

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 23. BOARD OF PHARMACY

[R05-191]

PREAMBLE

- 1. Sections Affected**

R4-23-408	<u>Rulemaking Action</u>
R4-23-605	Amend
	Amend
- 2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

Authorizing statutes: A.R.S. §§ 32-1904(A)(1) and (4) and 32-1904(B)(3)
Implementing statutes: A.R.S. §§ 32-1929, 32-1930, 32-1931, and 32-1963
- 3. A list of all previous notices appearing in the Register addressing the proposed rule:**

Notice of Rulemaking Docket Opening: 11 A.A.R. 487, January 21, 2005
- 4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name:	Dean Wright, Compliance Officer
Address:	Board of Pharmacy 4425 W. Olive Ave., Suite 140 Glendale, AZ 85302
Telephone:	(623) 463-2727, ext. 131
Fax:	(623) 934-0583
E-mail:	rxcop@cox.net
- 5. An explanation of the rule, including the agency's reasons for initiating the rule:**

Based on comments from licensees and permittees and issues of compliance, the Board staff identified possible changes to R4-23-408 (Computer Records) and R4-23-605 (Resident Drug Wholesaler Permit).

R4-23-408(D), (E), and (G) detail the requirements necessary if a pharmacy's computer system does not meet the requirements established in R4-23-408(A) and (B). The proposed rules will amend R4-23-408(D), (E), and (G) to also require compliance with R4-23-408(F). R4-23-408(F) addresses the issue of security and confidentiality of a patient's records within a pharmacy's computer system. R4-23-408(A) and (B) address a pharmacy's computer systems and data storage and retrieval.

Although the rule does not specifically state it, the Board believes that a drug wholesaler shall not package, repack, label, or relabel any drug or device. Since the Board rules for nonprescription drug retailers and nonresident drug wholesalers already state specifically that a nonprescription drug retailer or nonresident drug wholesaler shall not package, repack, label, or relabel a drug or device, the Board intends to amend R4-23-605 to specifically state that a full-service or nonprescription drug wholesaler shall not package, repack, label, or relabel a drug or device. It is the Board's contention that packaging, repackaging, labeling, and relabeling may only be done by a manufacturer or repackager properly permitted by the Board, by a pharmacist in performance of a pharmacist's duties in a properly permitted pharmacy, or by other persons specifically exempted by A.R.S. § 32-1921. The proposed rules will amend R4-23-605(D)(2) and (3) with language that requires that a wholesaler shall sell a drug only in the original container

Notices of Proposed Rulemaking

packaged and labeled by the manufacturer and not package, repackage, label, or relabel any drug. The rules will include format, style, and grammar necessary to comply with the current rules of the Secretary of State and Governor's Regulatory Review Council.

The Board believes that approval of this rule benefits the public and the pharmacy community by clearly establishing the standards for computer records and resident drug wholesaler permits.

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:

None

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 proposed rules will impact the Board, pharmacists, pharmacies, resident drug wholesalers, and the public. The proposed rules' impact on the Board will be the usual rulemaking-related costs, which are minimal. The proposed rules will have no economic impact on pharmacies or pharmacists. The proposed rules will clarify the requirements for a pharmacy's computer system and data storage and retrieval and address the issue of security and confidentiality of a patient's records within a pharmacy's computer system. The proposed rules will have no economic impact on resident drug wholesaler permittees. The proposed rules will specifically state that a resident drug wholesaler permittee, like a nonprescription drug retailer permittee and nonresident drug wholesaler permittee, shall not package, repackage, label, or relabel a drug or device. The Board has always told resident wholesaler permittees that they could not package, repackage, label, or relabel any drug, but the resident drug wholesaler permit rule did not specifically state the prohibition. The Board relied on the statute that states that only a manufacturer or repackager may package, repackage, label, or relabel a drug or device. The proposed rules have no economic impact on the public.

The public, Board, pharmacists, pharmacies, and resident drug wholesalers benefit from rules that are clear, concise, and understandable. The proposed rules benefit the public, the Board, and the pharmacy community by clearly establishing the standards for computer records and resident drug wholesaler permits.

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: Dean Wright, Compliance Officer
Address: Board of Pharmacy
4425 W. Olive Ave., Suite 140
Glendale, AZ 85302
Telephone: (623) 463-2727, ext. 131
Fax: (623) 934-0583
E-mail: rxcop@cox.net

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:

Comments may be written or presented orally. Written comments must be received by 5 p.m., Monday, July 11, 2005.

An oral proceeding is scheduled for:

Date: July 11, 2005
Time: 10:00 a.m.
Location: 4425 W. Olive Ave., Suite 140
Glendale, AZ 85302

A person may request information about the oral proceeding by contacting the person in this item.

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 23. BOARD OF PHARMACY

ARTICLE 4. PROFESSIONAL PRACTICES

Section
R4-23-408. Computer Records

ARTICLE 6. PERMITS AND DISTRIBUTION OF DRUGS

Section
R4-23-605. Resident Drug Wholesaler Permit

ARTICLE 4. PROFESSIONAL PRACTICES

R4-23-408. Computer Records

- A.** No change
1. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 2. No change
 3. No change
 4. No change
 5. No change
- B.** No change
1. No change
 2. No change
 3. No change
 4. No change
 5. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
 6. No change
- C.** No change
1. No change
 2. No change
 3. No change
 4. No change
 - a. No change
 - i. No change
 - ii. No change
 - iii. No change
 - b. No change
 - i. No change
 - ii. No change
 - iii. No change
- D.** If a pharmacy computer system does not comply with the requirements of subsections (A), ~~and (B)~~, and (F) the pharmacy permittee or pharmacist-in-charge shall bring the computer system into compliance within three months of a notice of noncompliance or violation letter. If the computer system is still noncompliant with subsection (A), ~~or (B)~~, or (F) after

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three months, the pharmacy permittee or pharmacist-in-charge shall immediately comply with the manual recordkeeping requirements of R4-23-402 and R4-23-407.

- E. If a pharmacy's personnel perform manual recordkeeping under subsection (D), the pharmacy's personnel shall continue manual recordkeeping until the pharmacist-in-charge sends proof, verified by a Board compliance officer, that the computer system complies with subsections (A), ~~and (B)~~, and (F).
- F. No change
 - 1. No change
 - 2. No change
- G. A computer system that does not comply with all the requirements of subsections (A), ~~and (B)~~, and (F) may be used in a pharmacy if:
 - 1. The computer system was in use in the pharmacy before July 11, 2001, and
 - 2. The pharmacy complies with the manual recordkeeping requirements of R4-23-402 and R4-23-407.

ARTICLE 6. PERMITS AND DISTRIBUTION OF DRUGS

R4-23-605. Resident Drug Wholesaler Permit

- A. No change
- B. No change
 - 1. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
 - g. No change
 - h. No change
 - i. No change
 - j. No change
 - k. No change
 - l. No change
 - m. No change
 - 2. No change
 - a. No change
 - b. No change
 - c. No change
- C. No change
- D. No change
 - 1. No change
 - a. No change
 - i. No change
 - ii. No change
 - iii. No change
 - b. No change
 - i. No change
 - ii. No change
 - iii. No change
 - 2. Drug sales.
 - a. A full-service drug wholesale permittee shall:
 - i. Sell, distribute, give away, or dispose of, any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical, only in the original container packaged and labeled by the manufacturer;
 - ii. Not package, repackage, label, or relabel any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical;
 - ~~iii.~~ Not sell, distribute, give away, or dispose of, any narcotic or other controlled substance, or prescription-only drug or device, to anyone except a pharmacy, drug manufacturer, or full-service drug wholesaler currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;

- ~~ii-iv.~~ Not sell, distribute, give away, or dispose of, any nonprescription drug, precursor chemical, or regulated chemical, to anyone except a pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
- ~~iii-v.~~ Maintain a copy of the current permit or license of each person or firm who buys, receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
- ~~iv-vi.~~ Provide permit and license records upon request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(4).

b. A nonprescription drug wholesale permittee shall:

- ~~i.~~ Sell, distribute, give away, or dispose of, any nonprescription drug, precursor chemical, or regulated chemical, only in the original container packaged and labeled by the manufacturer;
- ~~ii.~~ Not package, repackage, label, or relabel any nonprescription drug, precursor chemical, or regulated chemical;

~~i-iii.~~ Not sell or distribute, any nonprescription drug, precursor chemical, or regulated chemical, to anyone except a pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;

~~ii-iv.~~ Maintain a record of the current permit or license of each person or firm who buys, receives, or disposes of any nonprescription drug, precursor chemical, or regulated chemical; and

~~iii-v.~~ Provide permit and license records upon request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(4).

c. Nothing in this subsection shall be construed to prevent the return of a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical to the original source of supply.

3. Out-of-state drug sales.

a. A full-service drug wholesale permittee shall:

~~i.~~ Sell, distribute, give away, or dispose of, any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical, only in the original container packaged and labeled by the manufacturer;

~~ii.~~ Not package, repackage, label, or relabel any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical;

~~i-iii.~~ Not sell, distribute, give away, or dispose of, any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical, to anyone except a properly permitted, registered, licensed, or certified person or firm of other jurisdictions;

~~ii-iv.~~ Maintain a copy of the current permit, registration, license, or certificate of each person or firm who buys, receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and

~~iii-v.~~ Provide permit, registration, license, and certificate records upon request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(4); and

b. A nonprescription drug wholesale permittee shall:

~~i.~~ Sell, distribute, give away, or dispose of, any nonprescription drug, precursor chemical, or regulated chemical, only in the original container packaged and labeled by the manufacturer;

~~ii.~~ Not package, repackage, label, or relabel any nonprescription drug, precursor chemical, or regulated chemical;

~~i-iii.~~ Not sell or distribute, any nonprescription drug, precursor chemical, or regulated chemical, to anyone except a properly permitted, registered, licensed, or certified person or firm of another jurisdiction;

~~ii-iv.~~ Maintain a record of the current permit, registration, license, or certificate of each person or firm who buys, receives, or disposes of any nonprescription drug, precursor chemical, or regulated chemical; and

~~iii-v.~~ Provide permit, registration, license, or certificate records upon request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(4).

4. No change

a. No change

i. No change

ii. No change

b. No change

i. No change

ii. No change

E. No change

1. No change

- 2. No change
 - a. No change
 - b. No change
- 3. No change
- 4. No change
- 5. No change
- 6. No change
- 7. No change
- 8. No change
- 9. No change
- F. No change
 - 1. No change
 - a. No change
 - b. No change
 - c. No change
 - i. No change
 - ii. No change
 - iii. No change
 - d. No change
 - e. No change
 - i. No change
 - ii. No change
 - iii. No change
 - 2. No change
 - a. No change
 - b. No change
 - c. No change
 - i. No change
 - ii. No change
 - iii. No change
 - d. No change
 - e. No change
 - i. No change
 - ii. No change
 - iii. No change

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R05-189]

PREAMBLE

1. Sections Affected

Rulemaking Action

R9-27-101	Amend
R9-27-401	Amend
R9-27-402	Repeal
R9-27-405	Repeal
R9-27-406	Repeal
R9-27-408	Repeal
R9-27-501	Repeal
R9-27-503	Repeal
R9-27-504	Repeal
R9-27-505	Repeal
R9-27-506	Repeal
R9-27-507	Repeal

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R9-27-509	Amend
R9-27-510	Repeal
R9-27-511	Repeal
R9-27-512	Repeal
R9-27-513	Repeal
R9-27-514	Repeal
R9-27-515	Repeal
R9-27-516	Repeal
R9-27-701	Repeal
R9-27-702	Amend
R9-27-703	Amend
R9-27-704	Amend
R9-27-705	Repeal
R9-27-706	Repeal
R9-27-707	Repeal
R9-27-708	Repeal
R9-27-801	Repeal

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

Authorizing statute: A.R.S. § 36-2912

Implementing statute: A.R.S. § 36-2912

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

Notice of Rulemaking Docket Opening: 11 A.A.R. 1725, May 13, 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@azahcccs.gov

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. The changes identified were found to be necessary only in contract rather than in rule. 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) 253-9115

Notices of Proposed Rulemaking

E-mail: AHCCCSRules@azahcccs.gov

Proposed rule language will be available on the AHCCCS web site www.ahcccs.state.az.us the week of May 23, 2005. Please send written comments to the above address by 5:00 p.m., July 13, 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: July 13, 2005

Time: 2:00 p.m.

Location: AHCCCS
701 E. Jefferson
Phoenix, AZ 85034
Gold Room

Nature: Public Hearing

Date: July 13, 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: July 13, 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 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
HEALTH CARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED**

ARTICLE 1. DEFINITIONS

Section
R9-27-101. Location of Definitions

ARTICLE 4. CONTRACTS AND GSAS

Section
R9-27-401. General
R9-27-402. ~~Contract and GSAs Repealed~~
R9-27-405. ~~Contract and GSA Termination Repealed~~
R9-27-406. ~~Continuation Coverage Repealed~~
R9-27-408. ~~Contract Compliance Sanction Alternative Repealed~~

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Section

- R9-27-501. ~~Availability and Accessibility of Services Repealed~~
- R9-27-503. ~~Marketing and Discrimination Repealed~~
- R9-27-504. ~~Approval of Advertisements and Marketing Material Repealed~~
- R9-27-505. ~~Member Records and Systems Repealed~~
- R9-27-506. ~~Fraud or Abuse Repealed~~
- R9-27-507. ~~Release of Safeguarded Information Repealed~~
- R9-27-509. Information to Enrolled Members
- R9-27-510. ~~Discrimination Prohibition Repealed~~
- R9-27-511. ~~Equal Opportunity Repealed~~
- R9-27-512. ~~Periodic Reports and Information Repealed~~
- R9-27-513. ~~Medical Audits Repealed~~
- R9-27-514. ~~HCG Plan's Internal Quality Management and Utilization Review System Repealed~~
- R9-27-515. ~~Continuity of Care Repealed~~
- R9-27-516. ~~Financial Resources Repealed~~

ARTICLE 7. STANDARD FOR PAYMENTS

Section

- R9-27-701. ~~HCGA Liability; Payments to HCG Plans Repealed~~
- R9-27-702. Prohibition Against Charges to Members
- R9-27-703. Payments by HCG Plans
- R9-27-704. HCG Plan's Liability to Noncontracting Hospitals for the Provision of Emergency and Subsequent Care to Enrolled Members
- R9-27-705. ~~Copayments Repealed~~
- R9-27-706. ~~Payments by Employer Groups Repealed~~
- R9-27-707. ~~Reinsurance Repealed~~
- R9-27-708. ~~Payments to Providers Repealed~~

ARTICLE 8. COORDINATION OF BENEFITS

Section

- R9-27-801. ~~Priority of Benefit Payment Repealed~~

ARTICLE 1. DEFINITIONS

R9-27-101. Location of Definitions

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

Definition	Section or Citation
"Accountable health plan"	A.R.S. § 20-2301
"ADHS"	R9-27-101
"AHCCCS"	R9-27-101
"Ambulance"	A.R.S. § 36-2201
"Certification"	29 U.S.C. 1181
"Clean claim"	A.R.S. § 36-2904
"COBRA continuation provisions"	A.R.S. § 36-2912
"Coinsurance"	R9-27-101
"Copayment"	R9-27-101
"Covered services"	R9-27-101
"Creditable coverage"	A.R.S. § 36-2912
"Day"	R9-27-101
"Deductible"	R9-27-101
"Dependent"	R9-27-101
"Disability"	R9-27-303
"Effective date of coverage"	R9-27-101
"Eligible employee"	A.R.S. § 36-2912
"Emergency ambulance service"	R9-27-101
"Emergency medical services"	R9-27-101
"Employer group"	R9-27-101

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“Employee member”	R9-27-101
“Enrollment”	R9-27-101
“Experimental services”	R9-27-101
“FDA”	R9-27-101
“Full-time employee”	R9-27-101
“GSA”	R9-27-101
“HCG”	R9-27-101
“HCGA” or “Healthcare Group Administration”	R9-27-101
“HCG benefit plan”	R9-27-101
“HCG Plan”	R9-27-101
“Health care coverage”	R9-27-101
“Health care practitioner”	R9-27-101
“Hospital”	R9-27-101
“Inpatient hospital services”	R9-27-101
“Medical services”	A.R.S. § 36-401
“Medically necessary”	R9-27-101
“Member”	R9-27-101
“Member handbook and evidence of coverage” or “member handbook”	R9-27-101
“Network”	R9-27-101
“Network provider”	R9-27-101
“Political subdivision”	R9-27-101
“Pre-existing condition”	A.R.S. § 36-2912
“Pre-existing condition exclusion”	A.R.S. § 36-2912
“Premium”	R9-27-101
“Pre-payment”	R9-27-101
“Prior authorization”	R9-27-101
“Qualifying event”	R9-27-101
“Renewal date”	R9-27-101
“Scope of services”	R9-27-101
“Spouse”	R9-27-101
“Subcontract”	R9-27-101
“Substantial gainful activity”	R9-27-303
“Utilization review”	R9-27-101
“Waiting period”	A.R.S. § 36-2912

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

“ADHS” means the Arizona Department of Health Services, the state agency mandated to serve the public health needs of all Arizona residents.

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

“Coinsurance” means a predetermined amount a member agrees to pay to a provider for covered services. A coinsurance payment is a percentage of the fee schedule rate for the services.

“Copayment” means a monetary amount specified by the HCGA that a member or dependent pays directly to a provider at the time a covered service is rendered.

“Covered services” means the health and medical services described in 9 A.A.C. 27, Article 2, the GSA, and the member handbook.

“Day” means a calendar day unless otherwise specified in the text.

“Deductible” means a fixed annual dollar amount a member agrees to pay for certain covered services before the HCG plan agrees to pay.

“Dependent” means the eligible spouse and children of an employee member under 9 A.A.C. 27, Article 3.

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

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

“Emergency medical services” means medical services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could not reasonably expect the absence of immediate medical atten-

tion to result in:

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

"Employer group" means a group or a self-employed person who meets the criteria specified in R9-27-301.

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

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

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

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

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

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

"Full-time employee" means an employee or a self-employed person who works at least 20 hours per week.

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

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

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

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

"HCG Plan" means a health plan offered by HCGA or by an entity that is under contract with the HCGA to provide covered or administrative services to members.

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

1. Accident only, dental only, vision only, disability income only or long-term care only insurance, fixed or hospital indemnity coverage, limited benefit coverage, specified disease coverage, credit coverage, or Taft-Hartley trusts;
2. Coverage that is issued as a supplement to liability insurance;
3. Medicare supplemental insurance;
4. Workers' compensation insurance; or
5. Automobile medical payment insurance.

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

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

"Inpatient hospital services" means services provided to a member who is admitted to a hospital for medical care and treatment. An inpatient hospital service is provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.

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

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

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

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

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

“Network provider” means a provider who has a subcontract with the member’s HCG Plan and renders covered services to a member.

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

“Premium” means the monthly pre-payment amount due to HCGA by the employer group.

“Pre-payment” means submission of the employer group’s full premium payment at least 30 days in advance of coverage under the GSA.

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

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

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

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

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

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

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

A marketing organization, or

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

ARTICLE 4. CONTRACTS AND GSAS

R9-27-401. General

- A. Contracts to provide services. The HCGA shall establish contracts to provide services with qualified HCG Plans under A.R.S. § 36-2912.
- B. GSAs with employer groups. The HCGA shall establish GSAs with employer groups under A.R.S. § 36-2912.
- C. Contracts and GSAs. Contracts and GSAs entered into under A.R.S. § 36-2912 and on file with the HCGA are public records unless otherwise made confidential by law.

R9-27-402. ~~Contracts and GSAs Repealed~~

- ~~A. Requirements for a health plan. A health plan shall meet the requirements of A.R.S. § 36-2912 and all HCGA contract requirements.~~
- ~~B. Requirements for an employer group. An employer group shall meet the requirements of A.R.S. § 36-2912 and all GSA requirements.~~

R9-27-405. ~~Contract And GSA Termination Repealed~~

- ~~A. Contract between the HCGA and an HCG Plan. Under this Article and as specified in contract, the HCGA may suspend, deny, refuse, fail to renew, or terminate a contract or require the HCG Plan to terminate a subcontract for good cause which may include the following reasons:
 - 1. Submission of any misleading, false, or fraudulent information;
 - 2. Provision of any services in violation of or not authorized by licensure, certification, or other law;
 - 3. A material breach of contract;
 - 4. Failure to provide and maintain quality health care services to members, as determined by standards established by the state; and
 - 5. Failure to reimburse a medical provider within 60 days of receipt of a clean claim unless a different period is specified by contract.~~
- ~~B. Group Service Agreement between the HCGA and an employer group. The GSA may be terminated with written notice from either the HCGA or an employer group to the other party within time frames specified in the GSA.~~
- ~~C. Termination of a member by the HCGA or HCG Plan.
 - 1. Cause for immediate termination of coverage. The HCGA or HCG Plan may terminate a member’s coverage for the following:
 - a. Fraud or misrepresentation when applying for coverage or obtaining services; or
 - b. Violence, or threatening or other substantially abusive behavior toward the HCGA or the HCG Plan employees or agents, or contracting or noncontracting providers or their employees or agents.
 - 2. Cause for termination with 30 days written notice. The HCGA or the HCG Plan may terminate coverage of a member~~

for the following reasons:

- a. Repeated and unreasonable demands for unnecessary medical services;
 - b. Failure to pay any copayment, coinsurance, deductible, or required financial obligation; and
 - e. Material violation of any provision of the GSA.
3. Termination by reason of ineligibility:
- a. Termination of employment;
 - b. Failure of employer to pay premium. Termination shall be effective the first day of the month for which the premium has not been paid;
 - e. Coverage of a dependent member shall automatically cease on the last day of the month in which the dependent member loses coverage, for any reason described in R9-27-406.
 - d. Subject to continuation coverage, as described in R9-27-406, on the effective date of termination of coverage, the HCG Plan shall have no further obligation to provide services and benefits to a member whose coverage has been terminated; except that a member confined to a hospital at the effective date of termination shall continue to receive coverage until there has been a determination by the HCG Plan Medical Director or designee that care in the hospital is no longer medically necessary for the condition for which the member was admitted to the hospital; and
 - e. An employee member whose coverage terminates according to this subsection shall not be eligible for re-enrollment until the employer group's next open enrollment period. The employee shall meet all the eligibility criteria prescribed by these rules before re-enrollment.
- D. The HCGA may exclude employer groups or employee members from enrollment who have committed fraud or misrepresentation while enrolled with another HCG Plan or health benefits carrier.

R9-27-406. Continuation Coverage Repealed

Continuation coverage. Employer groups with at least 20 employees on a typical business day during the preceding calendar year shall provide continuation coverage as required by 29 U.S.C. 1161 et seq. The employer group shall collect the premium from the employee and pay the premium to HCGA.

R9-27-408. Contract Compliance Sanction Alternative Repealed

The Director may impose a sanction or penalty upon a HCG plan or employer group that violates any provision of the rules as specified in contract or the GSA.

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-27-501. Availability and Accessibility of Services Repealed

Availability and accessibility of services. An HCG Plan shall ensure that, within each service area, an adequate number of hospitals, medical care facilities, and service providers are available and reasonably accessible to provide covered services, to members. At a minimum, an HCG Plan shall have:

1. A designated emergency medical service facility, providing care 24 hours a day, seven days a week. An emergency medical service facility shall be accessible to members in each service area with at least one physician and registered nurse on call or on duty at the facility at all times.
2. An emergency medical service system employing at least one physician, a registered nurse, a physician assistant, or a nurse practitioner, accessible by telephone 24 hours a day, seven days a week, to:
 - a. Provide information to providers who need verification of patient membership and treatment authorization; and
 - b. Provide emergency medical services specified in R9-27-101.
3. An emergency medical services call log that contains the following information:
 - a. Member's name;
 - b. Member's address;
 - e. Member's telephone number;
 - d. Date of call;
 - e. Time of call; and
 - f. Instructions given to each member.
4. A written procedure plan for the communication of emergency medical service information to the member's primary care provider and other authorized staff.
5. An appointment system for each of the HCG Plan's service locations. The HCG Plan shall ensure that:
 - a. A member with an acute or urgent problem is triaged and provided same day service when necessary;
 - b. A time specific appointment for routine medically necessary care from the primary care provider is available within three weeks of the member's request and on the same day for emergency care; and
 - e. A referral appointment to a specialist is:
 - i. On the same day for emergency care;
 - ii. Within three days for urgent care; and

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- iii. Within 30 days for routine care.
- 6. Primary care providers that an enrolled member may select or to whom the member may be assigned. An HCG Plan that does not ordinarily include primary care providers shall enter into an affiliation or subcontract with an organization or individual to provide primary care. The HCG Plan shall agree to provide services under the primary care provider's guidance and direction. The primary care provider is responsible for:
 - a. Supervising, coordinating, and providing initial and primary care to members;
 - b. Initiating referrals for specialty care; and
 - c. Maintaining continuity of member care.
- 7. Primary care physicians and specialists providing inpatient services to a member shall have staff privileges in a minimum of one general acute care hospital under subcontract with the contracting health plan, within or near the service area of the HCG Plan.

R9-27-503. Marketing and Discrimination Repealed

HCGA marketing representatives shall not engage in any marketing or other pre-enrollment practices that discriminate against an applicant 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.

R9-27-504. Approval of Advertisements and Marketing Material Repealed

- A.** Submission of marketing material. The HCG Plan shall submit proposed marketing strategies and marketing material in writing to the HCGA for review and approval before distributing the marketing material or implementing any marketing activity.
- B.** Review of marketing material. The HCGA shall review and approve or disapprove all proposed marketing material and strategies. The HCGA shall notify the HCG Plan in writing of the approval or disapproval of the proposed marketing material and marketing strategies. The notification shall include a statement of objections and recommendations.
- C.** Drafts. To minimize the expense of revising marketing material or other copy, an HCG Plan may submit the material in draft form subject to final approval.
- D.** Submission and maintenance of final copies. An HCG Plan shall submit two copies of the proof or final approved copy of material to the HCGA, which shall maintain the proof or copy for five years.

R9-27-505. Member Records and Systems Repealed

Member record. Each HCG Plan shall maintain a member service record for each member that contains encounter data, grievances, complaints, and service information.

R9-27-506. Fraud or Abuse Repealed

Suspected fraud or abuse. All HCG Plans, providers, and noncontracting providers shall advise the HCGA immediately in writing of suspected fraud or abuse.

R9-27-507. Release of Safeguarded Information Repealed

- A.** Information to be safeguarded concerning an applicant or member of the HCG program includes:
 - 1. Name, address, and social security number;
 - 2. Evaluation of personal information; and
 - 3. Medical data and services including diagnosis and history of disease or disability.
- B.** Unrestricted information. The restrictions upon disclosure of information shall not apply to summary data, utilization data, and other information that does not identify an individual applicant or member.
- C.** Safeguarded information concerning a member or applicant shall be disclosed only to:
 - 1. The member or applicant, or, in the case of a minor, the parent, custodial relative, or guardian;
 - 2. Individuals authorized by the member or applicant; and
 - 3. Persons or agencies for official purposes.
 - 4. Safeguarded information may be released to these parties only under the conditions specified in subsections (D), (E), and (F).
- D.** A member or authorized representative may view the member's medical record after written notification to the provider and at a reasonable time and place.
- E.** Release to individuals authorized by the individual concerned. The HCGA or a HCG Plan shall release medical records and any other HCG-related confidential information of a member or applicant to individuals authorized by the member or applicant only under the following conditions:
 - 1. Authorization for release of information must be obtained from the member, applicant, or authorized representative. In the case of a minor, the member's or applicant's parent, custodial relative, or guardian shall submit an authorization for release of information.
 - 2. Authorization used for release of information must be, submitted in writing separate from any other document, and must specify the following:
 - a. Information or records, in whole or in part, which are authorized for release;

- b. To whom the release shall be made;
 - e. The period of time for which the authorization is valid, if limited; and
 - d. ~~The dated signature of the member, applicant, or authorized representative. In the case of a minor member or applicant, signature of a parent, custodial relative, or guardian is required unless the minor is able to understand the consequences of authorizing and not authorizing.~~
3. ~~If a grievance or appeal has been filed, the grievant, appellant, or designated representative shall be permitted to review, obtain, or copy any nonprivileged record necessary for the proper presentation of the case. The grievant or appellant also may authorize release of safeguarded information deemed necessary to the contested issue, to any opposing party in the case.~~
- F.** ~~Release to persons or agencies for official purposes.~~
- 1. ~~Safeguarded information, case records, and medical services information may be disclosed without the consent of the member, to agents or employees of a review committee.~~
 - 2. ~~For purposes of this Section, "review committee" means an organizational structure within the Plan whose primary purpose is to:~~
 - a. ~~Evaluate and improve the quality of health care;~~
 - b. ~~Review and investigate the conduct of licensed health care providers to determine whether disciplinary action should be imposed; and~~
 - e. ~~Encourage proper and efficient utilization of health care services and facilities.~~
 - 3. ~~Any member, agent, or employee of a review committee, who in good faith and without malice, furnishes records, information, or assistance related to the duties of the review committee; or, who takes an action or makes a decision or recommendation related to the duties or functions of the review committee shall not be subject to liability for civil damages as a consequence of the action. This does not relieve a person of liability that arises from that person's medical treatment of a patient.~~
 - 4. ~~Information considered by a review committee related to the duties or functions of the committee, including records of their actions and proceedings, are confidential and are not subject to subpoena or order to produce except:~~
 - a. ~~When otherwise subject to discovery as a patient's medical records.~~
 - b. ~~In proceedings before an appropriate state licensing or certifying agency. If the information is transferred to an appropriate state licensing or certifying agency, the information shall be kept confidential and shall be subject to the same provisions concerning discovery and use in legal actions.~~
 - 5. ~~A member of a review committee or staff engaged in work for the committee or any other person assisting or furnishing information to the review committee shall not be subpoenaed to testify in a judicial or quasi-judicial proceeding if the subpoena is based solely on review committee activities.~~
- G.** ~~Subcontractors are not required to obtain written consent from a 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.~~

R9-27-509. Information to Enrolled Members

- A.** ~~Member handbook. Each HCG Plan HCGA shall produce and distribute a printed member handbook to each enrolled member by the effective date of coverage or as otherwise stated in contract. The member handbook shall include the following:~~
- 1. ~~A description of all available services and an explanation of any service limitation, and exclusions from coverage, or charges for services, when applicable;~~
 - 2. ~~An explanation of the procedure for obtaining covered services, including a notice stating the HCG Plan shall only be liable for services authorized by a member's primary care provider or the HCG Plan;~~
 - 3. ~~A list of the names, telephone numbers, and business addresses of primary care providers available for selection by the member, and a description of the selection process, including a statement that informs members they may request another primary care provider, if they are dissatisfied with their selection;~~
 - 4. ~~Locations, telephone numbers, and procedures for obtaining emergency health services;~~
 - 5. ~~Explanation of the procedure for obtaining emergency health services outside the HCG Plan's service area;~~
 - 6. ~~Causes for which a member may lose coverage;~~
 - 7. ~~A description of the grievance and request for hearing procedures;~~
 - 8. ~~Copayment, coinsurance, and deductible schedules;~~
 - 9. ~~Information on obtaining health services and on the maintenance of personal and family health;~~
 - 10. ~~Information regarding emergency and medically necessary transportation offered by the HCG Plan; and~~
 - 11. ~~Other information necessary to use the program.~~
- B.** ~~Notification of changes in services. Each HCG Plan HCGA shall prepare and distribute to members a printed member handbook insert describing any changes that the HCG Plan HCGA proposes to make in services provided within the HCG~~

Plan's service areas. The insert shall be distributed to all affected members and dependents 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 or service locations.

R9-27-510. ~~Discrimination Prohibition Repealed~~

~~**A.** Discrimination. The HCGA or a HCG Plan shall not discriminate against an applicant or a member because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex or physical or mental disability in accordance with Title VII of the U.S. Civil Rights Act of 1964, 42 U.S.C., Section 2000 D, regulations promulgated under the Act, or as otherwise provided by law or regulation. For the purpose of providing covered services under contract under A.R.S. Title 36, Chapter 29, discrimination on the grounds of race, creed, color, religion, ancestry, marital status, age, sex, national origin, sexual preference, or physical or mental disability includes the following:~~

- ~~1. Denying a member any covered service or availability of a facility for any reason except provided under R9-27-202 or for a pre-existing condition as described in R9-27-210;~~
- ~~2. Providing 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 HCG members under contract, except when medically indicated;~~
- ~~3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service, or restricting a member's enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and~~
- ~~4. Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, or physical or mental disability of the member to be served.~~

~~**B.** Provision of covered services. An HCG Plan shall take affirmative action to ensure that a member is 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 when medically indicated.~~

R9-27-511. ~~Equal Opportunity Repealed~~

~~Equal opportunity requirements. An HCG Plan shall comply with the following equal opportunity employment requirements:~~

- ~~1. All solicitations or advertisements placed by or on behalf of an HCG Plan shall state that it is an equal opportunity employer.~~
- ~~2. An HCG Plan shall send a notice prepared by the HCGA to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding. The notice shall advise the labor union or workers' representative of the HCG Plan's commitment as an equal opportunity employer and shall be posted in conspicuous places available to employees and applicants for employment.~~

R9-27-512. ~~Periodic Reports and Information Repealed~~

~~**A.** Contract performance. Upon request by the HCGA, each HCG Plan shall furnish to the HCGA information from its records relating to contract performance.~~

~~**B.** Separation of records. Each HCG Plan shall maintain separate records to identify all HCG-related transactions.~~

R9-27-513. ~~Medical Audits Repealed~~

~~**A.** Conducting a medical audit. HCGA shall conduct a medical audit of each HCG Plan at least once every 12 months. Unless HCGA determines that advance notice will render a medical review less useful, the HCGA shall notify the HCG Plan no later than three weeks in advance of the date of an onsite medical review. HCGA may conduct, without prior notice, an inspection of the HCG Plan facility or perform other elements of a medical review, either in conjunction with the medical audit or as part of an unannounced inspection program.~~

~~**B.** Procedure for medical audit. As part of the medical audit, the HCGA may perform any or all of the following procedures:~~

- ~~1. Conduct private interviews and group conferences with:
 - a. Members;
 - b. Physicians and other health care practitioners;
 - c. Members of the HCG Plan's administrative staff including its principal management persons; and~~
- ~~2. Examine records, books, reports, and papers of the HCG Plan, any management company of the HCG Plan, and all providers or subcontractors providing health care and other services to the HCG Plan. The examination may include:
 - a. Minutes of medical staff meetings;
 - b. Peer review and quality of care review records;
 - c. Duty rosters of medical personnel;
 - d. Appointment records;
 - e. Written procedures for the internal operation of the HCG Plan;
 - f. Contracts;
 - g. Correspondence with members and providers of health care services and other services to the HCG Plan; and
 - h. Additional documentation deemed necessary by the HCGA to review the quality of medical care.~~

R9-27-514. ~~HCG Plan's Internal Quality Management and Utilization Review System Repealed~~

- A.** ~~Quality management and utilization review. An HCG Plan shall comply with the following quality management and utilization review requirements:~~
- ~~1. Annually prepare and submit to HCGA for review and approval a written quality management plan that includes utilization review. The quality management plan must be designed and implemented with actions to promote the provision of quality health care services.~~
 - ~~2. Design and implement procedures for continuously reviewing the performance of health care personnel and the utilization of facilities, services, and costs.~~
 - ~~3. Medical records and systems:~~
 - ~~a. Ensure that a member's medical records are maintained by the primary care provider, and include a record of all medical services received by the member from the HCG Plan and its subcontracting and noncontracting providers.~~
 - ~~b. Ensure that medical records are maintained in a manner that:~~
 - ~~i. Conforms to professional medical standards and practices;~~
 - ~~ii. Permits professional medical review and medical audit processes; and~~
 - ~~iii. Facilitates a system for follow-up treatment.~~
 - ~~4. Develop and implement a program of utilization review methods for hospitals that, at a minimum, includes:~~
 - ~~a. Prior authorization of nonemergency hospital admissions;~~
 - ~~b. Concurrent review of inpatient stays; and~~
 - ~~c. Retrospective review of hospital claims to ensure that covered hospital services are not used unnecessarily or unreasonably.~~
- B.** ~~Evaluation of utilization control system. The HCG Plan's utilization control system is subject to evaluation by the HCGA to determine cost effectiveness, and to measure whether quality management and utilization review methods are reducing, controlling, or eliminating unnecessary or unreasonable utilization. An HCG Plan may subcontract with an organization or entity designed to conduct activities regarding prior authorization, concurrent review, retrospective review, or any combination of these activities. A subcontract to conduct quality management or utilization review activities is subject to prior approval by the HCGA.~~

R9-27-515. ~~Continuity of Care Repealed~~

- ~~Requirements for continuity of care. An HCG Plan shall establish and maintain a system to ensure continuity of care that includes:~~
- ~~1. Referral of members needing specialty health care services;~~
 - ~~2. Monitoring of members with chronic medical conditions;~~
 - ~~3. Providing hospital discharge planning and coordination including post-discharge care; and~~
 - ~~4. Monitoring the operation of the system through professional review activities.~~

R9-27-516. ~~Financial Resources Repealed~~

- A.** ~~Adequate reserves. An HCG Plan shall demonstrate to the HCGA that it has adequate financial reserves, administrative abilities, and soundness of program design to carry out its contractual obligations.~~
- B.** ~~Contract provisions. Contract provisions required by the HCGA may include:~~
- ~~1. Maintenance of deposits;~~
 - ~~2. Performance bonds;~~
 - ~~3. Financial reserves; or~~
 - ~~4. Other financial security.~~

ARTICLE 7. STANDARD FOR PAYMENTS

R9-27-701. ~~HCGA Liability; Payments to HCG Plans Repealed~~

- A.** ~~Liability for covered services. The HCGA is not liable for the provision of covered services or the completion of a plan of treatment for any member.~~
- B.** ~~Liability for subcontracts:~~
- ~~1. The HCGA is not liable for subcontracts that the HCG Plan executes for the provision of:~~
 - ~~a. Administrative or management services;~~
 - ~~b. Medical services;~~
 - ~~c. Covered health care services; or~~
 - ~~d. For any other purpose.~~
 - ~~2. Each HCG Plan shall indemnify and hold the HCGA harmless from:~~
 - ~~a. Any and all liability arising from the HCG Plan's subcontracts;~~
 - ~~b. All judgment and injunctive costs of defense of any litigation for liability;~~
 - ~~c. Satisfy any judgment entered against the HCGA arising from an HCG Plan subcontract.~~

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- 3. All deposits, bonds, reserves, and security posted under R9-27-516 are forfeited to the HCGA to satisfy any obligations of this Section.
- ~~C. Payments. All payments to an HCG Plan shall be made under the terms and conditions of the contract executed between the HCG Plan and HCGA as specified in this Article.~~
- ~~D. Premium. Premium payments, less HCGA administrative charges and reinsurance fees, shall be paid monthly to an HCG Plan that has either posted a performance bond or has otherwise provided sufficient security to the HCGA.~~

R9-27-702. Prohibition Against Charges to Members

~~Prohibition against charges to members. An HCG Plan, subcontractor, or noncontracting provider reimbursed by an HCG Plan shall not charge, submit a claim, demand, or otherwise collect payment from a member or person acting on behalf of a member for any covered service except to collect an authorized copayment, coinsurance, and deductible. This prohibition shall not apply if the HCGA determines that a member willfully withheld information pertaining to the member's enrollment in an HCG Plan. An HCG Plan shall have the right to recover from a member that portion of payment made by a third party to a member when the payment duplicates HCG benefits and has not been assigned to the HCG Plan.~~

Upon notice from the member that the member is covered by HCG, a provider shall not charge, submit a claim, demand, or otherwise collect payment from a member or a person acting on behalf of a member for any covered services except the provider may collect or bill the member:

- 1. For any copayment, coinsurance, or deductible as described in the GSA;
- 2. If the member requests the provision of services, other than emergency medical services, that are excluded under the GSA or have not been authorized by the HCG Plan; or
- 3. For the difference between any payment received from the HCG Plan and billed charges for services other than emergency services if the provider has obtained, prior to the delivery of the service, the written agreement of the member to accept financial responsibility for the difference.

R9-27-703. Payments by HCG Plans

- ~~A. Payment for covered services. An HCG Plan shall pay the provider for all covered services rendered to the HCG Plan's member if the services were arranged by the HCG Plan's agent or employee, subcontracting provider, or other individual acting on behalf of the HCG Plan.~~
- ~~B. Payment for medically necessary outpatient services. An HCG Plan shall reimburse a subcontracting provider or noncontracting provider for covered health care services provided to the HCG Plan member. Reimbursement shall be made within the time period specified by contract between an HCG Plan and a subcontracting provider or noncontracting provider or within 60 days of receipt of a clean claim, if a time period is not specified.~~
- ~~C. Payment for in-state inpatient and outpatient hospital services including emergency services.
 - 1. An HCG Plan shall reimburse an in-state subcontracting provider for the provision of inpatient or outpatient hospital services, including emergency services specified in R9-27-209, at the subcontracted rate.
 - 2. An HCG Plan shall reimburse an in-state noncontracting provider for the provision of inpatient or outpatient hospital services, including emergency services specified in R9-27-209, according to the reimbursement methodology stated in A.R.S. § 36-2903.01(J).~~
- ~~D. Payment for emergency services. An HCG Plan shall pay for all emergency care services rendered to the HCG Plan member by a noncontracting provider if the services:
 - 1. Conform to the definition of emergency medical services in Article 1 and Article 2 of these rules; and
 - 2. Conform to the notification requirements in Article 2 of these rules.~~
- ~~E. Payment for out-of-state inpatient and outpatient hospital services. An HCG Plan shall reimburse an out-of-state subcontracting provider at the subcontracted rate. An HCG Plan shall reimburse an out-of-state noncontracting provider for the provision of inpatient and outpatient hospital services at the lower of negotiated discounted rates or 80% of billed charges.~~
- ~~F. Payment for emergency ambulance services. An HCG Plan shall reimburse an out-of-state subcontracting provider at the subcontracted rate. An HCG Plan shall reimburse a noncontracting provider for emergency ambulance services at the lower of negotiated discounted rates or 80% of the billed charges.~~
- ~~G. Nonpayment of a claim. In the absence of a contract with an HCG Plan, an HCG Plan is not required to pay a claim for a covered service that is submitted more than six months after the date of the service or that is submitted as a clean claim more than 12 months after the date of service.~~
- ~~H. Notice of a denied claim. An HCG Plan shall provide written notice to a provider whose claim is denied or reduced by an HCG Plan within 30 days of adjudication of the claim. This notice shall include a statement describing the provider's right to:
 - 1. Grieve the HCG Plan's rejection or reduction of the claim; and
 - 2. Submit a grievance to the HCGA, or its designee under 9 A.A.C. 27, Article 6.~~
- A. A HCG Plan is not responsible for reimbursing a provider if the member requests the provision of services, other than emergency medical services, that are excluded under the GSA, have not been authorized by the HCG Plan, or are not the result of a referral to the provider by the HCG Plan or the member's primary care physician.

- B. A HCG Plan shall reimburse a network provider for covered services as specified in the contract between the plan and the provider.
- C. If a member receives emergency medical services from a provider other than a network provider, or if the HCG Plan authorizes services to be delivered by, or refers a member to, a provider other than a network provider, the HCG Plan shall reimburse the provider for covered services at the lesser of billed charges or an amount negotiated with the provider less any copayments, coinsurance, or deductible as described in the GSA.
- D. The HCG Plan shall adjudicate claims from providers within 60 days of the receipt of a clean claim from the provider unless a different time is specified in the contract between the HCG Plan and the provider.

R9-27-704. HCG Plan's Liability to Noncontracting Hospitals for the Provision of Emergency and Subsequent Care to Enrolled Members

- ~~A. Liability to noncontracting hospitals. An HCG Plan is liable for reimbursement for a member's emergency medical condition:
 - 1. Until the time the member's condition is stabilized and the member is transferable to a subcontractor; or
 - 2. Until the member is discharged post-stabilization, subject to the requirements of A.R.S. § 36-2909(E) and Article 2 of these rules.~~
- ~~B. Liability when transfer of member is not possible. Subject to the provisions of subsection (A), if a member cannot be transferred for post-stabilization services to a facility that has a subcontract with the HCG Plan of record, the HCG Plan shall pay the provider for all appropriately documented medically necessary treatment provided the member before the date of discharge or transfer. The reimbursement is the lower of a negotiated discounted rate or prospective tiered per diem rate.~~
- ~~C. Member refusal of transfer. If a member refuses transfer from a noncontracting hospital to a hospital affiliated with the member's HCG Plan, neither the HCGA nor the HCG Plan shall be liable for any costs incurred subsequent to the date of refusal if:
 - 1. After consultation with the member's HCG Plan, the member continues to refuse the transfer; and
 - 2. The member is provided and signs a written statement of liability, before the date of discharge or transfer informing the member of the medical impact and financial consequences of refusing to transfer. If the member refuses to sign a written statement, a statement signed by two witnesses indicating that the member was informed may be substituted.~~

The provisions of HCG Plan's Liability to Noncontracting Hospitals for the Provision of Emergency and Subsequent Care to Enrolled Members shall be met in accordance with the terms of the health plan network contract with HCGA and the GSA contract with employer groups. Unless the GSA states otherwise the following requirements shall be met:

- 1. Liability to noncontracting hospitals. An HCG Plan is liable for reimbursement for a member's emergency medical condition until the time the member's condition is stabilized and the member is transferable to a subcontractor, or is discharged post-stabilization.
- 2. Member refusal of transfer. Subject to subsection (1), if a member refuses transfer from a noncontracting hospital to a hospital affiliated with the member's HCG Plan, neither the HCGA nor the HCG Plan shall be liable for any costs incurred subsequent to the date of refusal if:
 - a. After consultation with the member's HCG Plan, the member continues to refuse the transfer; and
 - b. The member is provided and signs a written statement of liability before the date of discharge or transfer informing the member of the medical impact and financial consequences of refusing to transfer. If the member refuses to sign a written statement, a statement signed by two witnesses indicating that the member was informed may be substituted.

R9-27-705. Copayments Repealed

- ~~A. Payment of copayment. A member shall be required to pay a copayment directly to a provider at the time covered services are rendered.~~
- ~~B. Determination of copayment. The HCGA shall establish the amount of copayment a member shall be charged. The HCGA shall consider the following in determining the amount of copayment:
 - 1. The impact the amount of the copayment will have on the population served, and
 - 2. The copayment amount charged by other group health plans or health insurance carriers for particular services.~~
- ~~C. Copayment provisions. The HCGA shall include the copayment provisions in the contract with an HCG Plan and the employer group.~~
- ~~D. Schedule of copayments. HCGA shall provide a schedule of the copayments to members at the time of enrollment.~~

R9-27-706. Payments by Employer Groups Repealed

~~An employer group shall submit the monthly premium payment to the HCGA by the first day of the month prior to the month of coverage. The monthly premium payment is delinquent if received or postmarked after the 25th day of the month prior to the month of coverage and subject to R9-27-405 and the GSA:~~

- ~~1. An employer group shall pay the monthly premium to HCGA with sufficient funds in the form of a:
 - ~~a. Cashier's check;~~~~

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- b. Personal check,
 - e. Money order,
 - d. Automatic debit from a checking or savings account, or
 - e. Other means approved by the HCGA.
2. An employer group whose payment is returned for nonsufficient funds shall pay the monthly premium in the form of a:
- a. Cashier's check,
 - b. Money order, or
 - e. Other means approved by the HCGA.

R9-27-707. Reinsurance Repealed

- ~~A.~~ Provision of reinsurance. The HCGA may elect to provide reinsurance through a private reinsurer.
- ~~B.~~ Insured entity. For purposes of the HCGA's reinsurance program, the insured entity shall be the HCG Plan with which the HCGA contracts.
 - 1. The HCGA shall deduct a specified amount per member, per month, from the employer group's monthly premium to cover the cost of the reinsurance contract.
 - 2. The HCG Plan shall comply with the reimbursement requirements of the reinsurance agreement between the reinsurer and the HCGA.

R9-27-708. Payments to Providers Repealed

The Administration or a contractor shall pay providers under A.A.C. R9-22-714.

ARTICLE 8. COORDINATION OF BENEFITS

R9-27-801. Priority of Benefit Payment Repealed

- ~~A.~~ HCG Plans shall coordinate all third-party benefits. Services provided under the HCG Plan are not intended to duplicate other benefits available to a member.
- ~~B.~~ Order of payment for members with other insurance. If a member has other coverage, payment for services shall occur in the following order:
 - 1. A policy, plan, or program that has no coordination of benefits provision or nonduplication provision shall make payment first.
 - 2. If a member is covered by another plan or policy that coordinates benefits:
 - a. The plan that provides or authorizes the service shall make payment first.
 - b. A plan, other than a prepaid plan, that covers a person as an employee shall make payment before a plan that covers the person as a dependent.
 - 3. If coverage is provided to a dependent child and both parents have family coverage:
 - a. The plan of the employee whose birthday occurs first in the calendar year shall be primary, and the plan of the employee whose birthday occurs last in the calendar year shall be secondary.
 - b. If both employees have the same birthday, the plan of the employee, that has been in force longer shall pay first.
 - e. If one of the plans determines the order of benefits based upon the gender of an employee, and the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits.
 - 4. If coverage is provided to a dependent child of divorced employees, the order of benefit shall be:
 - a. The plan of the employee with custody of the child shall pay first;
 - b. The plan of the spouse of the employee with custody of the child shall pay second; and
 - e. The plan of the employee not having custody of the child shall pay last.
- ~~C.~~ Primary payors. An HCG Plan shall not be primary payors for claims involving workers' compensation, automobile insurance, or homeowner's insurance.
- ~~D.~~ Lien and subrogation rights. An HCG Plan shall have lien and subrogation rights as those held by health care services organizations licensed under A.R.S. Title 20, Chapter 4, Article 9.