care”	R9-22-101
“Sterilization”	R9-22-102
“Subcontract”	R9-22-101
“Subcontractor”	R9-31-101
“Third-party”	R9-22-110
“Third-party liability”	R9-22-110
“Tier”	R9-22-107
“Tiered per diem”	R9-31-107
“TRBHA”	R9-31-116
“Tribal facility”	A.R.S. § 36-2981
“Utilization management”	R9-22-105

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

“AHCCCS” means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

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

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

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

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

“Native American” means Indian as specified in 42 CFR 36.1.

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

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

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

R9-31-105. General Provisions and Standards Repealed

~~Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning: “Pre-existing condition” means an illness or injury that is diagnosed or treated within a six-month period preceding the effective date of coverage.~~

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-31-501. General Provisions and Standards Related Definitions

~~**A.** As specified in A.R.S. § 36-2986, the Director has full operational authority to adopt rules or to use the appropriate rules adopted for this Article.~~

~~**B.** Pre-existing Conditions. Eligibility for the program may not be denied based on a child having a pre-existing medical condition as specified in 42 U.S.C. 1397, August 5, 1997, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.~~

~~1. Except as otherwise provided in Article 3 of this Chapter, a contractor shall be responsible for providing the full scope of covered services to each member from the effective date of eligibility until the time of notification of termination, suspension, or transfer of the member’s enrollment. This responsibility includes providing treatment for all of a member’s pre-existing conditions.~~

~~2. A contractor or subcontractor shall not adopt or use any procedure to identify individuals who have an existing or anticipated medical or psychiatric condition in order to discourage or exclude the individuals from enrolling in the contractor’s health plan or encourage the individuals to enroll in another health plan.~~

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning: "Pre-existing condition" means an illness or injury that is diagnosed or treated within a six-month period preceding the effective date of coverage.

R9-31-502. Availability and Accessibility of Service Pre-existing Conditions

- A.** A contractor shall provide adequate numbers of available and accessible:
1. Institutional facilities;
 2. Service locations;
 3. Service sites; and
 4. Professional, allied, and paramedical personnel for the provision of covered services, including all emergency medical services for 24 hours a day, seven days a week.
- B.** A contractor shall minimally provide the following:
1. A ratio of primary care providers to members, as specified in contract.
 2. A designated emergency services facility, providing care 24 hours a day, seven days a week, accessible to members in each contracted service area. One or more physicians and one or more nurses shall be on call or on duty at the facility at all times.
 3. An emergency services system employing at least one physician, registered nurse, physician's assistant, or nurse practitioner, accessible by telephone 24 hours a day, seven days a week, to members who need information in an emergency, and to providers who need verification of patient membership and treatment authorization.
 4. An emergency services call log or database to track the following information:
 - a. Member's name;
 - b. Address and telephone number;
 - c. Date and time of call;
 - d. Nature of complaint or problem; and
 - e. Instructions given to member.
 5. A written procedure for communicating emergency services information to a member's primary care provider, and other appropriate organizational units.
 6. An appointment standard as specified in contract for the following:
 - a. Emergency appointments;
 - b. Urgent care appointments; and
 - c. Routine care appointments.
 7. Waiting times for members with appointments that do not exceed 45 minutes, except when the provider is unavailable due to an emergency.
- C.** A contractor shall have an affiliation with or subcontract with an organization or individual to provide primary care services. The contractor shall agree to provide services under the primary care provider's guidance and direction:
1. A primary care provider selected by or to whom an enrolled member is assigned shall be responsible for:
 - a. Supervising, coordinating, and providing initial and primary care to the member;
 - b. Initiating referrals for specialty care;
 - c. Maintaining continuity of member care; and
 - d. Maintaining an individual medical record for each assigned member.
 2. A primary care provider or specialist providing inpatient services to a member shall have staff privileges in a minimum of one general acute care hospital under subcontract with the contractor, within the service area of the contractor.
- A.** Pre-existing Conditions. Eligibility for the program may not be denied based on a child having a pre-existing medical condition as specified in 42 U.S.C. 1397, August 5, 1997, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
- B.** A contractor or subcontractor shall not adopt or use any procedure to identify individuals who have an existing or anticipated medical or psychiatric condition in order to discourage or exclude the individuals from enrolling in the contractor's health plan or encourage the individuals to enroll in another health plan.

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

- A.** A contractor or the any person or entity acting as the contractor's marketing agent shall not offer or give any form of compensation or reward, or engage in any behavior or activity that may be reasonably construed as coercive, to induce or procure Title XXI enrollment. A contractor may make program applications available, but shall not assist with the completion of an application or suggest that an applicant enroll with particular contractor. Any marketing solicitation offering a benefit, good, or service, in excess of the covered services in 9 A.A.C. 31, Article 2 shall be deemed an inducement.
- B.** Any person or entity acting as the contractor's marketing agent shall not misrepresent itself, the contractor represented, or the program, through false advertising, false statements, or in any other manner to induce a member of a current contractor to enroll with the prospective contractor. The Administration shall deem violations of this subsection to include, false or

misleading claims, inferences, or representations that:

1. A member will lose benefits under the program or any other health or welfare benefits to which the member is legally entitled, if the member does not enroll with the prospective contractor;
2. Marketing representatives are employees of the state or representatives of the Administration, a county, or any contractor other than the contractor with whom they are employed, or by whom they are reimbursed; and
3. The represented contractor is recommended or endorsed as superior to its competition by any state or county agency, or any organization, unless the organization has certified its endorsement in writing to the contractor and the Administration.

C. Any person or entity acting as the contractor's marketing agent shall not engage in any marketing or pre-enrollment practice that discriminates against a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.

D. The Administration shall hold a contractor responsible for the performance of any person or entity acting as the contractor's marketing agent, subcontractor or agent, program, or process under its employ or direction and shall make the contractor subject to the contract sanctions in 9 A.A.C. 31, Article 6.

Any person or entity acting as a marketing agent shall follow the requirements in R9-22-504.

R9-31-505. ~~Approval of Advertisements and Marketing Materials~~ Repealed

A. A contractor shall submit its proposed advertisements, marketing materials, and paraphernalia for review and approval by the Administration before distributing the materials or implementing the activities.

B. A contractor shall submit all proposed marketing materials in writing to the Administration.

C. The Administration shall review and approve or disapprove all marketing materials. The Administration shall include a statement of objections and recommendations in a notice of disapproval.

D. To minimize the expense of revising advertising or other copy, a contractor may submit the marketing materials in draft form, subject to final approval and filing of a proof or final copy.

E. A contractor shall provide two copies of the proof or final approved copy of marketing materials to the Administration.

R9-31-507. ~~Member Record~~ Repealed

As specified in A.R.S. § 36-2986, a contractor shall maintain a member service record that contains at least the following for each member:

1. Encounter data,
2. Grievances and requests for hearing,
3. Any informal complaints, and
4. Service information.

R9-31-508. ~~Limitation of Benefit Coverage for Illness or Injury due to Catastrophe~~

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

The Director may limit the scope of health care benefits as described in R9-22-508.

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

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

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

1. Both the receiving and relinquishing contractor shall:
 - a. Coordinate with the other contractor to facilitate and schedule appointments for medically necessary services for the transitioned member within the Administration's timelines specified in the contract. A contractor's policies and procedures regarding transition of members are subject to review and approval by the Administration;
 - b. Assist in the referral of transitioned members to other community health agencies or county medical assistance programs for medically necessary services not covered by the Administration, as appropriate; and
 - c. Develop policies and procedures for transitioning members who have significant medical conditions, are receiving ongoing services, or have, at the time of the transition, received prior authorization or approval for undelivered, specific services.
2. The relinquishing contractor shall notify the receiving contractor of relevant information about the member's medical condition and current treatment regimens within the timelines defined in contract.
3. The relinquishing contractor shall forward medical records and other materials regarding the member's medical condition to the receiving contractor. The cost of reproducing and forwarding medical records and other materials shall be borne by the relinquishing contractor.
4. Within the contract-specified timelines, the receiving contractor shall ensure that the member selects or is assigned to a primary care provider, and provide the member with:

Notices of Proposed Rulemaking

- a. Information regarding the contractor's providers;
- b. Emergency numbers, and
- e. Instructions about how to obtain new services.

~~C. A contractor shall not use a county or noncontracting provider health resource alternative that diminishes the contractor's contractual responsibility or accountability for providing the full scope of covered services. The Administration may sanction a contractor under 9 A.A.C. 31, Article 6 for referrals made to other health agencies by the contractor, primarily to reduce expenditures incurred by the contractor on behalf of its members.~~

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

~~Transition and coordination of member care shall be conducted as described in R9-22-509.~~

R9-31-510. Transfer of Members Repealed

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

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

R9-31-511. Fraud or Abuse Repealed

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

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

~~A. The Administration, a contractor, a provider, and a noncontracting provider shall safeguard information concerning an applicant or member which includes the following:~~

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

~~B. The restriction upon disclosure of information does not apply to:~~

- 1. Summary data;
- 2. Statistics;
- 3. Utilization data, and
- 4. Other information that does not uniquely identify an applicant or member.

~~C. The Administration, a contractor, a provider, and a noncontracting provider shall use or disclose information concerning an applicant or member only under the conditions specified in subsections (D), (E), and (F) and only to:~~

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

~~D. Safeguarded information shall be viewed by or released for only:~~

- 1. An applicant;
- 2. A member; or
- 3. An unemancipated minor, with written permission of a parent, custodial relative, or designated representative, if:
 - a. An Administration employee or its authorized representative, or responsible caseworker is present during the examination of the eligibility record; or
 - b. As outlined in subsection (E) after written notification to the provider, and at a reasonable time and place.
- 4. A purpose as specified in R9-31-512(F).

~~E. An eligibility case record, medical record, and any other Title XXI-related confidential and safeguarded information regarding a member, applicant, or unemancipated minor shall be released to individuals authorized by the member, applicant, or unemancipated minor only under the following conditions:~~

- 1. Authorization for release of information is obtained from the member, applicant, or designated representative;
- 2. Authorization used for release is a written document, separate from any other document, that specifies the following information:

Notices of Proposed Rulemaking

- a. Information or records, in whole or in part, which are authorized for release;
 - b. To whom release is authorized;
 - e. The period of time for which the authorization is valid, if limited; and
 - d. A dated signature of the adult and mentally competent member, applicant, or designated representative. If the member, or applicant is a minor, the signature of a parent, custodial relative, or designated representative shall be required. If the member, or applicant is mentally incompetent, authorization shall be according to A.R.S. § 36-509;
3. If an appeal or grievance is filed, the member, applicant, or designated representative shall be permitted to review and obtain or copy any nonprivileged record necessary for the proper presentation of the case.
- F.** Release of safeguarded information to individuals or agencies for official purposes:
- 1. Official purposes directly related to the administration of the Title XXI program include:
 - a. Establishing eligibility and premiums, as applicable;
 - b. Determining the amount of medical assistance;
 - e. Providing services for members;
 - d. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the Title XXI program;
 - e. Performing evaluations and analyses of Title XXI operations;
 - f. Filing liens on property, as applicable;
 - g. Filing claims on estates, as applicable; and
 - h. Filing, negotiating, and settling medical liens and claims.
 - 2. For official purposes related to the administration of the Title XXI program and only to the extent required in performance of duties, safeguarded information, including case records and medical records, may be disclosed to the following persons without the consent of the applicant or member:
 - a. Employees of the Administration;
 - b. Employees of the U.S. Social Security Administration;
 - e. Employees of the Arizona Department of Economic Security;
 - d. Employees of the Arizona Department of Health Services;
 - e. Employees of the U.S. Department of Health and Human Services;
 - f. Employees of contractors, providers, and subcontractors;
 - g. Employees of the Arizona Attorney General's Office; or
 - h. Qualifying community health centers as specified in A.R.S. § 36-2907.06 and hospitals as specified in A.R.S. § 36-2907.08.
 - 3. Law enforcement officials:
 - a. Information may be released to law enforcement officials without the applicant's, or member's written or verbal consent, for the purpose of an investigation, prosecution, or criminal or civil proceeding relating to the administration of the Title XXI program.
 - b. Medical record. The Administration and contractors shall release safeguarded information contained in a member's medical record to law enforcement officials without the member's consent in situations of suspected of fraud or abuse against the Title XXI program.
 - e. A contractor shall release the medical record or information in the case record or other information developed in case management or utilization management operations without the member's written or verbal consent, for the purpose of an investigation, prosecution, or similar criminal proceeding not in connection with the Administration, only if the law enforcement official requesting the information has statutory authority to obtain the information.
 - 4. The Administration may release safeguarded information including case records and medical records to a review committee in accordance with the provisions of A.R.S. § 36-2986, without the consent of the applicant or member.
 - 5. Providers shall furnish requested records to the Administration and its contractors at no charge.
- G.** The holder of a medical record of a former applicant or member shall obtain written consent from the former applicant or member before transmitting the medical record to a primary care provider.
- H.** Subcontractors are not required to obtain written consent from a member before transmitting the member's medical records to a physician who:
- 1. Provides a service to the member under subcontract with the program contractor;
 - 2. Is retained by the subcontractor to provide services that are infrequently used or are of an unusual nature; and
 - 3. Provides a service under the contract.

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

R9-31-513. Discrimination Prohibition Repealed

- ~~A. A contractor, provider, or noncontracting provider shall not discriminate against a member:~~
- ~~1. Under Title VI of the U.S. Civil Rights Act of 1964, 42 U.S.C. 2000d,~~
 - ~~2. Because of:~~
 - ~~a. Marital status,~~
 - ~~b. Sexual preference,~~
 - ~~c. Age,~~
 - ~~d. Sex, or~~
 - ~~e. Behavioral disability, or~~
 - ~~3. In violation of any other rule or regulation provided by law.~~
- ~~B. For the purpose of providing a covered service under contract according to A.R.S. Title 36, Ch. 29, discrimination includes, the following if done on the grounds subsection (A):~~
- ~~1. Denying or providing a member any covered service or availability of a facility;~~
 - ~~2. Providing to a member any covered service that is different, or is provided in a different manner or at a different time from that provided to other members under contract, other public or private members, or the public at large except when medically necessary;~~
 - ~~3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service;~~
 - ~~4. Restricting a member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and~~
 - ~~5. Assigning to a member times or places for the provision of services that are different from those assigned to other members.~~
- ~~C. A contractor shall take affirmative action to ensure that members are provided covered services without discrimination under Section (A) except where medically indicated.~~

R9-31-514. Equal Opportunity Repealed

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

R9-31-518. Information to Enrolled Members

- ~~A. As specified in A.R.S. § 36-2986, each contractor shall produce and distribute printed information materials to each member within 10 days of receipt of notification of enrollment from the Administration. The information materials shall be written in English and all languages used by 200 members or 5%, whichever is greater, of the enrolled population. The information materials must meet the requirements specified in the contractor's current contract.~~
- ~~B. A contractor shall provide a member with the name, address, and telephone number of the member's primary care provider within 10 days from the date of enrollment. This notice shall include information on how the member may change primary care providers, if dissatisfied with the primary care provider assigned.~~
- ~~C. A contractor shall revise and distribute to members a service guide insert describing any change that the contractor proposes to make in services provided or service locations. The insert shall be distributed to all affected members at least 14 days before a planned change. Notification shall be provided as soon as possible when unforeseen circumstances require an immediate change in services, sites or locations.~~
- ~~D. A contractor shall submit informational and educational materials for approval by the Administration before distributing the materials to members.~~

Information to enrolled members shall be provided as described under R9-22-518.

R9-31-520. Financial Statements, Periodic Reports, and Information Repealed

- ~~A. Upon request by the Administration, a contractor shall furnish to the Administration information from its records relating to contract performance.~~
- ~~B. A contractor shall provide the Administration with the following:~~
- ~~1. An annual certified financial report prepared by a certified public accountant submitted no later than 120 days after the close of the contractor's fiscal year. The certified public accountants who prepare the report shall be independent of the contractor, subcontracting entities, their officers or directors, and any affiliates.~~
 - ~~2. Quarterly financial statements no later than 60 days after the end of the reporting month.~~
 - ~~3. Monthly financial statements, if required by the Administration submitted no later than 60 days after the end of the reporting period.~~
 - ~~4. Disclosure of information on ownership and control required by 42 CFR 455, Subpart B, September 30, 1986, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.~~

5. Cost reporting, audits, and financial reporting as specified in contract or provider agreement.

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

R9-31-521. Program Compliance Audits Repealed

A. As specified in A.R.S. § 36-2986, the Administration shall conduct a program compliance audit of a contractor at least once every 12 months during the term of its contract with the contractor. Unless the Administration determines that advance notice will render a program compliance audit less useful, a contractor shall be notified at least three weeks in advance of the date of an onsite program compliance audit. The Administration may conduct, without prior notice, inspections of contractor facilities or perform other elements of a program compliance audit, either in conjunction with the program compliance audit or as part of an unannounced inspection program.

B. The Administration's review team may perform any or all of the following procedures:

1. Conduct private interviews and group conferences with members, physicians, and other health professionals and members of a contractor's administrative staff including, but not limited to, the contractor's principal management persons;
2. Examine records, books, reports, and papers of a contractor and any management company, and all providers or subcontractors providing health care and other services to the contractor. The examination may include, but not be limited to: minutes of medical staff meetings, peer review and quality of care review records, duty rosters of medical personnel, appointment records, written procedures for the internal operation of the contractor, contracts and correspondence with members and with providers of health care services and other services to the plan, and additional documentation deemed necessary by the Administration to review the quality of medical care.

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

A. As specified in A.R.S. §§ 36-2986 and 36-2990, a contractor shall comply with Quality Management/Utilization Management (QM/UM) requirements specified in this Section and in contract. The contractor shall ensure compliance with QM/UM requirements that are accomplished through delegation or subcontract with another party.

B. A contractor shall:

1. Submit a written QM/UM plan that includes a description of the systems, methodologies, protocols, and procedures to be used in:
 - a. Monitoring and evaluating the types of services;
 - b. Identifying the numbers and costs of services provided;
 - c. Assessing and improving the quality and appropriateness of care and services;
 - d. Evaluating the outcome of care provided to members; and
 - e. Determining the steps and actions necessary to improve service delivery.
2. Submit the QM/UM plan on an annual basis within timelines specified in contract. If the QM/UM plan is changed during the year, the contractor shall submit the revised plan before implementation;
3. Receive approval from the Administration before implementing the initial QM/UM plan;
4. Ensure that a QM/UM committee operates under the control of the contractor's medical director, and includes representation from medical and executive management personnel. The committee shall:
 - a. Oversee the development, revision and implementation of the QM/UM plan; and
 - b. Ensure and allocate qualified QM/UM personnel and sufficient resources to implement the contractor's QM/UM activities.
5. Ensure that the QM/UM activities include at least:
 - a. Prior authorization for non-emergency or scheduled hospital admissions;
 - b. Concurrent review of inpatient hospitalization;
 - c. Retrospective review of hospital claims;
 - d. Program and provider audits designed to detect over or under utilization, service delivery effectiveness, and outcome;
 - e. Medical records audits;
 - f. Surveys to determine satisfaction of members;
 - g. Assessment of the adequacy and qualifications of the contractor's provider network;
 - h. Review and analysis of QM/UM data; and
 - i. Other activities necessary to improve the quality of care and the efficient, cost effective delivery and utilization of services.

C. A member's primary care provider shall maintain medical records that:

1. Are detailed and comprehensive and identify:
 - a. All medically necessary services provided to the member by the contractor and the subcontractors, and

Notices of Proposed Rulemaking

- b. All emergency services provided by nonproviders for a member.
 - 2. Conform to professional medical standards and practices for documentation of medical diagnostic and treatment data;
 - 3. Facilitate follow-up treatment; and
 - 4. Permit professional medical review and medical audit processes.
- ~~D. A subcontractor or its designee shall forward medical records or copies of medical records of all members assigned to the subcontractor or for whom the subcontractor has provided services, within 30 days following termination of a contract between the subcontractor and the contractor.~~
- ~~E. The Administration shall monitor contractors and their providers to ensure compliance with Administration QM/UM requirements and adherence to the contractor QM/UM plan.~~
- 1. A contractor and its providers shall cooperate with the Administration in the performance of its QM/UM monitoring activities; and
 - 2. A contractor and its providers shall develop and implement mechanisms for correcting deficiencies identified through the Administration's QM/UM monitoring.

A contractor shall comply with Quality Management/Utilization Management (QM/UM) requirements as described under R9-22-522.

R9-31-523. Financial Resources Repealed

- ~~A. As specified in A.R.S. § 36-2986, a contractor or offeror shall demonstrate upon request to the Administration that it has:~~
- 1. Adequate financial reserves;
 - 2. Administrative abilities; and
 - 3. Soundness of program design to carry out its contractual obligations.
- ~~B. As specified in A.R.S. § 36-2986, the Director requires that contract provisions include, but not be limited to:~~
- 1. Maintenance of deposits;
 - 2. Performance bonds;
 - 3. Financial reserves; or
 - 4. Other financial security.

R9-31-524. Continuity of Care Repealed

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

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

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

R9-31-1601. General Requirements

- ~~A. A Native American who is a member may receive:~~
- 1. Covered acute care services specified in this Chapter from:
 - a. ~~An IHS area office Indian Health Service (IHS) under A.R.S. § 36-2982 that has a signed IGA memorandum of agreement~~ with the Administration,
 - b. A Tribal Facility under A.R.S. § 36-2982, or
 - c. A contractor under A.R.S. § 36-2901.
 - 2. Covered behavioral health care services as specified in this Chapter from:
 - a. ~~An IHS area office Indian Health Service (IHS) under A.R.S. § 36-2982 that has a signed IGA memorandum of agreement~~ with the Administration,
 - b. A Tribal Facility under A.R.S. § 36-2982, or
 - c. A RBHA or TRBHA.
- ~~B. In providing covered services to a member, IHS and a Tribal Facility shall comply with:~~
- 1. Federal and state law;
 - 2. The IGA, if applicable; and
 - 3. This Chapter as applicable.
- ~~C. An individual or an entity that provides covered services for the IHS or a Tribal Facility shall be an AHCCCS registered provider.~~
- ~~D. The IHS and a Tribal Facility under 42 CFR 431.110 shall meet state requirements as a Medicaid provider. Medical records shall:~~
- 1. Conform to 9 A.A.C. 20 for documentation of medical, diagnostic and treatment data;
 - 2. Include a detailed record of:

- a. ~~All medically necessary services provided to a member by the IHS or a Tribal Facility;~~
 - b. ~~All emergency services provided by a provider or a noncontracting provider for a member enrolled with the IHS or receiving services from a Tribal Facility;~~
 - e. ~~All covered services provided through a referral to a facility or provider outside the IHS or Tribal facility network, and~~
3. ~~Facilitate follow up treatment.~~
- E.** As specified in A.R.S. §§ 36-2986 and 36-2992, the IHS or a Tribal Facility shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse.