



**NOTICES OF PROPOSED RULEMAKING**

This section of the *Arizona Administrative Register* contains Notices of Proposed Rulemakings.

A proposed rulemaking is filed by an agency upon completion and submittal of a Notice of Rulemaking Docket Opening. Often these two documents are filed at the same time and published in the same *Register* issue.

When an agency files a Notice of Proposed Rulemaking under the Administrative Procedure Act (APA), the notice is published in the *Register* within three weeks of filing. See the publication schedule in the back of each issue of the *Register* for more information.

Under the APA, 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)

The Office of the Secretary of State is the filing office and publisher of these rules. Questions about the interpretation of the proposed rules should be addressed to the agency that promulgated the rules. Refer to item #4 below to contact the person charged with the rulemaking and item #10 for the close of record and information related to public hearings and oral comments.

**NOTICE OF PROPOSED RULEMAKING**

**TITLE 9. HEALTH SERVICES**

**CHAPTER 21. ~~DEPARTMENT OF HEALTH SERVICES~~ ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM  
BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS**

[R16-46]

**PREAMBLE**

<b><u>1. Article, Part, or Section Affected (as applicable)</u></b>	<b><u>Rulemaking Action</u></b>
R9-21-101	Amend
R9-21-102	Amend
R9-21-103	Amend
R9-21-104	Amend
R9-21-105	Amend
R9-21-106	Amend
R9-21-201	Amend
R9-21-203	Amend
R9-21-204	Amend
R9-21-205	Amend
R9-21-206	Amend
R9-21-206.01	Amend
R9-21-208	Amend
R9-21-209	Amend
Exhibit A	Amend
R9-21-301	Amend
R9-21-303	Amend
R9-21-307	Amend
R9-21-309	Amend
R9-21-310	Amend
R9-21-311	Amend
R9-21-401	Amend
R9-21-402	Amend
R9-21-403	Amend
R9-21-404	Amend
R9-21-405	Amend
R9-21-406	Amend
R9-21-407	Amend
R9-21-408	Amend
R9-21-409	Amend
R9-21-410	Amend



**2. Citations to the agency’s statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**

Authorizing statute: A.R.S. § 36-502, 36-2907, 36-3403(A)(4)  
Implementing statute: A.R.S. § 36-3401, 36-3407, 36-3413

**3. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the proposed rule:**

Notice of Rulemaking Docket Opening: 22 A.A.R. 782, April 8, 2016 (*in this issue*).

**4. The agency’s contact person who can answer questions about the rulemaking:**

Name: Mariaelena Ugarte  
Address: AHCCCS  
Office of Administrative Legal Services  
701 E. Jefferson, Mail Drop 6200  
Phoenix, AZ 85034  
Telephone: (602) 417-4693  
Fax: (602) 253-9115  
E-mail: AHCCCSRules@azahcccs.gov  
Web site: www.azahcccs.gov

**5. An agency’s justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:**

The Administration is proposing rule to implement the statutory “behavioral health simplification and integration” where the AHCCCS Administration assumes full administrative and operational responsibility for the provision of behavioral health services effective July 1, 2016. Senate Bill 1257 (Laws 2015, Chapter 195) provides for the statutory transfer of behavioral health responsibilities from the Arizona Department of Health Services (ADHS) to AHCCCS. This rulemaking delineates the responsibilities of the AHCCCS Administration to oversee the provision of behavioral health services under Title 9 Chapter 21 of the Arizona Administrative Code (AAC) for persons with a serious mental illness (SMI) as defined under R9-21-101 and A.R.S. § 36-550.

Rules under Title 9, Chapter 21 of the AAC, first enacted in October 1993 and last amended in June 2003; apply to persons with a SMI diagnosis, regardless of Medicaid eligibility. The Administration has chosen to make changes to this Chapter in two phases. This rulemaking is the first phase, and because the Administration is assuming administrative and operational responsibility for the provision of behavioral health services to persons with a SMI diagnosis, within all rules, the terms “department”, “division”, or “director” were changed to “Administration” or “mental health agency”, where applicable, and cross-references were updated to statutes or other rule sections, as appropriate. More significant of these proposed changes includes alignment of the hearing process with the Administrative Procedure Act (APA), A.R.S. §41-1092, deletion of antiquated or inaccurate language, updating of language to reflect AHCCCS terminology, and updating of language to reflect AHCCCS organizational structure.

- Article 1’s objective is to describe General Provisions that apply to this Chapter. This Article describes definitions, the applicability of the SMI requirements, how time is computed when actions are made, the establishment of the Human Rights Committees, requirements of the Office of Human Rights and Advocates, and the state protection and Advocacy system. Within this Article, we have verified the use of the definitions described, updated cross-references, and added a section to guide the person to where the definitions can be found. The Article was updated to reflect that this Chapter will apply to the Administration and all mental health agencies. Sections were stricken that are no longer applicable, such as licensing (the Administration does not license or certify these agencies).
- Article 2’s objective is to describe the rights of persons with SMI. This Article describes Civil and Other Legal Rights, Right to Support and Treatment, Protection from Abuse, Neglect, Exploitation and Mistreatment, Restraint and Seclusion, Labor, Competency and Consent, Informed Consent, Medication, Property and Possessions, Records, Policies and Procedures of Service Providers, Notice of Rights, and Exhibits. Within this Article, no significant changes were made, except for the terms relative to the Administration assuming responsibility, cross-reference updates, and minor clarifications.
- Article 3’s objective is to describe the Individual Service Planning for behavioral health services for person with SMI. This Article describes General Provisions, Identification, Application, and Referral for Services of Persons with Serious Mental Illness, Eligibility Determination and Initial Assessment, Interim and Emergency Services, Assessments, Identification of Potential Service Providers, Selection of Service Providers, Implementation of the Individual Service Plan, Interim Services, Inpatient Treatment and Discharge Plan, Periodic



Review of Individual Service Plans, and Modification or Termination of Plans. Within this Article, no significant changes were made, except for the terms relative to the Administration assuming responsibility.

- Article 4's objective is to describe appeals, grievances, and requests for investigation for persons with SMI. This Article describes Appeals, General requirements, Initiating a Grievance or Investigation, Persons Responsible for Resolving Grievances and Requests for Investigations, Preliminary Disposition, Conduct of Investigation, Administrative Appeal, Further Appeal to Administrative Hearing, Notice and Records, and Miscellaneous requirements. Within this Article, there were several changes. Like the other Articles, there were updates made to reflect the terms relative to the Administration assuming responsibility, cross-reference updates, and minor clarifications. This Article, on its face, appears to have significant changes made. However, the Administration adheres to timelines and processes set forth in the APA (A.R.S. §41-1092), and much of the previous language in this Article relating to timelines was stricken and replaced with cross-references to the APA. There are also the removal of some of the processes that were used when ADHS had the responsibility, but to which the Administration does not adhere.
- Article 5 – Article 5's objective is to describe Court-Ordered Evaluation and Treatment for persons with SMI. This Article describes Court-Ordered Evaluations, Emergency Admissions for evaluation, Voluntary Admission, Court-Ordered Treatment, Coordination of Court-Ordered Treatment with ISP's and ITDP's, Review and Transfers of Court-Ordered Individuals, Requests for Notification, Voluntary Admission for Treatment, Informed Consent, Use of Psychotropic Medication, Seclusion and Restraint, and Exhibits. No changes were made to this Article.

The second phase, which will be initiated at a later date, is intended to address more substantive changes through further review of statute and relevant litigation as well as consideration of best practices for the treatment and support of persons with SMI, with particular emphasis on patient outcomes.

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

**7. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking 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 Administration does not anticipate an economic impact on small businesses, the public or the implementing agencies since funding and staffing will be transferred to the Administration from ADHS. This rulemaking intends to adopt rules to delineate the delivery system resulting from SB 1257. This rulemaking informs stakeholders of the revised operational structure and the new functional responsibilities. This transfer of responsibilities from ADHS to AHCCCS is budget neutral and this rulemaking is administrative in nature, not affecting the coverage of services, or the rights or protections of persons with SMI.

**9. The agency's contact person who can answer questions about the economic, small business and consumer impact statement:**

Name: Mariaelena Ugarte  
 Address: AHCCCS  
 Office of Administrative Legal Services  
 701 E. Jefferson, Mail Drop 6200  
 Phoenix, AZ 85034  
 Telephone: (602) 417-4693  
 Fax: (602) 253-9115  
 E-mail: AHCCCSRules@azahcccs.gov  
 Web site: www.azahcccs.gov

**10. The time, place, and nature of the proceedings to make, amend, repeal, or renumber the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:**

Proposed rule language will be available on the AHCCCS website [www.azahcccs.gov](http://www.azahcccs.gov) the week of March 18, 2016. Please send written or email comments to the above address by the close of the comment period, 5:00 p.m., May 9, 2016.

Date: May 9, 2016  
 Time: 1:00 p.m.  
 Location: AHCCCS  
 701 E. Jefferson



Phoenix, AZ 85034  
 Nature: Public Hearing  
 Date: May 9, 2016  
 Time: 1:00 p.m.  
 Location: ALTCS: Arizona Long-Term Care System  
 1010 N. Finance Center Dr., Suite 201  
 Tucson, AZ 85710  
 Nature: Public Hearing  
 Date: May 9, 2016  
 Time: 1:00 p.m.  
 Location: 2717 N. 4th St., Suite 130  
 Flagstaff, AZ 86004  
 Nature: Public Hearing

**11. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:**

No other matters have been prescribed.

- a. **Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**  
Not applicable
- b. **Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**  
Not applicable
- c. **Whether a person submitted an analysis to the agency that compares the rule’s impact of the competitiveness of business in this state to the impact on business in other states:**  
No analysis was submitted.

**12. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:**  
None

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

**TITLE 9. HEALTH SERVICES**

**CHAPTER 21. ~~DEPARTMENT OF HEALTH SERVICES~~ ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM  
BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS**

**ARTICLE 1. GENERAL PROVISIONS**

- Section  
 R9-21-101. Definitions and location of Definitions  
 R9-21-102. Applicability  
 R9-21-103. Computation of Time  
 R9-21-104. Office of Human Rights; Human Rights Advocates  
 R9-21-105. Human Rights Committees  
 R9-21-106. State Protection and Advocacy System

**ARTICLE 2. RIGHTS OF PERSONS WITH SERIOUS MENTAL ILLNESS**

- Section  
 R9-21-201. Civil and Other Legal Rights  
 R9-21-203. Protection from Abuse, Neglect, Exploitation and Mistreatment  
 R9-21-204. Restraint and Seclusion  
 R9-21-205. Labor  
 R9-21-206. Competency and Consent  
 R9-21-206.01. Informed Consent  
 R9-21-208. Property and Possessions  
 R9-21-209. Records  
 Exhibit A. Notice of Legal Rights for Persons with Serious Mental Illness

**ARTICLE 3. INDIVIDUAL SERVICE PLANNING FOR BEHAVIORAL HEALTH SERVICES FOR PERSONS**



**WITH SERIOUS MENTAL ILLNESS**

- Section
- R9-21-301. General Provisions
- R9-21-303. Eligibility Determination and Initial Assessment
- R9-21-307. The Individual Service Plan
- R9-21-309. Selection of Service Providers
- R9-21-310. Implementation of the Individual Service Plan
- R9-21-311. Interim Services

**ARTICLE 4. APPEALS, GRIEVANCES, AND REQUESTS FOR INVESTIGATION FOR PERSONS WITH SERIOUS MENTAL ILLNESS**

- Section
- R9-21-401. Appeals
- R9-21-402. General
- R9-21-403. Initiating a Grievance or Investigation
- R9-21-404. Persons Responsible for Resolving Grievances and Requests for Investigations
- R9-21-405. Preliminary Disposition
- R9-21-406. Conduct of Investigation
- R9-21-407. Administrative Appeal
- R9-21-408. Further Appeal to Administrative Hearing
- R9-21-409. Notice and Records
- R9-21-410. Miscellaneous

**ARTICLE 1. GENERAL PROVISIONS**

**R9-21-101. Definitions and Location of Definitions**

**A.** Location of definitions. Unless the context otherwise requires, terms used in this Chapter that are defined in A.R.S. § 36-501 shall have the same meaning as in A.R.S. § 36-501. In addition, the following definitions applicable to this Chapter are found in the following Section or Citation:

<u>“Abuse”</u>	<u>R9-21-101</u>
<u>“ADHS”</u>	<u>R9-22-101</u>
<u>“Administration”</u>	<u>A.R.S. § 36-2901</u>
<u>“Agency director”</u>	<u>R9-21-101</u>
<u>“AHCCCS”</u>	<u>R9-22-101</u>
<u>“Applicant”</u>	<u>R9-21-101</u>
<u>“ASH”</u>	<u>R9-21-101</u>
<u>“Authorization”</u>	<u>R9-21-101</u>
<u>“Behavioral health issue”</u>	<u>R9-21-101</u>
<u>“Burden of proof”</u>	<u>R9-21-101</u>
<u>“Case manager”</u>	<u>R9-21-101</u>
<u>“Client”</u>	<u>R9-21-101</u>
<u>“Client record”</u>	<u>R9-21-101</u>
<u>“Client who needs special assistance”</u>	<u>R9-21-101</u>
<u>“Clinical team”</u>	<u>R9-21-101</u>
<u>“Community services”</u>	<u>R9-21-101</u>
<u>“Condition requiring investigation”</u>	<u>R9-21-101</u>
<u>“County Annex”</u>	<u>R9-21-101</u>
<u>“Court”</u>	<u>A.R.S. § 36-501</u>
<u>“Court-ordered treatment”</u>	<u>R9-21-101</u>
<u>“Crisis services” or “emergency services”</u>	<u>R9-21-101</u>
<u>“Danger to others”</u>	<u>A.R.S. § 36-501</u>
<u>“Dangerous”</u>	<u>R9-21-101</u>
<u>“Department”</u>	<u>R9-21-101, A.R.S. § 36-501</u>
<u>“Designated representative”</u>	<u>R9-21-101</u>
<u>“Director”</u>	<u>A.R.S. § 36-501</u>
<u>“Discharge plan”</u>	<u>R9-21-101</u>
<u>“Division”</u>	<u>R9-21-101</u>
<u>“Drug used as a restraint”</u>	<u>R9-21-101</u>
<u>“DSM” or “Diagnostic and Statistical Manual of Mental Disorders”</u>	<u>R9-21-101</u>
<u>“Emergency safety situation”</u>	<u>R9-21-101</u>
<u>“Enrolled Children”</u>	<u>R9-21-101</u>
<u>“Evaluation”</u>	<u>A.R.S. § 36-501</u>
<u>“Exploitation”</u>	<u>R9-21-101</u>



<u>“Family member”</u>	<u>A.R.S. § 36-501</u>
<u>“Frivolous”</u>	<u>R9-21-101</u>
<u>“Generic services”</u>	<u>R9-21-101</u>
<u>“Grievance”</u>	<u>R9-21-101</u>
<u>“Guardian”</u>	<u>R9-21-101</u>
<u>“Hearing officer”</u>	<u>R9-21-101</u>
<u>“Human rights advocate”</u>	<u>R9-21-101</u>
<u>“Human rights committee”</u>	<u>R9-21-101</u>
<u>“Illegal”</u>	<u>R9-21-101</u>
<u>“Individual service plan” or “ISP”</u>	<u>R9-21-101</u>
<u>“Informed consent”</u>	<u>A.R.S. § 36-501</u>
<u>“Inhumane”</u>	<u>R9-21-101</u>
<u>“Inpatient facility”</u>	<u>R9-21-101</u>
<u>“Inpatient treatment and discharge plan” or “ITDP”</u>	<u>R9-21-101</u>
<u>“licensed physician”</u>	<u>A.R.S. § 36-501</u>
<u>“Long-term view”</u>	<u>R9-21-101</u>
<u>“Mechanical restraint”</u>	<u>R9-21-101</u>
<u>“Medical practitioner”</u>	<u>R9-21-101</u>
<u>“Meeting”</u>	<u>R9-21-101</u>
<u>“Mental disorder”</u>	<u>A.R.S. § 36-501</u>
<u>“Mental health agency”</u>	<u>R9-21-101</u>
<u>“mental health provider”</u>	<u>A.R.S. § 36-501</u>
<u>“Nurse”</u>	<u>R9-21-101</u>
<u>“Outpatient treatment”</u>	<u>A.R.S. § 36-501</u>
<u>“Party” or “parties”</u>	<u>R9-21-101</u>
<u>“Persistent or acute disability”</u>	<u>A.R.S. § 36-501</u>
<u>“Personal restraint”</u>	<u>R9-21-101</u>
<u>“PRN order” or “Pro re rata medication”</u>	<u>R9-21-101</u>
<u>“Professional”</u>	<u>A.R.S. § 36-501</u>
<u>“Program director”</u>	<u>R9-21-101</u>
<u>“Proposed patient”</u>	<u>A.R.S. § 36-501</u>
<u>“Psychiatrist”</u>	<u>A.R.S. § 36-501</u>
<u>“Psychologist”</u>	<u>A.R.S. § 36-501</u>
<u>“Qualified clinician”</u>	<u>R9-21-101</u>
<u>“Records”</u>	<u>A.R.S. § 36-501</u>
<u>“Region”</u>	<u>R9-21-101</u>
<u>“Regional authority”</u>	<u>R9-21-101</u>
<u>“Regional Behavioral Health Authority (RBHA)”</u>	<u>A.R.S. § 36-3401</u>
<u>“Restraint”</u>	<u>R9-21-101</u>
<u>“Seclusion”</u>	<u>R9-21-101</u>
<u>“Seriously Mentally Ill (SMI)”</u>	<u>R9-21-101</u>
<u>“Service provider”</u>	<u>R9-21-101</u>
<u>“Social worker”</u>	<u>A.R.S. § 36-501</u>
<u>“State Protection and Advocacy System”</u>	<u>R9-21-101</u>
<u>“Title XIX”</u>	<u>R9-21-101</u>
<u>“Treatment team”</u>	<u>R9-21-101</u>

**A.** In this Chapter, unless the context otherwise requires, the terms defined in A.R.S. § 36-501 shall have the same meaning as in A.R.S. § 36-501.

**B.** In this Chapter, unless the context otherwise requires:

1. “Abuse” means, with respect to a client, the infliction of, or allowing another person to inflict or cause, physical pain or injury, impairment of bodily function, disfigurement or serious emotional damage which may be evidenced by severe anxiety, depression, withdrawal or untoward aggressive behavior. Such abuse may be caused by acts or omissions of an individual having responsibility for the care, custody or control of a client receiving behavioral health services or community services under this Chapter. Abuse shall also include sexual misconduct, assault, molestation, incest, or prostitution of, or with, a client under the care of personnel of a mental health agency.
2. “Agency director” means the person primarily responsible for the management of an outpatient or inpatient mental health agency, service provider, regional authority or the ~~deputy director of the division Administration~~ Administration, or their designees.
3. ~~“AHCCCSA” means the Arizona Health Care Cost Containment System Administration.~~
4. “Applicant” means an individual who:



- a. Submits to a regional authority an application for behavioral health services under this Chapter or on whose behalf an application has been submitted; or
  - b. Is referred to a regional authority for a determination of eligibility for behavioral health services according to this Chapter.
5. “ASH” means the Arizona State Hospital.
6. “Authorization” means written permission for a mental health agency to release or disclose a client’s record or information, containing:
- a. The name of the mental health agency releasing or disclosing the client’s record or information;
  - b. The purpose of the release or disclosure;
  - c. The individual, mental health agency, or entity requesting or receiving the client’s record or information;
  - d. A description of the client’s record or information to be released or disclosed;
  - e. A statement:
    - i. Of permission for the mental health agency to release or disclose the client’s record or information; and
    - ii. That permission may be revoked at any time;
  - f. The date when or conditions under which the permission expires;
  - g. The date the document is signed; and
  - h. The signature of the client or, if applicable, the client’s guardian.
7. “Behavioral health issue” means an individual’s condition related to a mental disorder, personality disorder, substance abuse, or a significant psychological or behavioral response to an identifiable stressor or stressors.
8. “Behavioral health service” means the assessment, diagnosis, or treatment of an individual’s behavioral health issue.
9. “Burden of proof” means the necessity or obligation of affirmatively proving the fact or facts in dispute.
10. “Case manager” means the person responsible for locating, accessing and monitoring the provision of services to clients in conjunction with a clinical team.
11. “Client” means an individual who is seriously mentally ill and is being evaluated or treated for a mental disorder by or through a regional authority.
12. “Client record” means the written compilation of information that describes and documents the evaluation, diagnosis or treatment of a client.
13. “Client who needs special assistance” means a client who has been:
- a. Deemed by a qualified clinician, case manager, clinical team, or regional authority to need special assistance in participating in the ISP or ITP process, which may include, but is not limited to:
    - i. A client who requires 24-hour supervision;
    - ii. A client who is, in fact, incapable of making or communicating needs but is without a court-appointed fiduciary; or
    - iii. A client with physical disabilities or language difficulties impacting the client’s ability to make or communicate decisions or to prepare or participate in meetings; or
  - b. Otherwise deemed by a program director, the ~~deputy director of the Division Administration~~, or a hearing officer to need special assistance to effectively file a written grievance, to understand the grievance and investigation procedure, or to otherwise effectively participate in the grievance process under this Chapter.
14. “Clinical team” refers to the interdisciplinary team of persons who are responsible for providing continuous treatment and support to a client and for locating, accessing and monitoring the provision of behavioral health services or community services. A clinical team consists of a psychiatrist, case manager, vocational specialist, psychiatric nurse, and other professionals or paraprofessionals, such as a psychologist, social worker, consumer case management aide, or rehabilitation specialist, as needed, based on the client’s needs. The team shall also include a team leader who is a certified behavioral health supervisor ~~under Laws 1992, Ch. 310~~.
15. “Community services” means services ~~required to be provided under A.R.S. Title 36, Chapter 5, Article 10~~ such as clinical case management, outreach, housing and residential services, crisis intervention and resolution services, mobile crisis teams, day treatment, vocational training and opportunities, rehabilitation services, peer support, social support, recreation services, advocacy, family support services, outpatient counseling and treatment, transportation, and medication evaluation and maintenance.
16. “Condition requiring investigation” means, within the context of the grievance and investigation procedure set forth in Article 4 of this Chapter, an incident or condition which appears to be dangerous, illegal, or inhumane, including a client death.
17. “County Annex” means the Maricopa County Psychiatric Annex of the Maricopa Medical Center.
18. “Court-ordered treatment” means treatment ordered by the court ~~under A.R.S. Title 36, Chapter 5~~.
19. “Court-ordered evaluation” means evaluation ordered by the court ~~under A.R.S. Title 36, Chapter 5~~.
20. “Crisis services” or “emergency services” means immediate and intensive, time-limited, crisis intervention and resolution services which are available on a 24-hour basis and may include information and referral, evaluation and counseling to stabilize the situation, triage to an inpatient setting, clinical crisis intervention services, mobile crisis



services, emergency crisis shelter services, and follow-up counseling for clients who are experiencing a psychiatric emergency.

- 21. “Dangerous” as used in Article 4 of this Chapter means a condition that poses or posed a danger or the potential of danger to the health or safety of any client.
- 22. “Department” means the Arizona Department of Health Services.
- 23. “Designated representative” means a parent, guardian, relative, advocate, friend, or other person, designated by a client or guardian who, upon the request of the client or guardian, assists the client in protecting the client’s rights and voicing the client’s service needs.
- 24. “Discharge plan” means a hospital or community treatment and discharge plan prepared according to Article 3 of these rules.
- 25. “Division” means the Division of Behavioral Health Services of the Department.
- 26. “Drug used as a restraint” means a pharmacological restraint as used in A.R.S. § 36-513 that is not standard treatment for a client’s medical condition or behavioral health issue and is administered to:
  - a. Manage the client’s behavior in a way that reduces the safety risk to the client or others,
  - b. Temporarily restrict the client’s freedom of movement.
- 27. “DSM” means the latest edition of the “Diagnostic and Statistical Manual of Mental Disorders,” edited by the American Psychiatric Association.
- 28. “Emergency safety situation” means unanticipated client behavior that creates a substantial and imminent risk that the client may inflict injury, and has the ability to inflict injury, upon:
  - a. The client, as evidenced by threats or attempts to commit suicide or to inflict injury on the client; or
  - b. Another individual, as evidenced by threats or attempts to inflict injury on another individual or individuals, previous behavior that has caused injury to another individual or individuals, or behavior that places another individual or individuals in reasonable fear of sustaining injury.
- 29. “Enrolled Children” means persons under the age of 18 who receive behavioral health services by or through a regional authority.
- 30. “Exploitation” means the illegal or improper use of a client or a client’s resources for another’s profit or advantage.
- 31. “Frivolous,” as used in this Chapter, means a grievance that is devoid of merit. Grievances are presumed not to be frivolous unless the program director has good reason to believe that the grievance:
  - a. Involves conduct that is not within the scope of this Chapter,
  - b. Is impossible on its face, or
  - e. Is substantially similar to conduct alleged in two previous grievances within the past year that have been determined to be unsubstantiated as provided in this Chapter.
- 32. “Generic services” means services other than behavioral health services or community services for which clients may have a need and ~~includes~~ include, but ~~are~~ is not limited to, health, dental, vision care, housing arrangements, social organizations, recreational facilities, jobs, and educational institutions.
- 33. “Grievance” means a complaint regarding an act, omission or condition, as provided in this Chapter.
- 34. “Guardian” means an individual appointed by court order according to A.R.S. Title 14, Chapter 5, or similar proceedings in another state or jurisdiction where said guardianship has been properly domesticated under Arizona law.
- 35. “Hearing officer” refers to an impartial person designated by the director to hear a dispute and render a written decision.
- 36. “Human rights advocate” means the human rights advocates appointed by the director under R9-21-105.
- 37. “Human rights committee” means the human rights committee established under ~~R9-21-106~~ A.R.S. § 41-3803 by the Department.
- 38. “Illegal” means, within the context of the grievance and investigation procedure set forth in Article 4 of this Chapter, an incident or occurrence which is or was likely to constitute a violation of a state or federal statute, regulation, court decision or other law, including the provisions of these Articles.
- 39. “Individual service plan” or “ISP” means the written plan for services to a client, prepared in accordance with Article 3 of this Chapter.
- 40. “Inhumane” as used in Article 4 of this Chapter means an incident, condition or occurrence that is demeaning to a client, or which is inconsistent with the proper regard for the right of the client to humane treatment.
- 41. “Inpatient facility” means the Arizona State Hospital, the County Annex, or any other inpatient treatment facility ~~licensed-registered with~~ licensed and funded by or through the ~~Department Administration~~ Department Administration to provide behavioral health services, including psychiatric health facilities, ~~licensed~~ licensed psychiatric hospitals, ~~licensed and~~ licensed and psychiatric units in general hospitals, ~~and licensed inpatient or behavioral health facilities in jails.~~
- 42. “Inpatient treatment and discharge plan” or “ITDP” means the written plan for services to a client prepared and implemented by an inpatient facility in accordance with Article 3 of this Chapter.
- 43. “Long-term view” means a planning statement that identifies, from the client’s perspective, what the client would like to be doing for work, education, and leisure and where the client would like to be living for up to a three-year



- period. The long-term view is based on the client's unique interests, strengths, and personal desires. It includes predicted times for achievement.
44. "Mechanical restraint" means any, device, article, or garment attached or adjacent to a client's body that the client cannot easily remove and that restricts the client's freedom of movement or normal access to the client's body, but does not include a device, article, or garment:
- a. Used for orthopedic or surgical reasons, or
  - b. Necessary to allow a client to heal from a medical condition or to participate in a treatment program for a medical condition.
45. "Medical practitioner" means a:
- a. Physician, ~~licensed according to A.R.S. Title 32, Chapter 13 or 17;~~
  - b. Physician assistant, ~~licensed according to A.R.S. Title 32, Chapter 25;~~ or
  - e. Nurse practitioner, ~~licensed according to A.R.S. Title 32, Chapter 15.~~
46. "Meeting" means an encounter or assembly of individuals which may be conducted in person or by telephone or by video-conferencing.
47. "Mental health agency" includes a regional authority, service provider, inpatient facility, ~~or an agency licensed an entity that conducts to conduct screening, and evaluation and treatment under this Chapter Article 5.~~
48. "Nurse" means an individual licensed as a registered nurse or a practical nurse according to A.R.S. Title 32, Chapter 15.
49. "Party" or "parties" as used in Articles 3 and 4 of these rules means the person filing a grievance under this Chapter, the agency director who issued any final resolution or decision of such a grievance, the person whose conduct is complained of in the grievance, any client or applicant who is the subject of the request or grievance, the legal guardian of client or applicant, and, in selected cases, the appropriate human rights committee.
50. "Personal restraint" means the application of physical force without the use of any device, for the purpose of restricting the free movement of a client's body, but for a behavioral health agency licensed as a level 1 RTC or a Level I sub-acute agency ~~according to A.A.C. R9-20-102~~ does not include:
- a. Holding a client for no longer than five minutes, without undue force, in order to calm or comfort the client; or
  - b. Holding a client's hand to escort the client from one area to another.
51. "PRN order" or "Pro re ~~ata nata~~ medication" means medication given as needed.
52. "Program director" means the person with the day-to-day responsibility for the operation of a programmatic component of a service provider, such as a specific residential, vocational, or case management program.
53. "Qualified clinician" means a behavioral health professional who is licensed or certified under A.R.S. Title 32, or a behavioral health technician who is supervised by a licensed or certified behavioral health professional.
54. "Region" means the geographical region designated by the ~~Department Administration~~ in its contract with the regional authority.
55. "Regional authority" means the ~~regional behavioral health authority~~ Regional Behavioral Health Authority (RBHA) under contract with the ~~Department Administration~~ to organize and administer the delivery of behavioral health services or community services to clients and enrolled children within a defined geographic area.
56. "Restraint" means personal restraint, mechanical restraint, or drug used as a restraint.
57. "Seclusion" means restricting a client to a room or area through the use of locked doors or any other device or method which precludes a client from freely exiting the room or area or which a client reasonably believes precludes his unrestricted exit. In the case of an inpatient facility, confining a client to the facility, the grounds of the facility, or a ward of the facility does not constitute seclusion. In the case of a community residence, restricting a client to the residential site, according to specific provisions of an individual service plan or court order, does not constitute seclusion.
58. "Seriously mentally ill" means a person 18 years of age or older who is either seriously mentally ill or chronically mentally ill as those terms are defined in A.R.S. § 36-550.
59. "Service provider" means an agency, inpatient facility or other mental health provider funded by or through, under contract or subcontract with, ~~licensed by,~~ certified by, approved by, registered with, or supervised by, the ~~Department, Administration~~ or receiving funds under Title XIX, to provide behavioral health services or community services.
60. "State Protection and Advocacy System" means the agency designated as the Protection and Advocacy System for individuals with mental illness, according to ~~42 U.S.C. 10801-51~~ 42 U.S.C. 10801-10851.
61. "Title XIX" means Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq.
62. "Treatment team" means the multidisciplinary team of persons who are responsible for providing continuous treatment and support to a client who is a current resident of an inpatient facility.

#### **R9-21-102. Applicability**

With regard to the provision of behavioral health services or community services to clients under A.R.S. Title 36 Chapter 5, this Chapter shall apply to the ~~Department Administration~~ and to all mental health agencies, ~~funded by or through, under contract or subcontract with, licensed by, certified by, approved by, registered with, or supervised by the Department or receiving funds under Title XIX, to provide behavioral health services or community services.~~ This Chapter shall not apply



to the Arizona Department of Corrections.

**R9-21-103. Computation of Time**

For any period of time prescribed or allowed by this Chapter, the time shall be calculated as follows:

1. The period of time shall not include the day of the act, event or default from which the designated period of time begins to run;
2. ~~If the period of time is designated as calendar days, the period of time shall include each day after the day of the act, event or default from which the designated period of time begins to run;~~
3. ~~If the period of time is not designated as calendar days:~~
  - a. If the period of time prescribed or allowed is less than 11 days, the period of time shall not include intermediate Saturdays, Sundays and legal holidays;
3. ~~b. If the period of time is 11 days or more, the period of time shall include intermediate Saturdays, Sundays and legal holidays;~~
  - e. ~~If the last day of the period of time is not a Saturday, Sunday, or legal holiday, the period of time shall include the last day of the period of time; and~~
4. ~~d. If the last day of the period of time is a Saturday, Sunday, or legal holiday, the period of time shall extend until the end of the next day that is not a Saturday, Sunday or legal holiday.~~

**R9-21-104. Office of Human Rights; Human Rights Advocates**

- A. ~~The director shall establish an An~~ Office of Human Rights ~~shall be established for clients within the Department Administration.~~ The office shall have its own chief officer ~~appointed by the director. The chief officer shall report directly to the director and~~ who shall be responsible for the management and control of the office, as well as the hiring, training, supervision, and coordination of ~~all Department~~ human rights advocates.
- B. No change
- C. The human rights advocates shall be given access to all:
  1. Clients; and
  2. Client records from a service provider, regional authority, or the ~~Department Administration~~, except as prohibited by federal or state law.
- D. No change
- E. No change
- F. No change
- G. No change

**R9-21-105. Human Rights Committees**

- A. According to A.R.S. §§ 41-3803 and 41-3804, the ~~Department Administration~~ shall establish human rights committees to provide independent oversight to ensure that the rights of clients and enrolled children are protected. The ~~Department Administration~~ shall establish at least one human rights committee for each region and the Arizona State Hospital. Upon the establishment of a human rights committee, if more than 2,500 clients reside within a region, the ~~Department Administration~~ shall establish additional human rights committees until there is one human rights committee for each 2,500 clients in a region.
- B. No change
- C. The ~~director Administration~~ shall appoint the initial members to each regional committee and the human rights committee for the Arizona State Hospital. ~~The Director shall appoint members~~ Members shall be appointed to fill vacancies on a human rights committee, subject to the approval of the committee.
- D. Each committee shall meet at least four times each year. Within three months of its formation, each committee shall establish written guidelines governing the committee’s operations. These guidelines shall be consistent with A.R.S. §§ 41-3803 and 41-3804. The adoption and amendment of the committee’s guidelines shall be by a majority vote of the committee and shall be submitted to the ~~Director Administration~~ for approval.
- E. No employee of or individual under contract with the ~~Department Administration~~, regional authority, or service provider may be a voting member of a committee.
- F. No change
- G. No change
- H. No change
- I. A committee may request the services of a consultant or staff person to advise the committee on specific issues. The cost of the consultant or staff person shall be assumed by the ~~Department Administration~~ or regional authority subject to the availability of funds specifically allocated for that purpose. A consultant or staff person may, in the sole discretion of the committee, be a member of another committee or an employee of the ~~Department Administration~~, regional authority, or service provider. No committee consultant or staff person shall vote or otherwise direct the committee’s decisions.
- J. Committee members and committee consultants and staff persons shall have access to client records according to A.R.S. §§ ~~36-509(13)~~ 36-509(A)(11) and 41-3804(I). If a human rights committee’s request for information or records is denied, the committee may request a review of the decision to deny the request according to A.R.S. § 41-3804(J). Nothing in this rule shall be construed to require the disclosure of records or information to the extent that such information is protected by A.R.S. § 36-445 et seq.
- K. On the first day of the months of January, April, July, and October of each year, each committee shall issue a quarterly report summarizing its activities for the prior quarter, including any written objections to the ~~Director Administration~~ according to A.R.S. § 41-3804(F), and make any recommendations for changes it believes the ~~Department Administra-~~



tion or regional authorities should implement. In addition, the committee may, as it deems appropriate, issue reports on specific problems or violations of client's rights. The report of a regional committee shall be delivered to the regional authority and the ~~Division~~ Administration.

- L. The ~~Department~~ Administration shall provide training and support to human rights committees.
- M. No change
- N. No change
- O. No change

#### **R9-21-106. State Protection and Advocacy System**

Staff of mental health agencies shall cooperate with the State Protection and Advocacy System in its investigations and advocacy for clients and shall provide the System access to clients, records and facilities to the extent permitted and required by federal law, ~~42 U.S.C.A. 10801-51~~ 42 U.S.C. 10801-10851. Nothing in this rule shall be construed to create an independent cause of action that does not already exist for the State Protection and Advocacy System either in state court or any administrative proceeding provided by these rules.

### **ARTICLE 2. RIGHTS OF PERSONS WITH SERIOUS MENTAL ILLNESS**

#### **R9-21-201. Civil and Other Legal Rights**

- A. Clients shall have all rights accorded by applicable law, including but not limited to those prescribed in A.R.S. §§ 36-504 through ~~36-514~~ 36-517.02 and in ~~9 A.A.C. 20~~. Any individual or agency providing behavioral health services or community services as defined in R9-21-101 shall not abridge these rights, including the following:
1. Those civil rights set forth in A.R.S. § 36-506;
  2. The right to acquire and dispose of property, to execute instruments, to enter into contractual relationships, to hold professional or occupational or vehicle operator's licenses, unless the ~~Client~~ client has been adjudicated incompetent or there has been a judicial order or finding that such client is unable to exercise the specific right or category of rights. In the case of a client adjudicated incompetent, these rights may be exercised by the client's guardian, in accordance with applicable law;
  3. The right to be free from unlawful discrimination by the ~~Department~~ Administration or by any mental health agency on the basis of race, creed, religion, sex, sexual preference, age, physical or mental handicap or degree of handicap; provided, however, classifications based on age, sex, category or degree of handicap shall not be considered discriminatory, if based on written criteria of client selection developed by a mental health agency and approved by the ~~Department~~ Administration as necessary to the safe operation of the mental health agency and in the best interests of the clients involved;
  4. The right to equal access to all existing behavioral health services, community services, and generic services provided by or through the state of Arizona;
  5. The right to religious freedom and practice, without compulsion and according to the preference of the client;
  6. The right to vote, unless under guardianship, including reasonable assistance when desired in registering and voting in a nonpartisan and noncoercive manner;
  7. The right to communicate including:
    - a. The right to have reasonable access to a telephone and reasonable opportunities to make and receive confidential calls and to have assistance when desired and necessary to implement this right;
    - b. The unrestricted right to send and receive uncensored and unopened mail, to be provided with stationery and postage in reasonable amounts, and to receive assistance when desired and necessary to implement this right;
  8. The right to be visited and visit with others, provided that reasonable restrictions may be placed on the time and place of the visit but only to protect the privacy of other clients or to avoid serious disruptions in the normal functioning of the mental health agency;
  9. The right to associate with anyone of the client's choosing, to form associations, and to discuss as a group, with those responsible for the program, matters of general interest to the client, provided that these do not result in serious disruptions in the normal functioning of the mental health agency. Clients shall receive cooperation from the mental health agency if they desire to publicize and hold meetings and clients shall be entitled to invite visitors to attend and participate in such meetings, provided that they do not result in serious disruptions in the normal functioning of the mental health agency;
  10. The right to privacy, including the right not to be fingerprinted and photographed without authorization, except as provided by A.R.S. § 36-507(2);
  11. The right to be informed, in appropriate language and terms, of client rights;
  12. The right to assert grievances with respect to infringement of these rights, including the right to have such grievances considered in a fair, timely, and impartial procedure, as set forth in Article 4 of these rules, and the right not to be retaliated against for filing a grievance;
  13. The right of access to a human rights advocate in order to understand, exercise, and protect a client's rights;
  14. The right to be assisted by an attorney or designated representative of the client's own choice, including the right to meet in a private area at the program or facility with an attorney or designated representative. Nothing in this ~~Section~~ Chapter shall be construed to require the ~~Department~~ Administration or any mental health agency to pay for the services of an attorney who consults with or represents a client;



- 15. The right to exercise all other rights, entitlements, privileges, immunities provided by law, and specifically those rights of consumers of behavioral health services or community services set forth in A.R.S. §§ 36-504 through ~~514~~ 36-517.02;
- 16. The same civil rights as all other citizens of Arizona, including the right to marry and to obtain a divorce, to have a family, and to live in the community of their choice without constraints upon their independence, except those constraints to which all citizens are subject.

B. No change

**R9-21-203. Protection from Abuse, Neglect, Exploitation, and Mistreatment**

A. No mental health agency shall mistreat a client or permit the mistreatment of a client by staff subject to its direction. Mistreatment includes any intentional, reckless or negligent action or omission which exposes a client to a serious risk of physical or emotional harm. Mistreatment includes but is not limited to:

- 1. Abuse, neglect, or exploitation;
- 2. Corporal punishment;
- 3. Any other unreasonable use or degree of force or threat of force not necessary to protect the client or another person from bodily harm;
- 4. Infliction of mental or verbal abuse, such as screaming, ridicule, or name calling;
- 5. Incitement or encouragement of clients or others to mistreat a client;
- 6. Transfer or the threat of transfer of a client for punitive reasons;
- 7. Restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- 8. Any act in retaliation against a client for reporting any violation of the provisions of this Chapter to the ~~Department~~ Administration; or
- 9. Commercial exploitation.

B. The following special sanctions shall be available to the Department and/or the Administration, in addition to those set forth in 9 A.A.C. 10, Article 10 of ~~its~~ the Department's rules, to protect the interests of the client involved as well as other current and former clients of the mental health agency.

- 1. Mistreatment of a client by staff or persons subject to the direction of a mental health agency may be grounds for suspension or revocation of the license of the mental health agency or the provision of ~~Departmental~~ financial assistance, and, with respect to employees of the ~~Department~~ mental health agency, grounds for disciplinary action, which may include dismissal.
- 2. Failure of an employee of the ~~Department~~ Administration to report to the ~~Department~~ any instance of mistreatment within any mental health agency subject to this Chapter shall be grounds for disciplinary action, which may include dismissal.
- 3. Failure of ~~an agency director~~ a mental health agency to report client deaths and allegations of sexual and physical abuse to the ~~Department~~ Administration and to comply with the procedures described in Article 4 of this Chapter for the processing and investigation of grievances and reports shall be grounds for suspension of the license of the mental health agency or the provision of ~~Departmental~~ financial assistance, and, with respect to a service provider directly operated by the Department, grounds for disciplinary action, which may include dismissal.
- 4. ~~The agency director~~ A mental health agency shall report all allegations of mistreatment and denial of rights to the Office of Human Rights and the regional authority for review and monitoring in accordance with R9-21-105.

C. ~~An agency director~~ A mental health agency shall report all incidents of abuse, neglect, or exploitation to the appropriate authorities as required by A.R.S. § 46-454 and shall document all such reports in the mental health agency's records.

D. ~~Where an agency director~~ If a mental health agency has reasonable cause to believe that a felony relevant to the functioning of the program has been committed by staff persons subject to the agency's direction, a report shall be filed with the county attorney.

E. The identity of persons making reports of abuse, neglect, exploitation, or mistreatment shall not be disclosed by the ~~agency director~~ mental health agency or by the ~~Department~~ Administration, except as necessary to investigate the subject matter of the report.

**R9-21-204. Restraint and Seclusion**

A. A mental health agency shall only use restraint or seclusion to the extent permitted by and in compliance with this Chapter, ~~9 A.A.C. 20~~, and other applicable federal or state law.

B. No change

C. No change

D. A service provider shall at all times have staff qualified ~~according to 9 A.A.C. 20~~ on duty to provide:

- 1. Restraint and seclusion according to this Section, and
- 2. The behavioral health services the mental health agency is authorized to provide ~~according to 9 A.A.C. 20~~.

E. No change

F. No change

G. A mental health agency shall only use restraint or seclusion according to:

- 1. A written order given:
  - a. By a physician providing treatment to a client; or
  - b. If a physician providing treatment to a client is not present on the premises or on-call:





- 7. The specific and measurable criteria for client release from mechanical restraint or seclusion with documentation to support that the client was notified of the release criteria and the client’s response;
- 8. The date and times the restraint or seclusion actually began and ended;
- 9. The time and results of the face-to-face assessment required in subsection (L);
- 10. For the monitoring of a client in restraint or seclusion required by subsection (P):
  - a. The time of the monitoring,
  - b. The name of the staff member who conducted the monitoring, and
  - c. The observations made by the staff member during the monitoring; and
- 11. The outcome of the restraint or seclusion.
- N. No change
- O. No change
- P. No change
- Q. No change
- R. No change
- S. No change
- T. No change
- U. No change
- V. Not later than the tenth day of every month, the program director shall prepare and file with the ~~Division Administration~~ and the Office of Human Rights a written report describing the use of any form of restraint or seclusion during the preceding month in the mental health agency or by any employees of the agency. In the case of an inpatient facility, the report shall also be filed with any patient or human rights committee for that facility.
- W. The ~~Department’s human rights committee,~~ the Office of Human Rights, and any applicable ~~regional~~ human rights committee shall review such reports to determine if there has been any inappropriate or unlawful use of restraint or seclusion and to determine if restraint or seclusion may be used in a more effective or appropriate fashion.
- X. If any human rights committee or the Office of Human Rights determines that restraint or seclusion has been used in violation of any applicable law or rule, the committee or Office may take whatever action is appropriate, including investigating the matter itself or referring the matter to the ~~Division Administration~~ for remedial action.

**R9-21-206. Competency and Consent**

- A. No change
- B. No change
- C. Only an applicant or client who is competent may provide informed consent, authorization, or permission as required in this Chapter. A mental health agency shall use the following criteria to determine if an applicant or client is competent and the appropriateness of establishing or removing a guardianship, temporary guardianship, conservatorship, or guardianship ad litem for the client:
  - 1. An applicant or client shall be determined to be in need of guardianship or conservatorship only if the applicant’s or client’s ability to make important decisions concerning the applicant or client or the applicant’s or client’s property is so limited that the absence of a person with legal authority to make such decisions for the applicant or client creates a serious risk to the applicant’s or client’s health, welfare or safety.
  - 2. Although the capability of the applicant or client to make important decisions is the central factor in determining the need for guardianship, the capabilities of the applicant’s or client’s family, the applicant’s or client’s living circumstances, the probability that available treatment will improve the applicant’s or client’s ability to make decisions on the applicant’s or client’s behalf, and the availability and utility of nonjudicial alternatives to guardianships such as trusts, representative payees, citizen advocacy programs, or community support services should also be considered.
  - 3. If the applicant or client has been determined to be incapable of making important decisions with regard to the applicant’s or client’s personal or financial affairs, and if nonjudicial, less restrictive alternatives such as trusts, representative payees, cosignatory bank accounts, and citizen advocates are inadequate to protect the applicant or client from a substantial and unreasonable risk to the applicant’s or client’s health, safety, welfare, or property, the applicant’s or client’s nearest living relatives shall be notified with an accompanying recommendation that a guardian or conservator be appointed.
  - 4. If the applicant or client is capable of making important decisions concerning the applicant’s or client’s health, welfare, and property, either independently or through other less restrictive alternatives such as trusts, representative payees, cosignatory bank accounts, and citizen advocates, the applicant’s or client’s nearest living relative shall be notified with an accompanying recommendation that any existing guardian or conservator be removed.
  - 5. If the client has been determined to require or no longer require assistance in the management of financial or personal affairs, and the nearest living relative cannot be found or is incapable of or not interested in caring for the client’s interest, the mental health agency shall assist in the recruitment or removal of a trustee, representative payee, advocate, conservator, or guardian. Nothing in this ~~Section Chapter~~ shall be construed to require the ~~Department Administration~~ or any regional authority or service provider to pay for the recruitment, appointment or removal of a trustee, representative payee, advocate, conservator, or guardian.
  - 6. The assessment or periodic review shall identify the specific area or areas of the client’s functioning that forms the basis of the recommendation for the appointment or removal of a guardian or conservator, such as an inability to



respond appropriately to health problems or consent to medical care, or an inability to manage savings or routine expenses.

**D.** No change

**R9-21-206.01. Informed Consent**

**A.** Except in an emergency according to A.R.S. §§ 36-512 or 36-513 or R9-21-204, or a court order according to A.R.S. Title 36, Chapter 5, Articles 4 and 5, a mental health agency shall obtain written informed consent in at least the following circumstances:

1. Before providing a client a treatment with known risks or side effects, including:
  - a. Psychotropic medication,
  - b. Electro-convulsive therapy, or
  - c. Telemedicine;
2. Before ~~having~~ a client ~~participate~~ participates in research activities ~~approved under Department rules or policy~~; and
3. Before admitting a client to any medical detoxification, inpatient facility, or residential program operated by a mental health agency.

**B.** The informed consent in subsection (A) shall be voluntary and shall be obtained ~~from~~:

1. If the client is determined to be competent according to R9-21-206, the client; or
2. If a court of competent jurisdiction has adjudicated the client incompetent, the client's guardian.

**C.** No change

**D.** No change

**E.** No change

**F.** No change

**G.** No change

**H.** No change

**R9-21-208. Property and Possessions**

**A.** No change

**B.** If a mental health agency, which offers assistance to its clients in managing their funds, takes possession or control of a client's funds at the request of the client, guardian, or by court order, the mental health agency shall issue a receipt to the client or guardian for each transaction involving such funds. If deposited funds in excess of \$250 are held by the mental health agency, where the likelihood of the client's stay will exceed 30 days, an individual bank account or an amalgamated client trust account shall be maintained for the benefit of the client. All interest shall become the property of the client or the fair allocation of the interest in the case of an amalgamated client trust account. The mental health agency shall provide a bond to cover client funds held.

1. Unless a guardian, conservator, or representative payee has been appointed, the client shall have an unrestricted right to manage and spend deposited funds.
2. The mental health agency shall obtain prior written permission from the client, the guardian or conservator for any arrangement involving shared or delegated management responsibilities. The permission shall set forth the terms and conditions of the arrangement.
3. Where the mental health agency has shared or delegated management responsibilities, the mental health agency shall meet the following requirements:
  - a. Client funds shall not be applied to goods or services which the mental health agency is obligated by law or funded by contract to provide, except as permitted by ~~the a~~ client fee schedule authorized by the ~~Department Administration~~;
  - b. The mental health agency and its staff shall have no direct or indirect ownership or survivorship interest in the funds;
  - c. Such arrangements shall be accompanied by a training program, documented in the ISP, to eliminate the need for such assistance;
  - d. Staff shall not participate in arrangements for shared or delegated management of the client's funds except as representatives of the mental health agency;
  - e. Any arrangements made to transfer a client from one mental health agency to another shall include provisions for transferring shared or delegated management responsibilities to the receiving mental health agency;
  - f. The client shall be informed of all proposed expenditures and any expression of preference within reason shall be honored; and
  - g. Expenditures shall be made only for purposes which directly benefit the client in accordance with the client's interests and desires.
4. A record shall be kept of every transaction involving deposited funds, including the date and amount received or disbursed, and the name of the person to or from whom the funds are received or disbursed. The client, guardian, conservator, mental health agency or regional human rights advocate or other representative may demand an accounting at any reasonable time, including at the time of the client's transfer, discharge or death.
5. Any funds so deposited shall be treated for the purpose of collecting charges for care the same as any other property held by or on behalf of the client. The client or guardian shall be informed of any possible charges before the onset of services.



**R9-21-209. Records**

- A. No change
- B. No change
- C. Inspection by specially authorized persons or entities shall be permitted as follows unless otherwise prohibited by federal or state law:
  1. Records of a client may be available to those individuals and agencies listed in A.R.S. § 36-509.
  2. Records of a client shall be open to inspection upon proper judicial order, whether or not such order is made in connection with pending judicial proceedings.
  3. Records of a client shall be made available to a physician who requests such records in the treatment of a medical emergency, provided that the client is given notice of such access as soon as possible.
  4. Records of a client shall be made available to ~~Division~~ staff authorized by the ~~Department~~ Administration to monitor the quality of services being provided by the mental health agency to the client.
  5. Records of a client shall be made available to guardians and family members actively participating in the client’s care, treatment or supervision as provided by A.R.S. §§ 36-504, 36-509(A)(8) and (B). Except when inspection of a client’s record is required under a proper judicial order or by a physician in a medical emergency, a client, guardian or family member may challenge the decision to allow or deny inspection of the record by filing a request for administrative and judicial review in accordance with the provisions of A.R.S. § 36-517.01 or other applicable federal or state law. Once a request is filed, no further disclosure of records shall be made until the review has been completed.
- D. No change
- E. No change
- F. No change
- G. No change
- H. No change

**Exhibit A. Notice of Legal Rights for Persons with Serious Mental Illness**

If you have a serious or chronic mental illness, you have legal rights under federal and state law. Some of these rights include:

- The right to appropriate mental health services based on your individual needs;
- The right to participate in all phases of your mental health treatment, including individual service plan (ISP) meetings;
- The right to a discharge plan upon discharge from a hospital;
- The right to consent to or refuse treatment (except in an emergency or by court order);
- The right to treatment in the least restrictive setting;
- The right to freedom from unnecessary seclusion or restraint;
- The right not to be physically, sexually, or verbally abused;
- The right to privacy (mail, visits, telephone conversations);
- The right to file an appeal or grievance when you disagree with the services you receive or your rights are violated;
- The right to choose a designated representative(s) to assist you in ISP meetings and in filing grievances;
- The right to a case manager to work with you in obtaining the services you need;
- The right to a written ISP that sets forth the services you will receive;
- The right to associate with others;
- The right to confidentiality of your psychiatric records;
- The right to obtain copies of your own psychiatric records (unless it would not be in your best interests to have them);
- The right to appeal a court-ordered involuntary commitment and to consult with an attorney and to request judicial review of court-ordered commitment every 60 days;
- The right not to be discriminated against in employment or housing.

If you would like information about your rights, you may request a copy of the “Your Rights in Arizona as an Individual with Serious Mental Illness” brochure or you may also call the ~~Arizona Department of Health Services~~ Administration, Office of Human Rights at 1-800-421-2124.

ADHS/BHS Form MH-211 (9/93)

**ARTICLE 3. INDIVIDUAL SERVICE PLANNING FOR BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS**

**R9-21-301. General Provisions**

- A. Responsibilities of the regional authority, clinical team, and case manager.
  1. The regional authority is responsible for providing, purchasing, or arranging for all services identified in individual service plans.
    - a. The regional authority shall perform all intake and case management for its region. The regional authority may contract with a mental health agency to perform intake or case management but only with the written approval of the ~~Department~~, Administration, which may be given in its sole discretion.
    - b. Other services may be provided directly by programs operated by the ~~Department~~ Administration or by the regional authority through contracts with service providers ~~that are licensed or approved by the Department~~, or through arrangements with other agencies or generic providers.



2. The regional authority and the clinical team shall work diligently to ensure equal access to generic services for its clients in order to integrate the client into the mainstream of society.
  3. The initial clinical team shall work to meet the individual's needs from the date of application or referral for services until such time as eligibility is established and an Individual Service Plan (ISP) is developed.
  4. The assigned clinical team shall be primarily responsible for providing continuous treatment, outreach and support to a client, for identifying appropriate behavioral health services or community services, and for developing, implementing and monitoring individual service plans for clients.
  5. The case manager, in conjunction with the clinical team, shall:
    - a. Locate services identified in the ISP;
    - b. Confirm the selection of service providers and include the names of such providers in the ISP;
    - c. Obtain a written client service agreement from each provider;
    - d. Be responsible for ensuring that services are actually delivered in accordance with the ISP; and
    - e. Monitor the delivery of services rendered to clients. Monitoring shall consider, at a minimum, the consistency of the services with the goals and objectives of the ISP.
  6. The case manager shall also be responsible to:
    - a. Initiate and maintain close contact with clients and service providers;
    - b. Provide support and assistance to a client, with the client's permission and consistent with the client's individual needs;
    - c. Ensure that each service provider participates in the development of the ISP for each client of the service provider;
    - d. Ensure that each inpatient facility, according to R9-21-312, develops an Inpatient Treatment and Discharge Plan (ITDP) that is integrated in and consistent with the ISP;
    - e. Assess progress toward, and identify impediments to, the achievement of the client's goals and objectives identified in the ISP;
    - f. Promote client involvement in the development, review, and implementation of the ISP;
    - g. Attempt to resolve problems and disagreements with respect to any component of the ISP;
    - h. Assist in resolving emergencies concerning the implementation of the ISP;
    - i. Attend all periodic reviews of the ISP and ITDP meetings;
    - j. Assist in the exploration of less restrictive alternatives to hospitalization or involuntary commitment; and
    - k. Otherwise coordinate services provided to the client.
  7. If a case manager is assigned to a client who, at any time, is admitted to an inpatient facility, the case manager shall ensure the development, modification or revision of a client's ISP and the integration of the ITDP according to this Article.
    - a. The inpatient facility clinician responsible for coordinating the ITDP shall immediately notify the client's case manager of the time of the admission and ensure that all treatment and discharge planning includes the case manager.
    - b. The case manager shall be provided notice of all treatment and discharge meetings, shall participate as a full member of the inpatient facility treatment team in such meetings, shall receive periodic and other reports concerning the client's treatment, and shall be responsible for identifying and securing appropriate community services to facilitate the client's discharge.
    - c. If no case manager has been assigned, the inpatient facility clinician primarily responsible for the client's inpatient care shall, within three days of admission, make a referral to the appropriate regional authority for the appointment of a case manager.
    - d. Delays in the assignment of a case manager or in the development or modification of an ISP or ITDP shall not be construed to prevent the clinically appropriate discharge of a client from an inpatient facility.
    - e. Inpatient facilities shall establish a mechanism for the credentialing of case managers and other members of the clinical team in order that they may participate in ITDP meetings.
- B.** No change  
**C.** No change  
**D.** Notices to the individual.
1. Any individual or mental health agency required to give notice to an individual of any documents, including eligibility determinations, assessment reports, ISPs, and ITDPs according to this rule shall do so by:
    - a. Providing a copy of the document to the individual;
    - b. Providing copies to any designated representative and guardian;
    - c. Personally explaining to the individual and designated representative and/or guardian any right to accept, reject, or appeal the contents of the document and the procedures for doing so under this Article.
  2. Individuals requesting or receiving behavioral health services or community services shall be informed:
    - a. Of the right to request an assessment;
    - b. Of the right to have a designated representative assist the client at any stage of the service planning process;



- c. Of the right to participate in the development of any plan prepared under this Article, including the right to attend all planning meetings;
- d. Of the right to appeal any portion of any assessment, plan, or modification to an assessment or plan, according to R9-21-401;
- e. Of the ~~authority of the Department Administration's authority~~ to require necessary and relevant information about the individual's needs, income, and resources;
- f. Of the availability of assistance from the regional authority in obtaining information necessary to determine the need for behavioral health services or community services;
- g. Of the ~~authority of the Department Administration's or mental health agency's or mental health agency~~ authority to charge for services and assessments; and
- h. That if the individual declines the services of a case manager or an ISP, the individual has the right to apply for services at a subsequent time;
- i. That if the individual declines any particular service or treatment modality, it will not jeopardize other accepted services.

- E. No change
- F. No change

**R9-21-303. Eligibility Determination and Initial Assessment**

- A. No change
- B. No change
- C. The qualified clinician in subsection (B) shall obtain information necessary to make an eligibility determination, including:
  - 1. Identifying data and residence, including a social security number if available;
  - 2. The reasons for the request or referral for services;
  - 3. The individual's psychiatric diagnosis;
  - 4. The individual's present level of functioning, based upon the criteria set forth in the definition of "seriously mentally ill" in R9-21-101;
  - 5. The individual's history of mental health treatment;
  - 6. The individual's abilities, needs, and preferences for services; and
  - 7. A preliminary determination as to the individual's need for special assistance ~~as defined by R9-21-101(B)(13)~~.

- D. No change
- E. To be eligible for behavioral health services or community services according to this Chapter the individual must be:
  - 1. A resident of the state of Arizona, and
  - 2. Seriously mentally ill ~~as defined in R9-21-101~~.

- F. No change
- G. No change
- H. No change

**R9-21-307. The Individual Service Plan**

- A. General provisions.
  - 1. An individual service plan (ISP) shall be developed by the clinical team and each client.
  - 2. The ISP shall include the most appropriate and least restrictive services, consistent with the client's needs and preferences, as identified in the assessment conducted according to R9-21-305, and without regard to the availability of services or resources.
  - 3. The ISP shall identify those services which maximize the client's strengths, independence, and integration into the community.
  - 4. Generic services available to the general public should be utilized, to the maximum extent possible, when adequate to meet the client's needs and if access can be arranged by the case manager or client.
  - 5. If all needed services are not available, a plan for alternative services shall detail those services which are, to the maximum extent possible, adequate, appropriate, consistent with the client's needs, and least restrictive of the client's freedom.
  - 6. The clinical team shall solicit and actively encourage the participation of the client and guardian.
  - 7. The clinical team shall inform the client of the right to have a designated representative throughout the ISP process and to invite family members or other persons who could contribute to the development of the ISP. The case manager shall seek to obtain a representative for clients who need special assistance or otherwise have limited capacity to articulate their own preferences and to protect their own interests in the ISP process and shall advise the relevant human rights committee that the client has been determined to need special assistance.
  - 8. The ISP shall contain goals and objectives which are measurable and which facilitate meaningful evaluation of the progress toward attaining those goals and objectives.
  - 9. The ISP shall incorporate a specific description of the client objectives, services, and interventions for each mental health agency which will provide services to the client. Each existing service provider will bring to the ISP meeting a detailed written description of the objectives and services currently in effect for the client.



10. For residents of an inpatient facility, the facility's treatment and discharge plan shall be developed according to R9-21-312 and shall be incorporated in the ISP.
11. Prior to the planned discharge of a new client from an inpatient facility, the clinical team shall develop an ISP which describes the community services, including alternative housing and residential supports, that will be provided when the client leaves the facility.
12. The ISP shall be written in language which can be easily understood by a lay person.
13. In developing the ISP, the case manager shall facilitate resolution of differences among service providers and, if resolution is not achieved, shall refer the matter to the regional authority, which shall resolve the matter in accordance with ~~Department~~ the Administration's policy.

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

**R9-21-309. Selection of Service Providers**

- A. Within seven days of the distribution of the ISP to the service providers identified in the ISP, the case manager, after consultation with the clinical team and the provider, shall determine whether each of these providers are capable of serving the client.
  1. A contracted service provider shall not refuse to serve a client except for good cause related to the inability of the service provider to safely and professionally meet the client's needs as identified in the ISP, ~~or except for Department contractual limitations.~~
  2. If a contracted service provider believes it is incapable of meeting the client's needs or of implementing the ISP, the provider shall inform the case manager in writing within five days of receipt of the ISP. A contracted service provider shall specify the reasons for its conclusion.

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

**R9-21-310. Implementation of the Individual Service Plan**

- A. No change
- B. No change
- C. No change
- D. No change
- E. All contracts with service providers shall include:
  1. A provision that the service provider shall abide by the rules contained in this Chapter and shall not alter, terminate, or otherwise interrupt services required under the ISP except parts of the ISP that have been modified according to R9-21-314;
  2. A provision that the service provider shall cooperate with the ~~Department~~ Administration in collecting data necessary to determine if the ~~Department~~ Administration is meeting its obligations under this Chapter and A.R.S. Title 36, Chapter 5, Article 10; and
  3. A provision that the service provider agrees to maintain current client records that document progress toward achievement of ISP goals and objectives and that meet applicable requirements of law, contract, and professional standards.

**R9-21-311. Alternative Services**

- A. No change
- B. No change
- C. No change
- D. No change
- E. If the clinical team determines that a recommended service is unavailable or does not exist, it shall forward a description of that service to the director of the regional authority. The director shall:
  1. Use best efforts to locate the needed service through existing services or reallocated resources;
  2. Forward a description of the unmet service need to the ~~deputy director of the Division~~ Administration, if the appropriate service cannot be located or developed through existing services or reallocated resources; and
  3. maintain a list of unmet service needs.
- F. The ~~Division~~ Administration shall use information concerning unmet service needs to provide the appropriate service through existing services or reallocated resources or, if necessary, to plan for the development of the needed services.
- G. No change

**ARTICLE 4. APPEALS, GRIEVANCES, AND REQUESTS FOR INVESTIGATION FOR PERSONS  
WITH SERIOUS MENTAL ILLNESS**

**R9-21-401. Appeals**

- A. A client or an applicant may file an appeal concerning decisions regarding eligibility for behavioral health services, including Title XIX services, fees and waivers; assessments and further evaluations; service and treatment plans and planning decisions; and the implementation of those decisions. Appeals regarding a determination of categorical ineligi-



bility for Title XIX shall be directed to the agency that made the determination.

1. Disagreements among employees of the ~~Department Administration~~, the regional authority, clinical teams, and service providers concerning services, placement, or other issues are to be resolved using ~~Departmental~~ the Administration's guidelines, rather than this Article.
  2. The case manager shall attempt to resolve disagreements prior to utilizing this appeal procedure; however, the client's right to file an appeal shall not be interfered with by any mental health agency or the ~~Department Administration~~.
  3. The Office of Human Rights shall assist clients in resolving appeals according to R9-21-104.
  4. If a client or, if applicable, an individual on behalf of the client, files an appeal of a modification to or termination of a behavioral health service according to this Section, the client's service shall continue while the appeal is pending unless:
    - a. A qualified clinician determines that the modification or termination is necessary to avoid a serious or immediate threat to the health or safety of the client or another individual; or
    - b. The client or, if applicable, the client's guardian agrees in writing to the modification or termination.
- B.** Applicants and clients shall be informed of their right to appeal at the time an application for services is made, when an eligibility determination is made, when a decision regarding fees or the waiver of fees is made, upon receipt of the assessment report, during the ISP, ITDP, and review meetings, at the time an ISP, ITDP, and any modification to the ISP or ITDP is distributed, when any service is suspended or terminated, and at any other time provided by this Chapter. The notice shall be in writing in English and Spanish and shall include:
1. The client's right to appeal and to an administrative hearing according to A.R.S. § 41-1092.03;
  2. The method by which an appeal and an administrative hearing may be obtained;
  3. That the client may represent himself or use legal counsel or other appropriate representative;
  4. The services available to assist the client from the Office of Human Rights, Human Rights Committees, State Protection and Advocacy System, and other peer support and advocacy services;
  5. What action the mental health agency or ~~Department~~ regional authority intends to take;
  6. The reasons for the intended action;
  7. The specific rules or laws that support such action; and
  8. An explanation of the circumstances under which services will continue if an appeal or an administrative hearing is requested.
- C.** The right to appeal in this Section does not include the right to appeal a court order entered according to A.R.S. Title 36, Chapter 5, Articles 4 and 5. The following issues may be appealed:
1. Decisions regarding the individual's eligibility for behavioral health services;
  2. The sufficiency or appropriateness of the assessment or any further evaluation;
  3. The long-term view, service goals, objectives, or timelines stated in the ISP or ITDP;
  4. The recommended services identified in the assessment report, ISP, or ITDP;
  5. The actual services to be provided, as described in the ISP, plan for interim services, or ITDP;
  6. The access to or prompt provision of services provided under Title XIX;
  7. The findings of the clinical team with regard to the client's competency, capacity to make decisions, need for guardianship or other protective services, or need for special assistance;
  8. A denial of a request for a review of, the outcome of a review of, a modification to or failure to modify, or a termination of an ISP, ITDP, or portion of an ISP or ITDP;
  9. The application of the procedures and timetables as set forth in this Chapter for developing the ISP or ITDP;
  10. The implementation of the ISP or ITDP;
  11. The decision to provide service planning, including the provision of assessment or case management services, to a client who is refusing such services, or a decision not to provide such services to such a client; or
  12. Decisions regarding a client's fee assessment or the denial of a request for a waiver of fees;
  13. Denial of payment for a client; and
  14. Failure of the regional authority or the ~~Division Administration~~ to act within the time frames for appeal established in this Chapter.
- D.** Initiation of the appeal.
1. An appeal may be initiated by the client or by any of the following persons on behalf of a client or applicant requesting behavioral health services or community services:
    - a. The client's or applicant's guardian,
    - b. The client's or applicant's designated representative, or
    - c. A service provider of the client, if the client or, if applicable, the client's guardian gives permission to the service provider;
  2. An appeal is initiated by notifying the director of the regional authority or the director designee orally or in writing of the decision, report, plan or action being appealed, including a brief statement of the reasons for the appeal and the current address and telephone number, if available, of the applicant or client and designated representative.
  3. An appeal shall be initiated within 60 days of the decision, report, plan, or action being appealed. However, the director of the regional authority or the director designee shall accept a late appeal for good cause. If the regional



authority director or the director designee refuses to accept a late appeal, the director or director designee shall notify the individual or client in writing, with a statement of reasons for the decision. Within 10 days of the notification, the client or applicant may request review of that decision by the ~~deputy director of the Division Administration~~, who shall act within 15 days of receipt of the request for review. The decision of the ~~deputy director Administration~~ shall be final.

4. Within five days of receipt of an appeal, the director of the regional authority shall inform the client in writing ~~in English and Spanish~~ that the appeal has been received and of the procedures that shall be followed during the appeal.
- E. Informal conference with the regional authority.
1. Within seven days of receipt of the notice of appeal, the director of the regional authority or the director designee shall hold an informal conference with the client, any designated representative and/or guardian, the case manager and representatives of the clinical team, and a representative of the service provider, if appropriate.
    - a. The regional authority director or the director's designee shall schedule the conference at a convenient time and place and shall inform all participants in writing of the time, date, and location two days before the conference.
    - b. Individuals may participate in the conference by telephone.
  2. The director of the regional authority or the director's designee shall chair the informal conference and shall seek to mediate and resolve the issues in dispute. To the extent that resolution satisfactory to the client or guardian is not achieved, the regional authority director or director's designee shall clarify issues for further appeal and shall determine the agreement, if any, of the participants as to the material facts of the case.
  3. Except to the extent that statements of the participants are reduced to an agreed statement of facts, all statements made during the informal conference shall be considered as offers in compromise and shall be inadmissible in any subsequent hearing or court proceedings under this rule.
  4. If the informal conference with the director of the regional authority or the ~~director~~ director's designee does not resolve the issues in dispute to the satisfaction of the client or, if applicable, the client's guardian, and the issues in dispute are not related to the client's eligibility for behavioral health services, the client or, if applicable, the client's guardian shall be informed that the matter ~~shall may~~ be further appealed ~~to the Administration to the Division~~, and of the procedure for requesting a waiver of the informal conference with the ~~Division Administration~~.
  5. If a client or, if applicable, the client's guardian waives the right to an informal conference with the ~~Division Administration~~ according to subsection (E)(4) or, if the informal conference with the director of the regional authority or the director designee does not resolve the issues in dispute to the satisfaction of the client or, if applicable, the client's guardian, and the issues in dispute are related to the client's eligibility for behavioral health services, the regional authority shall, at the informal conference:
    - a. Provide written notice to the client or, if applicable, the client's guardian according to A.R.S. § 41-1092.03, and
    - b. Ask the client or, if applicable, the client's guardian whether the client or, if applicable, the client's guardian would like the regional authority to request an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client.
    - c. For a client who needs special assistance, send a copy of the notice in subsection (5)(a) to the appropriate human rights committee.
  6. If, at the informal conference, a client or, if applicable, the client's guardian requests that the regional authority file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client, the regional authority shall file the request within three days of the informal conference.
  7. If resolution satisfactory to the client or guardian is achieved, the director of the regional authority or the director designee shall issue a dated written notice to all parties which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved and the date by which the resolution will be implemented.
- F. Informal conference with the ~~Division Administration~~.
1. Within three days of the conclusion of an informal conference with the regional authority according to subsection (E)(4), the director of the regional authority or the director designee shall notify the ~~deputy director of the Division Administration~~ and shall immediately forward the client's notice of appeal, all documents relevant to the resolution of the appeal and any agreed statements of fact.
  2. Within 15 days of the notification from the regional authority director or the director designee, the ~~deputy director of the Division Administration~~ shall hold an informal conference with the client, any designated representative and/or guardian, the case manager, and representatives of the clinical team, the service provider, if appropriate, for the purpose of mediating and resolving the issues being appealed.
    - a. The ~~deputy director of the Division Administration~~ shall schedule the conference at a convenient time and place and shall inform the participants in writing of the time, date, and location five days prior to the conference.
    - b. Individuals may participate in the conference by telephone.



- c. If a client is unrepresented at the conference but needs assistance, or if for any other reason the ~~deputy director of the Division Administration~~ determines the appointment of a representative to be in the client's best interest, the ~~deputy director Administration~~ may designate a human rights advocate or other person to assist the client in the appeal.
- 3. To the extent that resolution satisfactory to the client or guardian is not achieved, the ~~deputy director Administration~~ shall clarify issues for further appeal and shall determine the agreement, if any, of the participants as to the material facts of the case.
- 4. If resolution satisfactory to the client or guardian is achieved, the ~~deputy director Administration~~ shall issue a dated written notice to all parties which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved, and the date by which the resolution will be implemented.
- 5. Except to the extent that statements of the participants are reduced to an agreed statement of facts, all statements made during the informal conference shall be considered as offers in compromise and shall be inadmissible in any subsequent hearing or court proceedings under this rule.
- 6. If all issues in dispute are not resolved to the satisfaction of the client or guardian at the informal conference with the ~~Division Administration~~, the ~~Division Administration~~ shall, at the informal conference:
  - a. Provide written notice to the client or, if applicable, the client's guardian according to A.R.S. § 41-1092.03, and
  - b. Ask the client or, if applicable, the client's guardian whether the client or, if applicable, the client's guardian would like the ~~Division Administration~~ to file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client.
  - c. For all clients including clients who needs special assistance, send a copy of the notice in subsection (6)(a) to the Office of Human Rights and the appropriate human rights committee.
- 7. If, at the informal conference, a client or, if applicable, the client's guardian requests that the ~~Division Administration~~ file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client, the ~~Division Administration~~ shall file the request within three days of the informal conference according to subsection (G).

G. The fair hearing.

- 1. Within three days of the informal conference with the ~~Division Administration~~, if the conference failed to resolve the appeal, or within five days of the date the conference was waived, the ~~deputy director of the Division Administration~~ shall ~~notify the director to forward a request to~~ schedule a fair hearing.
- 2. Within five days of the notification, the ~~director Administration~~ shall send a written notice of fair hearing to all parties, informing them of the time and place of the hearing, the name, address, and telephone number of the hearing officer, and the issues to be resolved. The notice shall also be sent to the appropriate human rights committee and the Office of Human Rights for all clients, including clients who need of special assistance.
- 3. ~~Not less than 20 nor more than 30 days from such notice, the Department shall hold a~~ A fair hearing shall be held on the appeal in a manner consistent with A.R.S. §§ 36-111 and 36-112, and 41-1061 § 41-1092 et seq. (the Administrative Procedure Act), and those portions of R9-1-101 through R9-1-126 9 A.A.C. 1 which are not inconsistent with this Article. The client or any designated representative and/or guardian may request that the hearing be scheduled in a shorter or longer time. The Department shall make reasonable efforts to accommodate such request.
- 4. During the pendency of the appeal, the client, any designated representative and/or guardian, the clinical team, and representatives of any service providers may agree to implement any part of the ISP or ITDP or other matter under appeal without prejudice to the appeal.
- 5. The hearing shall be conducted by an impartial hearing officer appointed by the Department. The hearing officer may not be an employee of the Department, a regional authority or of a service provider under contract or subcontract with the Department. The Department may contract with a qualified individual to serve as a hearing officer under this rule.
- 6-5. The client or applicant shall have the right to be represented at the hearing by a person chosen by the client or applicant at the client's or applicant's own expense, in accordance with Rule 31(a)(3), Rules of the Supreme Court.
- 7-6. The client, any designated representative and/or guardian, and the opposing party shall have the right to present any evidence relevant to the issues under appeal and to call and examine witnesses. The ~~Division Administration~~ shall have the right to appear to present legal argument.
- 8-7. The client and any designated representative and/or guardian shall have the right to examine and copy at a reasonable time prior to the hearing all records held by the ~~Department Administration~~, regional authority, or service provider pertaining to the client and the issues under appeal, including all records upon which the ISP or ITDP decisions were based.
- 9-8. Any portion of the hearing may be closed to the public if the client requests or if the hearing officer determines that it is necessary to prevent the unwarranted invasion of a client's privacy or that public disclosure would pose a substantial risk of harm to a client.
- 10. ~~Within five days of the conclusion of the hearing, the hearing officer shall prepare and send a written, proposed decision to the director of the Department, together with the appeal record. The proposed decision shall be based~~



exclusively on the evidence introduced at the hearing, shall designate these issues which relate to Title XIX services, and shall include findings of fact, conclusions, and a recommendation for appropriate action.

11. Within 15 days of the conclusion of the hearing, the director shall render a final written decision, based upon the findings, conclusions, and recommendations of the hearing officer.
  - a. The decision shall include a concise statement of the facts found, a summary of the evidence relied upon, the decision and the reasons for so deciding and a notice of the right to seek rehearing under R9-1-120 and judicial review under A.R.S. § 36-113.
  - b. The decision shall also include a notice to the parties of their right to appeal to AHCCCSA for review of decisions related to Title XIX services.
  - c. The decision shall be mailed by certified mail to the parties to the hearing, their designated representatives, and the Division.
  - d. The Department shall arrange to have the director decision explained to the client, together with the right to seek rehearing, judicial review, or appeal to AHCCCSA, in a manner that is understandable to the client or the client's designated representative.

#### H. Expedited appeal.

1. At the time an appeal is initiated, the applicant, client, or mental health agency may request orally or in writing an expedited appeal on issues related to crisis or emergency services or for good cause. Any appeal from a decision denying admission to or continued stay at an inpatient psychiatric facility due to lack of medical necessity shall be accompanied by all medical information necessary to resolution of the appeal and shall be expedited.
2. An expedited appeal shall be conducted in accordance with the provisions of this Section, except as provided for in this subsection.
3. Within one day of receipt of an expedited appeal, the director of the regional authority shall inform the client in writing in English and Spanish that the appeal has been received.
4. The director of the regional authority shall accept an expedited appeal on issues related to crisis or emergency services. The regional authority director shall also accept an expedited appeal for good cause. If the regional authority director refuses to expedite the appeal based on a determination that good cause does not exist, the director shall notify the applicant or client in writing within one day of the initiation of the appeal, with a statement of reasons for the decision, and shall proceed with the appeal in accordance with the provisions of this Section. Within three days of the notification of refusal to expedite the appeal for good cause, the client or applicant may request review of the decision by the deputy director of the Division Administration, who shall act within one day. The decision of the deputy director Administration shall be final.
5. If the regional authority director accepts the appeal for expedited consideration, the director shall hold the informal conference according to R9-21-401(E) within two days of the initiation of the appeal. The regional director regional authority shall schedule the conference at a convenient time and place and shall inform all participants of the time, date and location prior to the conference.
6. If the informal conference with the director of the regional authority or the director's designee does not resolve the issues in dispute to the satisfaction of the client or, if applicable, the client's guardian, and the issues in dispute are not related to the client's eligibility for behavioral health services, the client or, if applicable, the client's guardian shall be informed that the matter shall may be further appealed to the Division Administration, and of the procedure for requesting waiver of the informal conference with the Division Administration.
7. If a client or, if applicable, the client's guardian waives the right to an informal conference with the Division Administration or, if the informal conference with the director of the regional authority or the director's designee does not resolve the issues in dispute to the satisfaction of the client or, if applicable, the client's guardian, and the issues in dispute are related to the client's eligibility for behavioral health services, the regional authority shall, at the informal conference:
  - a. Provide written notice to the client or, if applicable, the client's guardian according to A.R.S. § 41-1092.03, and
  - b. Ask the client or, if applicable, the client's guardian whether the client or, if applicable, the client's guardian would like the regional authority to request an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client.
  - c. Send a copy of the notice in subsection (H)(7)(a) to the Office of Human Rights and the appropriate human rights committee.
8. If, at the informal conference, a client or, if applicable, the client's guardian requests that the regional authority file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client, the Division Administration shall file the request within one day of the informal conference.
9. Within one day of the conclusion of an informal conference with the regional authority, the director of the regional authority shall notify the deputy director of the Division Administration if the informal conference failed to resolve the appeal and shall immediately forward the client's notice of appeal and any agreed statements of fact unless the client or, if applicable, the client's guardian waived the client's right to an informal conference with the Division Administration or the issues in dispute are related to the client's eligibility for behavioral health services.



- 10. Within two days of the notification from the regional authority ~~director~~, the ~~deputy director of the Division Administration~~ shall hold the informal conference pursuant to subsection (F).
- 11. If all issues in dispute are not resolved to the satisfaction of the client or if applicable, the client’s guardian at the informal conference with the ~~Division Administration~~, the ~~Division Administration~~ shall, at the informal conference:
  - a. Provide written notice to the client or, if applicable, the client’s guardian according to A.R.S. § 41-1092.03, and
  - b. Ask the client or, if applicable, the client’s guardian whether the client or, if applicable, the client’s guardian would like the ~~Division Administration~~ to file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client.
  - c. For a client who needs special assistance, send a copy of the notice in subsection (H)(11)(a) to the Office of Human Rights and the appropriate human rights committee.
- 12. If, at the informal conference, a client or, if applicable, the client’s guardian requests that the ~~Division Administration~~ file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client, the ~~Division Administration~~ shall file the request within one day of the informal conference.
- 13. Within one day of the informal conference with the ~~Division Administration~~, if the conference failed to resolve the appeal, or within two days of the date the conference was waived, the ~~deputy director Administration~~ shall ~~notify the director~~ forward a request to schedule a fair hearing.
- 14. Within one day of notification, the ~~director Administration~~ shall send a written notice of an expedited fair hearing in accordance with subsection (G)(2) A.R.S. 41-1092, et seq.
- 15. ~~Within five days of such notice, the Department shall hold a~~ An expedited fair hearing ~~shall be held~~ on the appeal in accordance with ~~(G)(3) 41-1092 subsection (G)(3) and A.R.S. 41-1092, et seq.~~
- 16. ~~Within one day of the conclusion of the hearing, the hearing officer shall prepare and send a written, proposed decision to the director of the Department in accordance with (G)(10).~~
- 17. ~~Within two days of the conclusion of the hearing, the director shall render a final written decision in accordance with (G)(11). The decision of the director is the final decision of the Department on all issues and there shall be no right to a rehearing before the director.~~

**I.** Appeal of Title XIX services.

- 1. ~~Within 15 days of the decision of the director, the client may appeal the decisions relating to Title XIX services to AHCCCSA by filing a written notice of appeal with the Department. The client may request a de novo hearing or a record review with oral argument before AHCCCSA.~~
- 2. ~~An appeal to AHCCCSA does not preclude a client or individual from also seeking rehearing and judicial review subsection (J), if appropriate.~~

**J.** ~~Rehearing or review of decision. A client or applicant aggrieved by the director decision on issues not related to Title XIX services must file for rehearing within 30 days of service of the decision. The decision of the director on rehearing is the final decision of the Department on all decisions not related to Title XIX services.~~

**K.** No change

**L.** Implementation of final decision. Within five days after a satisfactory resolution is achieved at an informal conference or after the expiration of an appeal period when no appeal is taken, or after the exhaustion of all appeals and subject to the final decision thereon, ~~the director~~ the regional authority shall implement the final decision and shall notify the client, any designated representative and/or guardian, and ~~Division Administration~~ of such action.

**M.** Appeal log.

- 1. ~~The Department Administration and regional authority shall maintain a public log logs of all appeals filed under this rule Section. The director of the regional authority shall forward to the Department all information necessary for the accurate and timely maintenance of the public log.~~
- 2. ~~The log maintained by the Administration public log shall not include personally identifiable information but and shall be a public record, available for inspection and copying by any person.~~
- 3. With respect to each entry, the ~~Department’s public logs logs~~ shall contain:
  - a. A unique docket number or matter number assigned by the Department;
  - b. A substantive but concise description of the appeal including whether the appeal related to the provision of Title XIX services;
  - c. The date of the filing of appeal;
  - d. The date of the initial decision appealed from;
  - e. The date, nature and outcome of all subsequent decisions, appeals, or other relevant events; and
  - f. A substantive but concise description of the final decision and the action taken by the agency director ~~and deputy director of the Division~~ and the date the action was taken.

**R9-21-402. General**

**A.** It is the policy of the ~~Division Administration~~ to conduct investigations and bring matters to a resolution in four circumstances: first, in the event of a death of a client; second, whenever there is alleged to have occurred a rights violation; third, whenever there is alleged to exist a condition requiring investigation because it is dangerous, illegal or inhumane; and fourth, in any other case where an investigation would be in the public interest, as determined by the ~~director of the~~



~~Department or the deputy director of the Division Administration.~~ The purpose of R9-21-402 through R9-21-410 is to implement that policy. All investigations according to R9-21-402 through R9-21-410 shall be carried out in a prompt and equitable manner and with due regard for the dignity and rights of all persons involved. R9-21-402 through R9-21-410 do not obviate the need for systematically reporting, where appropriate, accidents and injuries involving clients.

B. No change

**R9-21-403. Initiating a Grievance or Investigation**

A. No change

B. No change

C. An employee of or individual under contract with one of the following shall file a grievance if the employee has reason to believe that a mental health agency has abridged one or more of a client's rights in Article 2 of this Chapter or that a condition requiring investigation exists, and shall receive disciplinary action for failure to comply with this subsection:

1. A service provider,
2. A regional authority,
3. An inpatient facility, or
4. ~~The Division Administration.~~

D. ~~The director of a~~ A service provider ~~or the director of a~~ regional authority shall file a grievance if it:

1. ~~The director receives~~ Receives a non-frivolous allegation that:
  - a. A mental health agency has abridged one or more of a client's rights in Article 2 of this Chapter, or
  - b. A condition requiring investigation exists; or
2. ~~The director has~~ Has reason to believe that there exists or has occurred a condition requiring investigation in a mental health agency or program.

E. ~~The director or deputy director of the Department~~ The Administration shall request an investigation if:

1. ~~The director or deputy director Administration~~ determines that it would be in the best interests of a client, the ~~Department Administration~~, or the public; or
2. ~~The director or deputy director Administration~~ receives a non-frivolous allegation or has reason to believe that:
  - a. A mental health agency has abridged one or more of a client's rights in Article 2 of this Chapter, or
  - b. A condition requiring investigation exists.

F. To file a grievance, an individual shall communicate the grievance orally or submit the grievance in writing to ~~the director of or~~ any employee of a mental health agency; who shall; forward the grievance to the appropriate person as identified in R9-21-404. If asked to do so by a client, an employee shall assist the client in making an oral or written grievance or shall direct the client to the available supervisory or managerial staff who shall assist the client in making an oral or written grievance.

G. Any grievance or request for investigation shall be accurately and completely reduced to writing on ~~a Department an Administration~~ an Administration-provided grievance or request for investigation form by:

1. The individual filing the grievance or request for investigation, or
2. The mental health agency to whom the grievance or request for investigation is made.

**R9-21-404. Persons Responsible for Resolving Grievances and Requests for Investigation**

A. Allegations involving rights violations:

1. Of other than physical abuse, sexual abuse, or sexual misconduct that occurred in a mental health agency, or as a result of an action of a person employed by a mental health agency, shall be addressed to and initially decided by:
  - a. ~~The director of the~~ appropriate regional authority, ~~if applicable~~; or
  - b. ~~If the mental health agency is operated exclusively by a governmental entity, the director of the agency~~ the allegation shall be addressed to and initially decided by that agency; or
2. Of physical abuse, sexual abuse, or sexual misconduct that occurred in a mental health agency, or as a result of an action of a person employed by a mental health agency, shall be addressed to and decided by the ~~deputy director of the Division Administration.~~

B. Allegations involving conditions requiring investigation:

1. Of other than a client death, which occurred in a mental health agency, or as a result of a person employed by a mental health agency, shall be addressed to and initially decided by:
  - a. ~~The director of the appropriate regional authority, if applicable~~; or
  - b. ~~If the mental health agency is operated exclusively by a governmental entity, the director of the agency~~; or
  - a. The appropriate regional authority; or
  - b. If the mental health agency is operated exclusively by a governmental entity, the allegation shall be addressed to and initially decided by that agency; or
2. Of a client death, which occurred in a mental health agency, or as a result of an action of a person employed by a mental health agency, shall be addressed to and decided by the ~~deputy director of the Division Administration.~~

C. Within five days of receipt by a mental health agency of a grievance or request for investigation:

1. ~~The director of the~~ mental health agency shall inform the person filing the grievance or request, in writing, that the grievance or request has been received;
2. If the mental health agency is operated exclusively by a governmental entity, the ~~director of the~~ mental health agency shall provide a copy of the grievance to the appropriate regional authority; and



- 3. If the client is in need of special assistance, the ~~agency director or deputy director~~ mental health agency shall immediately send a copy of the grievance or request to the Office of Human Rights and the human rights committee with jurisdiction over the agency.

**R9-21-405. Preliminary Disposition**

- A. The agency director ~~or any other official~~ before whom a grievance or request for investigation has been initiated shall immediately take whatever action may be reasonable to protect the health, safety and security of any client, witness, individual filing the grievance or request for investigation, or individual on whose behalf the grievance or request for investigation is filed.
- B. Summary disposition.
  - 1. ~~The agency~~ A mental health agency ~~director or deputy director of the Division or the Administration~~ may summarily dispose of any grievance or a request for an investigation where the alleged rights violation or condition occurred more than one year immediately prior to the date on which the grievance or request is made.
  - 2. ~~An agency director or deputy director of the Division~~ A mental health agency or the Administration who receives a grievance or request which is primarily directed to the level or type of mental health treatment provided to a client, which can be fairly and efficiently addressed within the procedures set forth in Article 3 and in R9-21-401, and which do not directly or indirectly involve any rights set forth in A.R.S. Title 36 or Article 2, may refer the grievance for resolution through the Individual Service Plan process or the appeal process in R9-21-401.
- C. Disposition without investigation.
  - 1. Within seven days of receipt of a grievance or request for an investigation, ~~an agency director or deputy director of the Division~~ a mental health agency or the Administration may promptly resolve a grievance or request without conducting a full investigation, where the matter:
    - a. Involves no dispute as to the facts;
    - b. Is patently frivolous; or
    - c. Is resolved fairly and efficiently within seven days without a formal investigation.
  - 2. Within seven days of receipt of the grievance or request described in subsection (C)(1), the ~~agency director or deputy director of the Division~~ mental health agency or the Administration shall prepare a written, dated decision.
    - a. The decision shall explain the essential facts, why the ~~agency director or deputy director~~ mental health agency or the Administration believes that the matter is appropriately resolved without the appointment of an investigator, and the resolution of the matter.
    - b. The ~~agency director or deputy director of the Division~~ mental health agency or the Administration shall send copies of the decision to the parties, together with a notice of appeal rights according to A.R.S. § 41-1092.03, and to anyone else having a direct interest in the matter.
  - 3. After the expiration of the appeal period without appeal by any party, or after the exhaustion of all appeals and subject to the final decision on the appeal, the ~~agency director or deputy director~~ mental health agency or the Administration shall promptly take appropriate action and prepare and add to the case record a written, dated report of the action taken to resolve the grievance or request.
- D. Matters requiring investigation.
  - 1. If the matter complained of cannot be resolved without a formal investigation according to the criteria set forth in subsection (C)(1), within seven days of receipt of the grievance or request the ~~agency director or deputy director~~ mental health agency or the Administration shall prepare a written, dated appointment of an impartial investigator who, in the judgment of the ~~agency director or deputy director~~ mental health agency or the Administration, is capable of proceeding with the investigation in an objective manner but who shall not be:
    - a. Any of the persons directly involved in the rights violation or condition requiring investigation; or
    - b. A staff person who works in the same administrative unit as, except a person with direct line authority over, any person alleged to have been involved in the rights violation or condition requiring investigation.
  - 2. Immediately upon the appointment of an investigator, the ~~agency director or deputy director~~ mental health agency or the Administration shall notify the person filing the grievance or request for investigation in writing of the appointment. The notice shall contain the name of the investigator, the procedure by which the investigation will be conducted and the method by which the person may obtain assistance or representation.
- E. If a client is a client who needs special assistance, the ~~agency director or deputy director~~ mental health agency or the Administration shall immediately send a copy of the grievance or request to the Office of Human Rights and the human rights committee with jurisdiction over the agency and shall send a copy of all decisions required by this Chapter made by the ~~agency director or the deputy director~~ mental health agency or the Administration regarding the grievance or request to the Office of Human Rights and the human rights committee with jurisdiction over the agency.

**R9-21-406. Conduct of Investigation**

- A. Within 10 days of the appointment, the investigator shall hold a private, face-to-face conference with the person who filed the grievance or request for investigation to learn the relevant facts that form the grounds for the grievance or request, unless the grievance or request has been initiated by ~~the agency director~~ a mental health agency or ~~deputy director of the Division~~ the Administration according to R9-21-403(E) R9-21-403 (D) or (E).
  - 1. In scheduling such conference, and again at the conference, if the client appears without a designated representative, the investigator shall advise the client that:



- a. The client may be represented by a designated representative of the client's own choice. The investigator shall also advise the client of the availability of assistance from the State Protection and Advocacy System, the Office of Human Rights, and the relevant human rights committee.
  - b. The client may make an audio tape of the conference and all future conferences, meetings or hearings to which the client may be a party during the investigation, provided that the client notify all other parties not later than the beginning of the meeting or hearing that the client intends to do so.
  - c. In any case where the person initiating the grievance or request, or the person(s) who is alleged to have been responsible for the rights violation or condition, is a client and is in need of special assistance and is unrepresented, the investigator shall give the Office of Human Rights notice of the need for representation.
2. Where the grievance has been initiated by the ~~agency director~~ mental health agency or ~~deputy director of the Division~~ the Administration of the Division, the investigator shall promptly determine which persons have relevant information concerning the occurrence of the alleged rights violation or condition requiring investigation and proceed to interview such individuals.
- B.** Within 15 days of the appointment, but only after the conference with the person initiating the grievance or request for investigation, the investigator shall hold a private, face-to-face conference with the person(s) complained of or thought to be responsible for the rights violation or condition requiring investigation to discuss the matter and, in scheduling the conference with such person(s) or with any other witness, the investigator shall advise the person(s) or any other witness that:
1. The individual may make ~~an audio tape~~ a recording of the conference and all future conferences, meetings or hearings during the course of the investigation, provided that the individual must notify all other parties to such meetings or hearings not later than the beginning of the meeting or hearing if the individual intends to so record.
  2. An employee of an inpatient facility, service provider, regional authority or the ~~Division~~ Administration has an obligation to cooperate in the investigation.
  3. Failure of an employee to cooperate may result in appropriate disciplinary action.
- C.** No change
- D.** No change
- E.** Within five days of receiving the investigator's report, the agency director ~~or deputy director of the Division~~ shall review the report and the case record and prepare a written, dated decision which shall either:
1. Accept the investigator's report in whole or in part, at least with respect to the facts as found, and state a summary of findings and conclusions and the intended action of the agency director ~~or deputy director of the Division~~, and send:
    - a. A copy of the decision to:
      - i. The investigator;
      - ii. The individual who filed the grievance or request for investigation;
      - iii. The individual who is the subject of the grievance or request for investigation, if applicable;
      - iv. The Office of Human Rights; and
      - v. The appropriate human rights committee; and
    - b. A notice to the individual who filed the grievance or request for investigation and, if applicable, the client who is the subject of the grievance or request for investigation or, if applicable, the client's guardian, of:
      - i. If the decision is from an agency director, the client's right to appeal to ~~the Division~~ the Administration according to R9-21-406 and to an administrative hearing according to A.R.S. § 41-1092.03; and
      - ii. If the decision is from the ~~deputy director of the Division~~ Administration, the client's right to an administrative hearing according to A.R.S. § 41-1092.03; or
  2. Reject the report for insufficiency of facts and return the matter for further investigation. In such event, the investigator shall complete the further investigation and deliver a revised report to the agency director ~~deputy director of the Division~~ or designee within 10 days. Upon receipt of the report, the agency director ~~or deputy director~~ shall proceed as provided in subsection (E)(1).
- F.** Actions that an agency director ~~or the deputy director of the Division~~ may take according to subsection (E)(1) include:
1. Identifying training or supervision for or disciplinary action against an individual responsible for a rights violation or condition requiring investigation identified during the course of investigating a grievance or request for investigation.
  2. Developing or modifying a mental health agency's policies and procedures;
  3. Notifying the regulatory entity that licensed or certified an individual according to A.R.S. Title 32, Chapter 33 of the findings from the investigation; or
  4. Imposing sanctions, including monetary penalties, according to terms of a contract, if applicable.
- G.** After the expiration of the appeal period set forth in R9-21-407, or after the exhaustion of all appeals and subject to the final decision on the appeal, the agency director ~~or deputy director of the Division~~ shall promptly take the action set forth in the decision and add to the case record a written, dated report of the action taken. A copy of the report shall be sent to the Office of Human Rights and the human rights committee if the client is in need of special assistance.

**R9-21-407. Administrative Appeal**

- A.** Any grievant or the client who is the subject of the grievance who is dissatisfied with the final decision of the agency



director may, within 30 days of receipt of the decision, file a notice of appeal with the ~~deputy director of the Division~~ the Administration. The appealing party shall send copies of the notice to the other parties and their representatives and to the agency director who shall forward the full case record to the ~~deputy director of the Division~~ Administration.

- B. The ~~deputy director of the Division~~ Administration shall review the notice of appeal and the case record, and may discuss the matter with any of the persons involved or convene an informal conference. Within 15 days of the filing of the appeal, the ~~deputy director of the Division~~ Administration shall prepare a written, dated decision which shall either:
  1. Accept the investigator’s report, in whole or in part, at least with respect to the facts as found, and affirm, modify or reject the decision of the agency director with a statement of reasons; or
  2. Reject the investigator’s report for insufficiency of facts and return the matter with instructions to the agency director for further investigation and decision. In such event, the further investigation shall be completed and a revised report and decision shall be delivered to the ~~deputy director of the Division~~ Administration within 10 days. Upon receipt of the report and decision, the ~~deputy director of the Division~~ Administration shall render a final decision, consistent with the procedures set forth in subsection (B)(1).
  3. A designated representative shall be afforded the opportunity to be present at any meeting or conference convened by the ~~deputy director of the Division~~ the Administration to which the represented party is invited.
  4. The ~~deputy director of the Division~~ Administration shall send copies of the decision to:
    - a. The parties, together with a notice of appeal rights according to A.R.S. § 41-1092.03;
    - b. The agency director; and
    - c. The Office of Human Rights and the applicable human rights committee for all clients, including clients who are in need of special assistance.

**R9-21-408. Further Appeal to Administrative Hearing**

- A. Any grievant or the client who is the subject of the grievance who is dissatisfied with the ~~decision~~ Director’s decision of the ~~deputy director of the Division~~ Administration may request a fair hearing before an administrative hearing officer.
  1. Within 30 days of the date of the ~~decision~~ Director’s decision, the appealing party shall file with ~~director~~ the Administration of the Department a notice requesting a fair hearing.
  2. Upon receipt of the notice, the ~~director~~ Administration shall send a copy to the parties, ~~to the deputy director of the Division~~, and to the Office of Human Rights and the human rights committee for clients who are in need of special assistance.
  3. ~~Within five days of the receipt of the notice of further appeal, the director of the Department shall appoint an impartial hearing officer. The hearing officer may not be an employee of the Department, a regional authority, or of a service provider under contract or subcontract with the Department. However, the Department may contract with a qualified individual to serve as the hearing officer under this rule. The director shall send copies of the appointment to the hearing officer together with the case record and to the parties including the Division.~~
  4. ~~Within five days of the appointment, the hearing officer shall inform the parties, the Office of Human Rights, and the human rights committee if the client is in need of special assistance, of the time and place of the hearing. The hearing shall be scheduled not less than 20 nor more than 30 days from the receipt of the request for fair hearing at a location convenient to all parties.~~
- B. The hearing shall be conducted consistent with A.R.S. §§ 36-111 and 36-112 and 41-1061 41-1092 et seq. (the Administrative Procedure Act), and those portions of R9-1-101 through R9-1-126 9 A.A.C. 1 which are consistent not inconsistent with this Article.
  1. The client shall have the right to be represented at the hearing by an individual chosen by the client at the client’s own expense, in accordance with Rule 31(a)(3), Rules of the Supreme Court.
    - a. If the client has not designated a representative to assist the client at the hearing and is in need of special assistance, the human rights committee, ~~through one of its members~~ or the human rights advocate unless refused by the client, shall make all reasonable efforts to represent the client.
    - b. ~~If the client is unrepresented and the deputy director of the Division determines the appointment of a representative to be in the client’s best interest, the deputy director shall designate a representative to assist the client in the appeal.~~
  2. ~~The client or other appealing party shall have the right to present any evidence relevant to the issues under appeal and shall have the right to call and examine witnesses.~~
  3. ~~The client or other party appealing on behalf of the client shall have the right to examine all records held by the Department pertaining to the client.~~
  4. ~~Any portion of the hearing may be closed to the public if the client requests or if the hearing officer~~ Administrative Law Judge determines that it is necessary to prevent an unwarranted invasion of the client’s privacy or that public disclosure would pose a substantial risk of harm to the client.
  5. ~~The standard of proof on all issues shall be a preponderance of the evidence.~~
  6. ~~The burden of proof on all issues shall be on the appealing party.~~
  7. ~~Within 10 days of the conclusion of the hearing, the hearing officer shall prepare, date, sign, and send a written recommended decision to director of the Department, together with the case record. The recommended decision shall include findings of fact, which shall be binding on the Department for administrative purposes, and conclusions and recommendations for action as appropriate.~~



- C. Within 20 days of the conclusion of the hearing, the director of the Department shall render a final written decision, based upon the recommendation of the hearing officer.
1. The decision shall include a concise statement of the facts found, a summary of the evidence relied upon, the decision and the reasons for so deciding, and a notice of the client's right to petition the director of the Department for a rehearing under R9-1-113 and to seek judicial review under A.R.S. § 36-113.
  2. The decision shall be mailed promptly to the client, the other parties, and their designated representatives.
  3. The Division Administration shall ~~arrange to have~~ explain the Director's decision explained to the client at the client's request, together with the right to seek rehearing and judicial review.
  4. ~~Except to the extent that the decision is subject to an order for rehearing, the decision of the director is the final decision of the Department on all issues.~~
- D. Within 30 days of the date of service of the decision of the director, the client or party appealing on behalf of the client may petition the director for a rehearing or review pursuant to R9-1-120.

#### R9-21-409. Notice and Records

- A. No change
- B. Notice and oversight by the Office of Human Rights and human rights committees.
1. Upon receipt of any grievance or request for investigation involving a client, including a client who is in need of special assistance, the agency director ~~or deputy director of the Division~~ shall immediately forward a copy of such grievance or request to the Office of Human Rights and the appropriate regional human rights committee.
  2. Upon receipt of such a grievance from the agency director ~~or the deputy director of the Division~~, at the request of a client, or on its own initiative, the Office of Human Rights and/or the appropriate human rights committee shall assist a client in filing a grievance or request, if necessary. The Office and/or committee shall use its best efforts to see that such client is represented by an attorney, human rights advocate, committee member, or other person to protect the individual's interests and present information on the client's behalf. The Office and/or committee shall maintain a list of attorneys and other representatives, including the state protection and advocacy system, available to assist clients.
  3. Whenever the human rights committee has reason to believe that a rights violation involving abuse or a dangerous condition requiring investigation, including a client death, has occurred or currently exists, or that any rights violation or condition requiring investigation occurred or exists which involves a client who is in need of special assistance, it may, upon written notice to the official before whom the matter is pending, become a party to the grievance or request. As a party it shall receive copies of all reports, plans, appeals, notices and other significant documents relevant to the resolution of the grievance or request and be able to appeal any finding or decision.
  4. The Office of Human Rights shall assist clients in resolving grievances according to R9-21-104.
- C. Notification of other persons.
1. Whenever any rule, regulation, statute, or other law requires notification of a law enforcement officer, public official, medical examiner, or other person that an incident involving the death, abuse, neglect, or threat to a client has occurred, or that there exists a dangerous condition or event, such notice shall be given as required by law.
  2. ~~An agency director~~ A mental health agency shall immediately notify the ~~deputy director of the Division~~ Administration when:
    - a. A client brings criminal charges against an employee;
    - b. An employee brings criminal charges against a client;
    - c. An employee or client is indicted or convicted because of any action required to be investigated by this Article; or
    - d. A client of an inpatient facility, ~~a~~ mental health agency, or ~~a~~ service provider dies. The agency director shall report such death according to the ~~Department's~~ Administration's policy on the reporting and investigation of deaths.
    - e. A client of an inpatient facility, ~~agency,~~ agency, a mental health agency, or a service provider allegedly is physically or sexually abused.
  3. The investigation by the ~~Department~~ Administration provided for by this Article is independent of any investigation conducted by police, the county attorney, or other authority.
- D. Case records.
1. A file, known as the case record, shall be kept for each grievance or request for investigation which is received by the ~~Division Administration, including~~ ASH, regional authority or service provider under contract or subcontract with the ~~Department Administration~~. The record shall include the grievance or request, the docket number ~~or matter number~~ assigned by the ~~Department~~, the names of all persons interviewed and the dates of those interviews, either a taped or written summary of those interviews, a summary of documents reviewed, copies of memoranda generated by the investigation, the investigator's report, the agency director's decision, and all documents relating to any appeal.
  2. The investigator shall maintain possession of the case record until the investigation report is submitted. Thereafter, the agency director shall maintain control over the case record, except when the matter is on appeal. During any appeal, the record will be in the custody of the official who hears or decides ~~hearing or deciding~~ the appeal.
- E. Public logs.



1. The ~~Department~~ Administration and regional authority shall maintain a ~~public log~~ logs of all deaths and non-frivolous grievances or requests for investigation for all inpatient facilities, agencies, and service providers, and mental health agencies which it operates, funds, or supervises. ~~The agency director of each facility or mental health agency shall forward to the Department all information necessary for the accurate and timely maintenance of the public log.~~
2. The ~~public log maintained by the Administration~~ shall not include ~~personal identities personally identifiable information~~ but and shall be a public record, available for inspection and copying by any person.
3. With respect to each grievance or request for investigation, the ~~Department's Administration's~~ Administration's public log shall contain:
  - a. A unique docket number or matter number, ~~consisting of a symbol for the agency, the last two digits of the year and a serial number assigned by the Department;~~
  - b. A substantive but concise description of the grievance or request for investigation;
  - c. The date of the filing of grievance;
  - d. The date of the initial decision or appointment of investigator;
  - e. The date of the filing of the investigator's final report;
  - f. A substantive but concise description of the investigator's final report;
  - g. The date of all subsequent decisions, appeals, or other relevant events; and
  - h. A substantive but concise description of the final decision and the action taken by the ~~agency director~~ mental health agency or ~~deputy director of the Division~~ the Administration.

**R9-21-410. Miscellaneous**

- A. Disqualification of official. The agency director, ~~deputy director of the Division~~, investigator, or any other official with authority to act on a grievance or request for investigation shall disqualify ~~himself~~ themselves from acting, if such official cannot act on the matter impartially and objectively, in fact or in appearance. In the event of such disqualification, the official shall forthwith prepare and forward a written, dated memorandum explaining the reasons for the decision to the ~~deputy director of the Division or designee or director of the Department or designee~~ Administration, as appropriate, who shall, within 10 days of receipt of the memorandum, take such steps as are necessary to resolve the grievance in an impartial, objective manner.
- B. Request for extension of time.
  1. The investigator or any other official of a mental health agency acting according to this Article may secure an extension of any time limit provided in this Article with the permission of the ~~director of the regional authority~~.
  2. The investigator or any other official of an inpatient facility operated exclusively by a governmental entity acting according to this Article may secure an extension of any time limit provided in this Article with the permission of the ~~deputy director of the Division~~ the CEO of the entity or his designee.~~Department.~~
  3. The investigator or any other official of the ~~office of the deputy director of the Division~~ Administration acting according to this Article may secure an extension of any time limit provided in this Article with the permission of the ~~director of the Department~~ Administration or designee.
  4. An extension of time may only be granted upon a showing of necessity and a showing that the delay will not pose a threat to the safety or security of the client.
  5. A request for extension shall be in writing, with copies to all parties. The request shall explain why an extension is needed and propose a new time limit which does not unreasonably postpone a final resolution of the matter.
  6. Such request shall be submitted to and acted upon by the ~~director of the regional authority, deputy director of the Division, or director of the Department, as appropriate,~~ prior to the expiration of the original time limit. Failure of the relevant official to act within the time allowed shall constitute a denial of the request for an extension.
- C. Procedural irregularities.
  1. Any party may protest the failure or refusal of any official with responsibility to take action in accord with the procedural requirements of this Article, including the time limits, by filing a written protest with the ~~deputy director of the Division~~ Administration ~~a written protest. A protest concerning the failure or refusal to take action by the deputy director of the Division or designee should be filed with the director of the Department.~~
  2. Within 10 days of the filing of such a protest, the ~~official with whom it is filed~~ Administration shall take appropriate action to ensure that if there is or was a violation of a procedure or timeline, it is promptly corrected, including, if appropriate, disciplinary action against the official responsible for the violation or by removal of an investigator and the appointment of a substitute. ~~or by removal of an investigator or hearing officer and the appointment of a substitute.~~
- D. ~~Deputy director's or director's investigation~~ Special Investigation.
  1. The ~~deputy director of the Division or director of the Department~~ Administration may at any time order that a special investigator review and report ~~directly to the director or deputy director~~ as to the facts of a grievance or condition requiring investigation, including a death or other matter.
  2. The special investigator, ~~deputy director and director~~ and the Administration shall comply with the time limits and other procedures for an investigation set forth in this Article.
  3. Any final decision issued by the ~~deputy director of the Division or the director of the Department~~ Administration based on such an investigation under this rule is appealable as provided in R9-21-408.



- 4. Nothing in this Article shall prevent the ~~Department or the Division~~ Administration from conducting an investigation independent of these rules.

**NOTICE OF PROPOSED RULEMAKING**

**TITLE 9. HEALTH SERVICES**

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

[R16-47]

**PREAMBLE**

- 1. Article, Part, or Section Affected (as applicable)**

R9-22-701	Amend
R9-22-712.35	Amend
R9-22-712.61	Amend
R9-22-712.66	Amend
R9-22-712.67	Amend
R9-22-712.71	Amend
R9-22-712.75	Amend
- 2. Citations to the agency’s statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**  
 Authorizing statute: A.R.S. § 36-2903.01(A)  
 Implementing statute: A.R.S. § 36-2903.01(G)(12)
- 3. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the proposed rule:**  
 Notice of Rulemaking Docket Opening: 22 A.A.R. 784, April 8, 2016 (*in this issue*).
- 4. The agency’s contact person who can answer questions about the rulemaking:**  
 Name: Mariaelena Ugarte  
 Address: AHCCCS  
 Office of Administrative Legal Services  
 701 E. Jefferson, Mail Drop 6200  
 Phoenix, AZ 85034  
 Telephone: (602) 417-4693  
 Fax: (602) 253-9115  
 E-mail: AHCCCSRules@azahcccs.gov  
 Web site: www.azahcccs.gov
- 5. An agency’s justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:**  
 The proposed rulemaking will amend and clarify rules specifying payments to hospitals for inpatient services under the Diagnostic Related Group (DRG) methodology. Significantly, this rulemaking will also include the addition of differential adjusted payments made to hospitals for both inpatient and outpatient services which satisfy specific criteria for receipt of VBP Differential Adjusted Payments by the AHCCCS Administration as well as Managed Care Contractors. The purpose of VBP Differential Adjusted Payments is to reward hospital providers that have taken designated actions to improve patients’ care experience, improve members’ health, and reduce the growth of the cost of care. Facilities which satisfy the criteria will receive increased payments for inpatient and outpatient services. Other topics of the proposed rulemaking include addition of a high acuity pediatric policy adjustor and clarification of payments for hospitalization of members who no longer meet inpatient criteria when they cannot be safely discharged, when no other setting is available, or when members must be transferred to another hospital for sub-acute services.
- 6. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to 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:**  
 A study was not referenced or relied upon when revising these regulations.



**7. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking 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 Administration anticipates a moderate economic impact on the implementing agency, small businesses and consumers for the rule changes:

- The Administration anticipates that the Value Based Purchasing (VBP) will result in approximately \$3.6 million of additional payments for the contract year October 1, 2016 through September 30, 2017 to about 19 qualifying hospitals that have taken designated actions to improve patients' care experience, improve members' health, and reduce the growth of the cost of care for inpatient and outpatient services.
- The Administration amended rule to clarify the description of how DRG payments are made, including transplant services. The amended rule also clarifies how DRG payments are made for Administrative days and transfers. These changes are not expected to have an economic impact on any party since the changes are only for clarification and do not change a service or payment. The revisions to the rules will enhance the public's understanding.
- In addition, the Administration added a high acuity pediatric policy adjustor for January 1, 2016 to recognize the higher cost of treating higher acuity pediatric patients. It is anticipated that the high acuity pediatric policy adjustor will result in annual additional payments of \$19.4 million to 53 hospitals.

**9. The agency's contact person who can answer questions about the economic, small business and consumer impact statement:**

Name: Mariaelena Ugarte  
 Address: AHCCCS  
 Office of Administrative Legal Services  
 701 E. Jefferson, Mail Drop 6200  
 Phoenix, AZ 85034  
 Telephone: (602) 417-4693  
 Fax: (602) 253-9115  
 E-mail: AHCCCSRules@azahcccs.gov  
 Web site: www.azahcccs.gov

**10. The time, place, and nature of the proceedings to make, amend, repeal, or renumber the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:**

Proposed rule language will be available on the AHCCCS website www.azahcccs.gov the week of March 18, 2016. Please send written or email comments to the above address by the close of the comment period, 5:00 p.m., May 9, 2016.

Date: May 9, 2016  
 Time: 10:00 a.m.  
 Location: AHCCCS  
 701 E. Jefferson  
 Phoenix, AZ 85034  
 Nature: Public Hearing

Date: May 9, 2016  
 Time: 10:00 a.m.  
 Location: ALTCS: Arizona Long-Term Care System  
 1010 N. Finance Center Dr., Suite 201  
 Tucson, AZ 85710  
 Nature: Public Hearing

Date: May 9, 2016  
 Time: 10:00 a.m.  
 Location: 2717 N. 4th St., Suite 130  
 Flagstaff, AZ 86004  
 Nature: Public Hearing



**11. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:**

No other matters have been prescribed.

**a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**

Not applicable

**b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**

Not applicable

**c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**

No analysis was submitted.

**12. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:**

None

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

**ARTICLE 7. STANDARDS FOR PAYMENTS**

Section

R9-22-701. Definitions

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

R9-22-712.61. DRG Payments: Exceptions

R9-22-712.66. DRG Service Policy Adjustor

R9-22-712.67. DRG Reimbursement: Transfers

R9-22-712.71. Final DRG Payment. The final DRG payment is the sum of the final DRG base payment and the final DRG outlier add-on payment

R9-22-712.75. DRG Reimbursement: Payment for Administrative Days

**ARTICLE 7. STANDARDS FOR PAYMENTS**

**R9-22-701. Standard for Payments Related Definitions**

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

“Accommodation” means room and board services provided to a patient during an inpatient hospital stay and includes all staffing, supplies, and equipment. The accommodation is semi-private except when the member must be isolated for medical reasons. Types of accommodation include hospital routine medical/surgical units, intensive care units, and any other specialty care unit in which room and board are provided.

“Aggregate” means the combined amount of hospital payments for covered services provided within and outside the GSA.

“AHCCCS inpatient hospital day or days of care” means each day of an inpatient stay for a member beginning with the day of admission and including the day of death, if applicable, but excluding the day of discharge, provided that all eligibility, medical necessity, and medical review requirements are met.

“Ancillary service” means all hospital services for patient care other than room and board and nursing services, including but not limited to, laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, and occupational).

“APC” means the Ambulatory Payment Classification system under 42 CFR 419.31 used by Medicare for grouping clinically and resource-similar procedures and services.

“Billed charges” means charges for services provided to a member that a hospital includes on a claim consistent with the rates and charges filed by the hospital with Arizona Department of Health Services (ADHS).

“Business agent” means a company such as a billing service or accounting firm that renders billing statements and receives payment in the name of a provider.

“Capital costs” means costs as reported by the hospital to CMS as required by ~~42 CFR 413.20~~ 42 CFR 413.20.

“Copayment” means a monetary amount, specified by the Director, that a member pays directly to a contractor or provider at the time covered services are rendered.



“Cost-to-charge ratio” (CCR) means a hospital’s costs for providing covered services divided by the hospital’s charges for the same services. The CCR is the percentage derived from the cost and charge data for each revenue code provided to AHCCCS by each hospital.

“Covered charges” means billed charges that represent medically necessary, reasonable, and customary items of expense for covered services that meet medical review criteria of AHCCCS or a contractor.

“CPT” means Current Procedural Terminology, published and updated by the American Medical Association. CPT is a nationally-accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians that provide a uniform language to accurately designate medical, surgical, and diagnostic services.

“Critical Access Hospital” is a hospital certified by Medicare under 42 CFR 485 Subpart F and 42 CFR 440.170(g).

“Direct graduate medical education costs” or “direct program costs” means the costs that are incurred by a hospital for the education activities of an approved graduate medical education program that are the proximate result of training medical residents in the hospital, including resident salaries and fringe benefits, the portion of teaching physician salaries and fringe benefits that are related to the time spent in teaching and supervision of residents, and other related GME overhead costs.

“DRI inflation factor” means Global Insights Prospective Hospital Market Basket.

“Eligibility posting” means the date a member’s eligibility information is entered into the AHCCCS Pre-paid Medical Management Information System (PMMIS).

“Encounter” means a record of a medically-related service rendered by an AHCCCS-registered provider to a member enrolled with a contractor on the date of service.

“Existing outpatient service” means a service provided by a hospital before the hospital files an increase in its charge master as defined in R9-22-712(G), regardless of whether the service was explicitly described in the hospital charge master before filing the increase or how the service was described in the charge master before filing the increase.

“Expansion funds” means funds appropriated to support GME program expansions as described under A.R.S. § ~~36-2903.01(H)(9)(b) and (c)(i)~~ 36-2903.01(G)(9)(b) and (c)(i).

“Factor” means a person or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the organization for an added fee or a deduction of a portion of the accounts receivable. Factor does not include a business agent.

“Fiscal intermediary” means an organization authorized by CMS to make determinations and payments for Part A and Part B provider services for a given region.

“Freestanding Children’s Hospital” means a separately standing hospital with at least 120 pediatric beds that is dedicated to provide the majority of the hospital’s services to children.

“GME program approved by the Administration” or “approved GME program” means a graduate medical education program that has been approved by a national organization as described in 42 CFR 415.152.

“Graduate medical education (GME) program” means an approved residency program that prepares a physician for independent practice of medicine by providing didactic and clinical education in a medical environment to a medical student who has completed a recognized undergraduate medical education program.

“HCAC” means a health care acquired condition described under ~~42 U.S.C. 1395ww(d)(4)(D)(iv)~~ 42 CFR 447.26 but does not include Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

“HCPCS” means the Health Care Procedure Coding System, published and updated by Center for Medicare and Medicaid Services (CMS). HCPCS is a listing of codes and descriptive terminology used for reporting the provision of physician services, other health care services, and substances, equipment, supplies or other items used in health care services.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as specified under 45 CFR 162, that establishes standards and requirements for the electronic transmission of certain health information by defining code sets used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

“ICU” means the intensive care unit of a hospital.

“Indirect program costs” means the marginal increase in operating costs that a hospital experiences as a result of having an approved graduate medical education program and that is not accounted for by the hospital’s direct program costs.

“Intern and Resident Information System” means a software program used by teaching hospitals and the provider community for collecting and reporting information on resident training in hospital and non-hospital settings.



“Medical education costs” means direct hospital costs for intern and resident salaries, fringe benefits, program costs, nursing school education, and paramedical education, as described in the Medicare Provider Reimbursement Manual.

“Medical review” means a clinical evaluation of documentation conducted by AHCCCS or a contractor for purposes of prior authorization, concurrent review, post-payment review, or determining medical necessity. The criteria for medical review are established by AHCCCS or a contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

“Medicare Urban or Rural Cost-to-Charge Ratio (CCR)” means statewide average capital cost-to-charge ratio published annually by CMS added to the urban or rural statewide average operating cost-to-charge ratio published annually by CMS.

“National Standard code sets” means codes that are accepted nationally in accordance with federal requirements under 45 CFR 160 and 45 CFR 164.

“New hospital” means a hospital for which Medicare Cost Report claim and encounter data are not available for the fiscal year used for initial rate setting or rebasing.

“NICU” means the neonatal intensive care unit of a hospital that is classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.

“Non-IHS Acute Hospital” means a hospital that is not run by Indian Health Services, is not a free-standing psychiatric hospital, such as an IMD, and is paid under ADHS rates.

“Observation day” means a physician-ordered evaluation period of less than 24 hours to determine whether a person needs treatment or needs to be admitted as an inpatient. Each observation day consists of a period of 24 hours or less.

“Operating costs” means AHCCCS-allowable accommodation costs and ancillary department hospital costs excluding capital and medical education costs.

“OPPC” means an Other Provider Preventable Condition that is: (1) a wrong surgical or other invasive procedure performed on a patient, (2) a surgical or other invasive procedure performed on the wrong body part, or (3) a surgical or other invasive procedure performed on the wrong patient.

“Organized health care delivery system” means a public or private organization that delivers health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization.

“Outlier” means a hospital claim or encounter in which the operating costs per day for an AHCCCS inpatient hospital stay meet the criteria described under this Article and A.R.S. § ~~36-2903.01(H)~~ 36-2903.01(G).

“Outpatient hospital service” means a service provided in an outpatient hospital setting that does not result in an admission.

“Ownership change” means a change in a hospital’s owner, lessor, or operator under 42 CFR 489.18(a).

“Participating institution” means an institution at which portions of a graduate medical education program are regularly conducted and to which residents rotate for an educational experience for at least one month.

“Peer group” means hospitals that share a common, stable, and independently definable characteristic or feature that significantly influences the cost of providing hospital services, including specialty hospitals that limit the provision of services to specific patient populations, such as rehabilitative patients or children.

“PPC” means prior period coverage. PPC is the period of time, prior to the member’s enrollment, during which a member is eligible for covered services. The time-frame is the first day of the month of application or the first eligible month, whichever is later, until the day a member is enrolled with a contractor.

“PPS bed” means Medicare-approved Prospective Payment beds for inpatient services as reported in the Medicare cost reports for the most recent fiscal year for which the Administration has a complete set of Medicare cost reports for every rural hospital as determined as of the first of February of each year.

“Procedure code” means the numeric or alphanumeric code listed in the CPT or HCPCS manual by which a procedure or service is identified.

“Prospective rates” means inpatient or outpatient hospital rates set by AHCCCS in advance of a payment period and representing full payment for covered services excluding any quick-pay discounts, slow-pay penalties, and first-and third-party payments regardless of billed charges or individual hospital costs.

“Public hospital” means a hospital that is owned and operated by county, state, or hospital health care district.

“Qualifying health information exchange organization” means a non-profit health information organization as defined in A.R.S. § 36-3801 that provides the statewide exchange of patient health information among disparate health care organizations and providers not owned, operated, or controlled by the health information exchange. A



qualifying health information exchange organization must include representation by the administration on its board of directors, and have a significant number of health care participants, including hospitals, laboratories, payers, community physicians and Federally Qualified Health Centers.

“Rebase” means the process by which the most currently available and complete Medicare Cost Report data for a year and AHCCCS claim and encounter data for the same year are collected and analyzed to reset the Inpatient Hospital Tiered per diem rates, or the Outpatient Hospital Capped Fee-For-Service Schedule.

“Reinsurance” means a risk-sharing program provided by AHCCCS to contractors for the reimbursement of specified contract service costs incurred by a member beyond a certain monetary threshold.

“Remittance advice” means an electronic or paper document submitted to an AHCCCS-registered provider by AHCCCS to explain the disposition of a claim.

“Resident” means a physician engaged in postdoctoral training in an accredited graduate medical education program, including an intern and a physician who has completed the requirements for the physician’s eligibility for board certification.

“Revenue code” means a numeric code, that identifies a specific accommodation, ancillary service, or billing calculation, as defined by the National Uniform Billing committee for UB-04 forms.

“Sub-acute services” means comprehensive inpatient care for a patient with an acute illness, injury or exacerbation of a disease process when the patient does not require acute inpatient hospitalization. Sub-acute care is rendered immediately after, or instead of, acute inpatient hospitalization.

“Specialty facility” means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.

“Sponsoring institution” means the institution or entity that is recognized by the GME accrediting organization and designated as having ultimate responsibility for the assurance of academic quality and compliance with the terms of accreditation.

“Tier” means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure, or revenue codes, peer group, NICU classification level, or any combination of these items.

“Tiered per diem” means an AHCCCS capped fee schedule in which payment is made on a per-day basis depending upon the tier (or tiers) into which an AHCCCS inpatient hospital day of care is assigned.

“Trip” means a one-way transport each time a taxi is called. If the taxi waits for the member then the transport continues to be part of the one-way trip. If the taxi leaves and is called to pick up the member, that is considered a new one-way trip.

**R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees**

- A. For all claims with a begin date of service on or before September 30, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule established under R9-22-712.20 (except for laboratory services and out-of-state hospital services) for the following hospitals submitting any claims:
  - 1. By 48 percent for public hospitals on July 1, 2005, and hospitals that were public anytime during the calendar year 2004;
  - 2. By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
  - 3. By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
  - 4. By 115 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the criteria during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
  - 5. By 113 percent for a Freestanding Children’s Hospital with at least 110 pediatric beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective; or
  - 6. By 14 percent for a University Affiliated Hospital which is a hospital that has a majority of the members of its board of directors appointed by the Board of Regents during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective.
- B. For all claims with a begin date of service on or after October 1, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services) for the following hospitals. A hospital shall receive an increase from only one of the following categories:
  - 1. By 73 percent for public hospitals;
  - 2. By 31 percent for hospitals in counties other than Maricopa and Pima with more than 100 licensed beds as of October 1 of that contract year;
  - 3. By 37 percent for hospitals in counties other than Maricopa and Pima with 100 or fewer licensed beds as of October 1 of that contract year;



4. By 100 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the critical access criteria;
  5. By 78 percent for a Freestanding Children's Hospital with at least 110 pediatric beds as of October 1 of that contract year; or
  6. By 41 percent for a University Affiliated Hospital, ~~which this~~ is a hospital that has a majority of the members of its board of directors appointed by the Arizona Board of Regents.
- C. In addition to subsections (A) and (B), an Arizona Level 1 trauma center as defined by R9-22-2101 shall receive a 50 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services and out-of-state hospital services) for Level 2 and 3 emergency department procedures.
- D. Hospitals with greater than 100 pediatric beds not receiving an increase under subsection (B) shall receive an 18 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services).
- E. For outpatient services with dates of service from October 1, 2016 through September 30, 2017, the payment otherwise required for outpatient hospital services provided by qualifying hospitals shall be increased by a percentage established by the administration. The percentage is published on the Administration's public website as part of its fee schedule subsequent to the public notice published no later than September 1, 2016. To qualify, a hospital providing outpatient hospital services must meet the following criteria:
1. By June 1, 2016, the hospital must have executed an agreement with and electronically submitted admission, discharge, and transfer information, as well as data from the hospital emergency department, to a qualifying health information exchange organization, and
  2. By June 1, 2016, the hospital must have CMS approval of an attestation by the hospital of Meaningful Use Stage 2 for Program Year 2015 (as described in 42 CFR 495.20) for the period of January 4, 2016 through February 29, 2016; or, for a Children's hospital that does not participate in Medicare, AHCCCS approval of an attestation by the hospital of Meaningful Use Stage 2 for Program Year 2015 (as described in 42 CFR 495.20) for the period of January 4, 2016 through April 30, 2016.
- ~~E.F.~~ Fee adjustments made under subsection (A), (B), (C), ~~and (D), and (E)~~ are on file with AHCCCS and current adjustments are posted on AHCCCS' web site.

#### **R9-22-712.60. Diagnosis Related Group Payments**

- A. Inpatient hospital services with discharge dates on or after October 1, 2014, shall be reimbursed using the diagnosis related group (DRG) payment methodology described in this section and sections R9-22-712.61 through R9-22-712.81.
- B. Payments made using the DRG methodology shall be the sole reimbursement to the hospital for all inpatient hospital services and related supplies provided by the hospital. Services provided in the emergency room, observation area, or other outpatient departments that are directly followed by an inpatient admission to the same hospital are not reimbursed separately. Are reimbursed through the DRG methodology and not reimbursed separately.
- C. Each claim for an inpatient hospital stay shall be assigned a DRG code and a DRG relative weight based on version 31 of the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health Information Systems. If version 31 of the APR-DRG classification system will no longer support assigning DRG codes and relative weights to claims, and 3M Health Information Systems issues a newer version of the APR-DRG classification system using updated DRG codes and/or updated relative weights, ~~then the more current version~~ an updated version established by 3M Health Information Systems will be used; however, if the ~~newer~~ version employs updated relative weights, those weights will be adjusted using a single adjustment factor applied to all relative weights to ensure that the statewide weighted average of the updated relative weights does not increase or decrease from the statewide weighted average of the relative weights used under version 31.
- D. Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to quick pay discounts and slow pay penalties under A.R.S. 36-2904.
- E. Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to the Urban Hospital Reimbursement Program under R9-22-718.
- F. For purposes of this section and sections R9-22-712.61 through R9-22-712.81:
1. "DRG National Average length of stay" means the national arithmetic mean length of stay published in version 31 of the All Patient Refined Diagnosis Related Group (APR-DRG) classification established by 3M Health Information Systems.
  2. "Length of stay" means the total number of calendar days of an inpatient stay beginning with the date of admission through discharge, but not including the date of discharge (including the date of a discharge to another hospital, i.e., a transfer) unless the member expires.
  3. "Medicare" means Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.*
  4. "Medicare labor share" means a hospital's labor costs as a percentage of its total costs as determined by CMS for purposes of the Medicare Inpatient Prospective Payment System.

#### **R9-22-712.61. DRG Payments: Exceptions**

- A. Notwithstanding section R9-22-712.60, claims for inpatient services from the following hospitals shall be paid on a per diem basis, including provisions for outlier payments, where rates and outlier thresholds are included in the capped fee schedule published by the Administration on its website and available for inspection during normal business hours at 701 E. Jefferson, Phoenix, Arizona. If the covered costs per day on a claim exceed the published threshold for a day, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the outlier CCR. The outlier



CCR will be the sum of the urban or rural default operating CCR appropriate to the location of the hospital and the state-wide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS. The resulting amount will be the total reimbursement for the claim. There is no provision for outlier payments for hospitals described under subsection (A)(3).

1. Hospitals designated as type: hospital, subtype; rehabilitation in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website in March of each year;
  2. Hospitals designated as type: hospital, subtype: long term in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;
  3. Hospitals designated as type: hospital, subtype; psychiatric in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;
  4. ~~Transplant facilities to the extent the inpatient days associated with the transplant exceed the terms of the contract.~~
- B.** Notwithstanding section R9-22-712.60, claims for inpatient services that are covered by a RBHA or TRBHA, where the primary principal diagnosis on the claim is a behavioral health diagnosis, shall be reimbursed as prescribed by ADHS a per diem rate described by a fee schedule established by the Administration; however, if the primary principal diagnosis is a medical physical health diagnosis, the claim shall be processed under the DRG methodology described in this section, even if behavioral health services are provided during the inpatient stay.
- C.** Notwithstanding section R9-22-712.60, claims for services associated with transplant services shall be paid in accordance with the contract between the AHCCCS administration and the transplant facility.
- D.** Notwithstanding section R9-22-712.60, claims from an IHS facility or from a hospital operated as a 638 facility IHS facility or 638 Tribal provider shall be paid the all-inclusive rate on a per visit basis in accordance with the rates published annually by IHS in the federal register. A 638 facility is a hospital operated by an Indian tribe or tribal organization, as defined in 25 USC 1603, funded, in whole or part, by the IHS as provided for in a contract or compact with IHS under 25 U.S.C. §§ 450 through 458aaa-18.
- E.** For hospitals that have contracts with the Administration for the provision of transplant services, inpatient days associated with transplant services are paid in accordance with the terms of the contract.

**R9-22-712.66. DRG Service Policy Adjustor**

In addition to subsection R9-22-712.65, for claims with DRG codes in the following categories, the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code, and the DRG provider policy adjustor shall be multiplied by the following service policy adjustors:

1. Normal newborn DRG codes: 1.55
2. Neonates DRG codes: 1.10
3. Obstetrics DRG codes: 1.55
4. Psychiatric DRG codes: 1.65
5. Rehabilitation DRG codes: 1.65
6. ~~Claims for members under age 19 assigned DRG codes other than listed above: 1.25~~  
Claims for members under age 19 assigned DRG codes other than listed above:
  - a. 1.25 for dates of discharge occurring on or after October 1, 2014 and ending no later than December 31, 2015 regardless of severity of illness level.
  - b. 1.25 for dates of discharge on or after January 1, 2016 for severity of illness levels 1 and 2.
  - c. 1.60 for dates of discharge on or after January 1, 2016 for severity of illness levels 3 and 4.

**R9-22-712.67. DRG Reimbursement: Transfers**

- A.** For purposes of this ~~subsection~~ Section a “transfer” means the transfer of a member from a hospital to a short-term general hospital for inpatient care, ~~to a designated cancer center, or children’s hospital, or a critical access hospital~~ except when a member is moved for the purpose of receiving sub-acute services.
- B.** Designated cancer center or children’s hospitals are those hospitals identified as such in the UB-04 billing manual published by the National Uniform Billing Committee.
- C.** The hospital the member is transferred from shall be reimbursed either the initial DRG base payment or the transfer DRG base payment, whichever is less.
- D.** The transfer DRG base payment is an amount equal to the initial DRG base payment, as determined after making any provider or service policy adjustors, divided by the DRG National Average length of stay for the DRG code multiplied by the sum of one plus the length of stay.
- E.** The hospital the member is transferred to shall be reimbursed under the DRG payment methodology without a reduction due to the transfer.
- F.** Unadjusted DRG base payment. The unadjusted DRG base payment is either the initial DRG base payment, as determined after making any provider or service policy adjustors, or the transfer DRG base payment, whichever is less.

**R9-22-712.71. Final DRG Payment**

The final DRG payment is the sum of the final DRG base payment, ~~and~~ the final DRG outlier add-on payment, and the Inpatient Value Based Purchasing (VBP) Differential Adjusted Payment.



- ~~A-1.~~ The final DRG base payment is an amount equal to the product of the covered day adjusted DRG base payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.
- ~~B-2.~~ The final DRG outlier add-on payment is an amount equal to the product of the covered day adjusted DRG outlier add-on payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.
- ~~C-3.~~ The factor for each hospital and for each federal fiscal year is published as part of the AHCCCS capped fee schedule and is available on the AHCCCS administration's website and is on file for public inspection at the AHCCCS administration located at 701 E Jefferson Street, Phoenix, Arizona.
4. For inpatient services with a date of discharge from October 1, 2016 through September 30, 2017, the Inpatient VBP Differential Adjusted Payment is the sum of the final DRG base payment and the final DRG outlier add-on payment multiplied by a percentage published on the Administration's public website as part of its fee schedule, subsequent to the public notice published no later than September 1, 2016. To qualify for the Inpatient VBP Differential Adjusted Payment, a hospital providing inpatient hospital services must meet the following criteria:
- By June 1, 2016, the hospital must have executed an agreement with and electronically submitted admission, discharge, and transfer information, as well as data from the hospital emergency department, to a qualifying health information exchange organization, and
  - By June 1, 2016, the hospital must have CMS approval of an attestation by the hospital of Meaningful Use Stage 2 for Program Year 2015 (as described in 42 CFR 495.20) for the period of January 4, 2016 through February 29, 2016; or, for a Children's hospital that does not participate in Medicare, AHCCCS approval of an attestation by the hospital of Meaningful Use Stage 2 for Program Year 2015 (as described in 42 CFR 495.20) for the period of January 4, 2016 through April 30, 2016.

**R9-22-712.75. DRG Reimbursement: Payment for Administrative Days**

- ~~A.~~ Administrative days are days of a hospital stay in which a member does not meet criteria for an acute inpatient stay, but is not discharged because an appropriate placement outside the hospital is not available, the Administration or the contractor fail to provide for the appropriate placement outside the hospital in a timely manner, or the member cannot be safely discharged or transferred.
- ~~A.~~ Administrative days are days in which a member is admitted as an inpatient to an acute care hospital, does not meet the criteria for an acute inpatient stay, but is admitted or not discharged because (1) an appropriate placement outside the hospital is not available, (2) the member cannot be safely discharged or transferred, or (3) the Administration or the contractor failed to provide for the appropriate placement outside the hospital in a timely manner.
- Administrative days may occur prior to an acute care episode, for example, when a woman with a high-risk pregnancy is admitted to a hospital while awaiting delivery.
  - Administrative days may also occur at the end of an acute care episode, for example, when a member is not discharged while awaiting placement in a nursing facility or other sub-acute or post-acute setting.
  - Administrative days may also include days in a receiving hospital when the member has been discharged from one acute care hospital for the purpose of receiving sub-acute services at the receiving hospital.
- B. Administrative days do not include days when the member is awaiting appropriate placement or services that are currently available but the hospital has not transferred or discharged the member because of the hospital's administrative or operational delays.
- C. Prior authorization is required for administrative days.
- D. A hospital shall submit a claim for administrative days separate from any claim for reimbursement for the inpatient stay otherwise reimbursable under the DRG payment methodology.
- E. Administrative days are reimbursed at the rate the claim would have paid had the services not been provided in an inpatient hospital setting but had been provided at the appropriate level of care (e.g., as nursing facility days).





in R9-22-712.10 through R9-22-710.50. The payment methodology specified in these regulations applies only to payments for outpatient hospital services provided by non-IHS acute hospitals.

**9. The agency's contact person who can answer questions about the economic, small business and consumer impact statement:**

Name: Mariaelena Ugarte  
Address: AHCCCS  
Office of Administrative Legal Services  
701 E. Jefferson, Mail Drop 6200  
Phoenix, AZ 85034  
Telephone: (602) 417-4693  
Fax: (602) 253-9115  
E-mail: AHCCCSRules@azahcccs.gov  
Web site: www.azahcccs.gov

**10. The time, place, and nature of the proceedings to make, amend, repeal, or renumber the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:**

Proposed rule language will be available on the AHCCCS website www.azahcccs.gov the week of March 18, 2016. Please send written or email comments to the above address by the close of the comment period, 5:00 p.m., May 9, 2016.

Date: May 9, 2016  
Time: 10:00 a.m.  
Location: AHCCCS  
701 E. Jefferson  
Phoenix, AZ 85034  
Nature: Public Hearing

Date: May 9, 2016  
Time: 10:00 a.m.  
Location: ALTCS: Arizona Long-Term Care System  
1010 N. Finance Center Dr., Suite 201  
Tucson, AZ 85710  
Nature: Public Hearing

Date: May 9, 2016  
Time: 10:00 a.m.  
Location: 2717 N. 4th St., Suite 130  
Flagstaff, AZ 86004  
Nature: Public Hearing

**11. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:**

No other matters have been prescribed.

**a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**

Not applicable

**b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**

Not applicable

**c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**

No analysis was submitted.

**12. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its 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 (AHCCCS)  
ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

R9-22-712.15. Outpatient Hospital Reimbursement: Affected Hospitals

ARTICLE 7. STANDARDS FOR PAYMENTS

**R9-22-712.15. Outpatient Hospital Reimbursement: Affected Hospitals**

~~Except as provided in R9-22-712(G), the AHCCCS Outpatient Capped Fee-For-Service Schedule shall apply to AHCCCS payments for outpatient services in all non-IHS acute hospitals.~~

The AHCCCS Outpatient Capped Fee-For-Service Schedule shall apply to AHCCCS payments for outpatient hospital services in all non-IHS acute hospitals. Services provided by an Outpatient Treatment Center (OTC) as defined in R9-10-101 that provides emergency room services under R9-10-1019 and that is subject to the requirements of 42 CFR 489.24, shall not be reimbursed as set forth in this Article regardless of whether the OTC operates under a hospital's single group license.