NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by first submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication. Due to time restraints, the Secretary of State's Office will no longer edit the text of proposed rules. We will continue to make numbering and labeling changes as necessary.

Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for adoption, amendment, or repeal of any rule. A.R.S. §§ 41-1013 and 41-1022.

NOTICE OF PROPOSED RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 8. ACUPUNCTURE BOARD OF EXAMINERS

PREAMBLE

1. Sections Affected	Rulemaking Action
Article 1	New Article
R4-8-101	New Section
R4-8-102	New Section
R4-8-103	New Section
R4-8-104	New Section
R4-8-105	New Section
Table 1.	New Table
R4-8-106	New Section
Article 2	New Article
R4-8-201	New Section
R4-8-202	New Section
R4-8-203	New Section
R4-8-204	New Section
R4-8-205	New Section
R4-8-206	New Section
R4-8-207	New Section
R4-8-208	New Section
R4-8-209	New Section
R4-8-210	New Section
Article 3	New Article
R4-8-301	New Section
R4-8-302	New Section
R4-8-303	New Section
R4-8-304	New Section
R4-8-305	New Section
R4-8-306	New Section
R4-8-307	New Section
R4-8-308	New Section
R4-8-309	New Section
R4-8-310	New Section
Article 4	New Article
R4-8-401	New Section
R4-8-402	New Section

Article 5	New Article
R4-8-501	New Section
R4-8-502	New Section
R4-8-503	New Section
R4-8-504	New Section
R4-8-505	New Section
R4-8-506	New Section

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

Authorizing statute: A.R.S. § 32-3903(A)(1)

Implementing statutes: A.R.S. §§ 32-3903(A)(6); 3922(A)(1), (2), and (3); 3922(C); 2924;3925(C) and (D); 3926(A) and (C); and Laws 1998, Chapter 2398, Sec. 3

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

Notice of Rulemaking Docket Opening: 5 A.A.R. 1540, May 21, 1999

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

Name: Elaine LeTarte

Address: 1400 West Washington, Room 230
Phoenix, AZ 85007

Telephone: (602) 542-3095

Facsimile number: (602) 542-3093

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

The proposed rules implement new statutes that were passed during the 1998 legislative session to create the Acupuncture Board of Examiners. The rules provide definitions; operational procedures for the Board; timeframes for Board approvals; application requirements for acupuncture, auricular acupuncture, visiting professors, and those seeking acupuncture licensing through grandfathering; standards and procedures for approval of acupuncture programs, auricular acupuncture training programs, clean needle technique courses, clinical training, and continuing education courses; regulation of treatment by acupuncture students and recordkeeping; and public participation procedures.

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

None

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

Not applicable

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

Cost impacts for the Board in making these rules will be moderate and include the cost of the rule consultant assisting with this rule adoption. There is also a remote possibility of additional cost to the Board in the event that it fails to meet the timeframes for approvals and must refund licensing or certification fees. Costs incurred by the Board in implementing this comprehensive regulatory scheme of individual licensure and certification, and program approvals will be substantial, with an estimated annual budget of approximately $40,000.

The cost of promulgating these rules will have a minimal impact on the Governor's Regulatory Review Council and the Secretary of State's Office. Minimal or no impacts are expected for any other agencies or political subdivisions of the state. Similarly, little or no cost impacts would be expected for consumers.

Fees to be incurred by applicants for acupuncture licensure, auricular acupuncture certification, visiting professor certification, or renewal will be minimal, ranging from a maximum of $250 to $600. Other statutory fees are also minimal. Other applicant costs will likely include costs for obtaining copies of official records and documenting education, and may include the cost of translating documents into English. Educational costs for persons seeking acupuncture licensure are estimated to be between $10,000 to $25,000 per year for a three- or four-year program of study. For auricular acupuncture, costs are anticipated to be much lower as the training is much shorter and less rigorous.

Costs for continuing education are estimated to range from $200 to $400 for the required 15 annual units of continuing education credit.

Costs for approval of acupuncture and auricular acupuncture programs, and clean needle technique courses are expected to be minimal, with the only real costs in completing and mailing the applications to the Board. Costs for existing programs to meet the standards for approval should be minimal as they are consistent with the existing accrediting agency standards with which existing programs already comply. However, costs to establish a new acupuncture program would be very expensive, involving provision for faculty, facilities, materials, and the necessary infrastructure. Costs for a new auricular acupuncture program would be minimal to moderate. Costs for a new clean needle technique course are expected to be minimal.

Current practitioners of acupuncture should incur only minimal costs in obtaining licensure through grandfathering. Costs would be in documenting that the applicant meets the statutory qualifications, particularly in having a CPA present a certified opinion of the applicant's practicing at least two years during the past five years. This could possibly cost several hundred dollars.

The principal benefit to be derived from implementing this comprehensive regulatory structure for acupuncture is the protection of public health and safety through assurance of properly educated and trained practitioners in programs that meet essential basic standards. While the costs for the system are ultimately passed to consumers of the services, the benefits outweigh such costs.

"Minimal cost" as used in this section means an amount less than $1,000.

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

Name: Elaine LeTarte

Address: 1400 West Washington, Room 230
Phoenix, AZ 85007

Telephone: (602) 542-3095

Facsimile number: (602) 542-3093

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

Date: April 5, 2000

Time: 12:30 p.m.

Location: 1400 West Washington, Basement Conference Room
Phoenix, Arizona

Nature: Public hearing to receive oral and written comment on proposed rules

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

Not applicable

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

"NADA Registered Trainer Resource Manual", 1999, published by the National Acupuncture Detoxification Association, 3220 N Street NW #275, Washington, D.C. 20007, at R4-8-301(A).

"Clean Needle Technique Manual for Acupuncturists", 4th Edition, 1997, published by the National Acupuncture Foundation, 1718 M. Street, Suite 195, Washington, D.C. 20036, at R4-8-302(A).

"Accreditation Handbook", January 1998 Update, pages 9 through 41, published by the Accreditation Commission for Acupuncture and Oriental Medicine, 1010 Wayne Avenue, Suite 1270, Silver Spring, MD 20910, at R4-8-304(C).

13. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 8. ACUPUNCTURE BOARD OF EXAMINERS

ARTICLE 1. GENERAL PROVISIONS

ARTICLE 2. LICENSING AND CERTIFICATION PROVISIONS

ARTICLE 3. TRAINING PROGRAMS AND CONTINUING EDUCATION

ARTICLE 4. REGULATORY PROVISIONS

ARTICLE 5. PUBLIC PARTICIPATION PROCEDURES

ARTICLE 1. GENERAL PROVISIONS

R4-8-101. Definitions

For purposes of this Chapter:

1. "NCCAOM" means the National Commission for the Certification of Acupuncture and Oriental Medicine.
2. "Acupuncturist" means a person licensed or certified by the Board to practice acupuncture in the State of Arizona.
3. "Administrative completeness review" means the Board's process for determining that a person has provided all of the information and documents required by this Chapter for an application.
4. "Applicant" means a person requesting a certificate or license from the Board.
5. "Application packet" means the fees, forms, documents, and additional information the Board requires to be submitted by an applicant or on an applicant's behalf.
6. "Day" means calendar day.
7. "Course" means a systematic learning experience, at least 1 hour in length, that assists participants to acquire knowledge, skills, and information relevant to the practice of acupuncture.
8. "Hour" means at least 50 minutes of course participation.
9. "Supervisor" means an acupuncturist licensed by the Board who is responsible for the oversight and direction of an acupuncture student.
10. "Clean needle technique" means a manner of needle sterilization that avoids the spread of disease and infection, protects the public and the patient, and complies with state and federal law, regulation, and rule.
11. "NADA" means the National Acupuncture Detoxification Association.
12. "Successful completion of a clean needle technique course" means a course participant has:
    a. Attended the course, and
    b. Received a passing score on an examination or other confirmation from the course provider that evidences that the participant mastered the course content.

R4-8-102. Certification of Documentation; Translation; Verification

A. An applicant shall ensure that documents submitted to the Board from the applicant or any program has an official or government seal or written verification authenticating the documents. The Board in its discretion may waive this requirement if the Board determines that an applicant cannot obtain the seal or verification through the exercise of due diligence.

B. An applicant shall ensure that official copies of diplomas, transcripts, licenses or certificates, examination scores, and other documents required for application are forwarded directly to the Board by the issuing agency.

C. An applicant shall ensure that all documents submitted in a language other than English are accompanied by an English translation, the accuracy of which is certified by the translator. The Board shall not accept a translation by the applicant.

D. All written verifications of statements or documents submitted by or on behalf of an applicant shall be under oath and shall be made under penalty of perjury.

R4-8-103. Filing of Address and Telephone Number

A person holding a license or certificate or any other authority issued under this Chapter shall file the person's current mailing address, residential telephone number, and business telephone number with the Board, and shall notify the Board, in writing, within 20 days of any change of mailing address, giving both the old and the new address, and of residential or business telephone numbers.

R4-8-104. Board Meetings

A. The Board shall conduct its annual meeting in January.

B. The Board shall provide public notice of the date, time, and place of its annual meeting at the office of the State of Arizona Board of Acupuncture Examiners at least 20 days before the meeting.

C. All special meetings of the Board shall be set at the direction of the Chairman.

R4-8-105. Timeframes for Licensing, Certification, and Approvals

A. The overall timeframe described in A.R.S. § 41-1072(2) for each type of license, certificate, and approval granted by the Board is listed in Table 1. The applicant and the Executive Director of the Board may agree in writing to extend the overall timeframe. The overall timeframe and the substantive timeframe may not be extended by more than 25% of the overall timeframe.

B. The administrative completeness review timeframe begins:

1. For approval or denial of a acupuncture license by grandfathered rights, when the applicant passes the Board Clinical Competency Examination;
2. For approval or denial of an application for licensure or other certification, when the Board receives an application packet; and
3. For approval or denial of an application for approval of a training program, clean needle course, or continuing education course, when the Board receives a request for approval.

C. If a timeframe's last day falls on a Saturday, Sunday or an official state holiday, the next business day is the timeframe's last day.

Table 1. Timeframes (in days)

Type of Applicant	Type of Approval	Statutory Authority	Overall Time-frame	Administrative Completeness Timeframe	Substantive Review Timeframe
Acupuncture License by Grandfathered Rights	Approval for Licensure	Laws 1998, Ch. 239, § 3	60	20	40
Acupuncture License	Approval for Licensure	A.R.S. § 32-3924	60	20	40
Visiting Professor Certificate	Approval for Certification	A.R.S. § 32-3926	60	20	40
Auricular Acupuncture Certificate	Approval for Certification	A.R.S. § 32-3922	60	20	40
Auricular Acupuncture Training Programs	Approval of training program	A.R.S. § 32-3922	60	20	40
Program of Acupuncture	Approval of training program	A.R.S. § 32-3924(2)	60	20	40
Clinical Training Program	Approval of training program	A.R.S. § 32-3924(2)	60	20	40
Clean Needle Technique Course	Approval of course	A.R.S. § 32-3924	60	20	40
Continuing Education Program	Approval for Continuing Education	A.R.S. § 32-3925	90	40	50
Exemption from continuing education	Approval of exemption	A.R.S. § 32-3925	30	10	20
License of certificate renewal	Approval of renewal	A.R.S. § 32-3925	60	20	40
License or certificate reinstatement	Approval of reinstatement of license	A.R.S. § 32-3925(D)	60	20	40

R4-8 106. Completion of Applications; Nonrefundable Fees

A. The Board shall deem an application administratively complete when the Board receives all documents required for licensure or certification. An applicant is responsible to ensure that the applicant's application is complete.

B. Application fees are nonrefundable except as required by A.R.S. § 41-1077.

ARTICLE 2. LICENSING AND CERTIFICATION PROVISIONS

R4-8-201. Application for Auricular Acupuncture Certificate

To be certified as an auricular acupuncturist to provide acupuncture services in alcoholism, substance abuse, and chemical dependency programs, an applicant shall submit an application packet to the Board that includes:

1. An application, on a form provided by the Board, that provides the following information about the applicant:
   a. Name, date of birth, and social security number;
   b. Home and business addresses and telephone numbers;
   c. Whether the applicant has ever been permitted by law to practice acupuncture in another state, territory, or district of the United States, or any other country or subdivision of any country, with a list of the states, license numbers, issuance dates, expiration dates, license limitations, current status, and whether the licenses were granted by endorsement, examination, or another means;
   d. Whether the applicant has ever had a licensing authority of any other state, district, or territory of the United States, or any other country or subdivision of any country, deny the applicant a license or certificate to practice acupuncture, or revoke, suspend, limit, restrict, or take any other action regarding the applicant's license or certificate to practice acupuncture, and if so, an explanation;
   e. Whether the applicant has ever been convicted of a crime, including driving under the influence of drugs or alcohol, other than a minor traffic offense, and if so, an explanation;
   f. Whether the applicant has ever had a claim for malpractice or a lawsuit filed against the applicant alleging professional malpractice or negligence in the practice of acupuncture, and if so, an explanation;
   g. Whether the applicant has any condition that may impair the applicant's ability to practice acupuncture safely and skillfully;
   h. Whether the applicant has ever resigned, voluntarily or involuntarily, from a health-care facility while under investigation or had a health-care facility terminate, restrict, or take any other action regarding the applicant's employment, professional training, or privileges; and
   i. A signed verification that the facts in the application are accurate, true, and complete;
2. The fees prescribed by the Board; and
3. Documentation of successfully completing a Board-approved training program in acupuncture for the treatment of alcoholism, substance abuse, or chemical dependency and a Board-approved clean needle technique course.

R4-8-202. Approval of Substance Abuse and Chemical Dependency Programs for the Practice of Auricular Acupuncture

A. An auricular acupuncture certificate holder shall provide acupuncture services only in alcoholism, substance abuse, and chemical dependency programs approved by the Board, or as are otherwise allowed under A.R.S. § 32-3922(B).

B. For purposes of this Section, the Board approves an alcoholism, substance abuse, and chemical dependency program that provides services and is licensed by the Arizona Department of Health Services as a behavioral health agency.

R4-8-203. Application for Acupuncture License

To be licensed to practice acupuncture, an applicant shall submit an application packet to the Board that includes:

1. An application, on a form provided by the Board, that provides the following information about the applicant:
   a. Name, date of birth, and social security number;
   b. Home and business addresses and telephone numbers;
   c. Whether the applicant has ever been permitted by law to practice acupuncture in another state, territory, or district of the United States, or country, with a list of the states, license numbers, issuance dates, expiration dates, license limitations, current status, and whether the licenses were granted by endorsement, examination, or another means;
   d. Whether the applicant is certified by the NCCAOM, and if so, whether the certification is active and current, and the dates of issuance and expiration;
   e. Whether the applicant is certified by another certifying body, and if so, the name and address of the certifying body, and the dates of issuance and expiration of the certification;
   f. Whether the applicant has passed a certifying or licensing examination in acupuncture, and if so, the name and address of the organization administering the examination;
   g. Whether the applicant has completed an acupuncture program accredited within the United States; and if so, the date of completion of the program;
   h. Whether the applicant has completed a minimum of 1,850 hours of training in acupuncture that includes at least 800 hours of clinical training, and if so, the names and addresses of the schools attended, dates of attendance, and the diploma or degree obtained;
   i. Whether the applicant has ever had a licensing authority of any other state, district, or territory of the United States or any other country or subdivision of any country, deny the applicant a license or certificate to practice

acupuncture, or revoke, suspend, limit, restrict, or take any other action regarding the applicant's license or certificate to practice acupuncture, and if so, an explanation;

j. Whether the applicant has ever been convicted of a crime, including driving under the influence of drugs or alcohol, other than a minor traffic offense, and if so, an explanation;

k. Whether the applicant has ever had a claim for malpractice or a lawsuit filed against the applicant alleging professional malpractice or negligence in the practice of acupuncture, and if so, an explanation;

l. Whether the applicant has any condition that may impair the applicant's ability to practice acupuncture safely and skillfully;

m. Whether the applicant has ever resigned, voluntarily or involuntarily, from a health- care facility while under investigation or had a health-care facility terminate, restrict, or take any other action regarding the applicant's employment, professional training, or privileges; and

n. A signed verification that the facts in the application are accurate, true, and complete;

2. One of the following:

a. Transcript that shows evidence of graduation from or completed training from an approved acupuncture program and includes a list of the courses studied and clinical training received, grades or scores for each course and clinical training, and the name and address of the approved program;

b. Documentation of and scores for certification from the NCCAOM, its successor, or another certifying body recognized by the Board; or

c. Documentation that the applicant has been permitted by law by another state, district, or territory of the United States, or another country or subdivision of a country with standards substantially similar to those in this Chapter with no license revoked;

3. Documentation of successfully completing a clean needle technique course approved by the Board;

4. A photograph of the applicant no larger than 2 x 2 inches taken during the preceding 12 months; and

5. The fee prescribed by the Board.

R4-8-204. Renewal of Licenses and Certificates

A. All licenses and certificates expire 12 months from the date issued.

B. A licensee or certificate holder shall submit renewal fees with a renewal application form provided and mailed to the licensee or certificate holder by the Board that furnishes up-to-date information concerning current practice status, location of practice, correct home and business mailing addresses, and telephone numbers on or before the date the license or certificate expires.

C. To renew a license or certificate, a licensee or certificate-holder shall submit an affidavit of attendance in continuing education that meets the requirements of A.R.S. § 32-3925 (C).

D. A licensee or certificate holder who fails to renew on or before the date the license or certificate expires shall immediately cease and desist from engaging further in any practice under these rules and A.R.S. Title 32, Chapter 39 until the license or certificate is renewed.

R4-8-205. Continuing Education Requirement

A. A licensee or certificate holder shall complete a minimum of 15 hours of Board-approved continuing education per year.

B. With an application for license or certificate renewal, an acupuncturist shall submit a signed statement under penalty of perjury that indicates whether the acupuncturist has complied with the continuing education requirement.

C. The Board, at its discretion, may audit a random sample of acupuncturists who report compliance with the continuing education requirement.

D. An acupuncturist selected for audit shall submit documentation or records of continuing education course work completed.

E. An acupuncturist shall retain for a minimum of 2 years records of all continuing education courses or programs completed which indicate the provider's name, title of the course or program, date and location of course or program, and number of continuing education credits awarded.

F. Instructors of approved continuing education courses may receive 1 hour of continuing education credit for each classroom hour taught, up to a maximum of 2 hours of continuing education credit per year. Participation as a member of a panel presentation for an approved course does not entitle the participant to earn continuing education credit as an instructor.

G. An acupuncturist may use up to 4 hours of continuing education in acupuncture practice management or medial ethics per year to meet the continuing education requirement.

R4-8-206. Reinstatement of License or Certificate

A. To reinstate an expired license or certificate, the former licensee or certificate holder shall submit the required renewal application, renewal fee, any applicable late fees, and affirmation of continuing education attendance within 12 months from the date of expiration.

B. If a license or certificate is expired for more than 12 months, the former licensee or certificate holder may reapply for licensure or certification only by complying with this Article.

C. A person whose license or certificate is expired for more than 3 years and who reapplies for licensure or certification shall take and pass a clinical competency examination before a new license or certificate will be issued.

R4-8-207. Exemption from Continuing Education

A. A licensed or certified acupuncturist may submit to the Board a written request to be exempt from the annual continuing education requirement for the following reasons:
1. Catastrophic illness or other serious disability; or
2. Military service of longer than 1 year in duration.

B. Exemption requests shall be submitted at least 30 days before the expiration of the license or certificate.

C. If granted by the Board, an exemption is for the 1 renewal period only. An exemption may be reapplied for annually, if necessary.

D. A denial of exemption may be appealed in accordance with A.R.S. Title 41, Chapter 6, Article 10.

R4-8-208. Application for Visiting Professor Certificate

A. To be approved by the Board, an applicant for a visiting professor certificate shall submit to the Board:
1. An application on a form provided by the Board that includes the information required in R4-8-201(1) and a signed verification that the facts in the application are accurate, true, and complete;
2. The required fees;
3. Written documentation of at least 5 years of experience in the practice of acupuncture; and
4. Evidence of skill and training in the subject that the applicant will be teaching, including 1 of the following:
   a. Written documentation from a college or university of experience, education, or other training in the subject the applicant will be teaching;
   b. Written documentation of experience in teaching the same or similar subject matter content within the 2 years preceding the application; or
   c. Written documentation of 1 year's experience within the last 2 years in the specialized area in which the applicant is teaching.
5. A detailed plan outlining the duties of the visiting professor.

B. The Board shall issue a visiting professor certificate to an applicant who complies with the requirements of this Section. An applicant who is denied a visiting professor certificate may request a hearing in accordance with A.R.S. Title 41, Chapter 6, Article 10.

R4-8-209. Application for Grandfathered Rights

A. An applicant for licensure by grandfathered rights shall submit an application packet to the Board on or before December 31, 2000 that includes:
1. An application on a form provided by the Board that provides the following information about the applicant:
   a. Name, date of birth, social security number, and home and business addresses and telephone numbers;
   b. A photograph of the applicant no larger than 2 x 2 inches and taken during the preceding 12 months;
   c. Whether the applicant has current active status as a diplomate of acupuncture from the NCCAOM, and if so, the dates of issue and expiration;
   d. Whether the applicant passed the NCCAOM examination, and if so, the date the examination was taken;
   e. Whether the applicant passed an acupuncture examination other than the NCCAOM, and if so, the date of examination and name and address of the organization that administered the examination;
   f. Whether the applicant has been permitted by law to practice acupuncture in another state, and if so, a list of the states and whether each license is active or inactive;
   g. Whether the applicant has at least 1,000 hours of combined training and experience in acupuncture or oriental medicine;
   h. Whether the applicant has ever had a licensing authority of any other state, district, or territory of the United States or any other country or subdivision of any country, deny the applicant a license or certificate to practice acupuncture, or revoke, suspend, limit, restrict, or take any other action regarding the applicant's license or certificate to practice acupuncture, and if so, an explanation;
   i. Whether the applicant has ever been convicted of a crime, including driving under the influence of drugs or alcohol, other than a minor traffic offense, and if so, an explanation;
   j. Whether the applicant has ever had a claim for malpractice or a lawsuit filed against the applicant alleging professional malpractice or negligence in the practice of acupuncture, and if so, an explanation;
   k. Whether the applicant has any condition that may impair the applicant's ability to practice acupuncture safely and skillfully;

l. Whether the applicant has ever resigned, voluntarily or involuntarily, from a health-care facility while under investigation or had a health-care facility terminate, restrict, or take any other action regarding the applicant's employment, professional training, or privileges; and
m. A signed verification that the facts in the application are accurate, true, and complete;
2. The required initial license fee;
3. Proof of residency in the State of Arizona on June 2, 1998;
4. Evidence of having passed a competency test, as described in R4-8-210, in contraindications, sanitary techniques, and complications; and
5. Documents that prove that the applicant has:
a. Current, active status as a diplomate of acupuncture from the NCCAOM, or
b. Current, active acupuncture licensure from another state; or
c. Complies with subsection (B).

B. An applicant applying for licensure by grandfathered rights who neither is a diplomate of acupuncture nor holds an acupuncture license from another state shall provide to the Board:
1. Documentation of the hours of experience and training in the practice of acupuncture, including specific dates and actual hours of practice provided, the name and address of each place of practice and program attended, and a description of the experience and training;
2. A statement signed by the applicant attesting to the applicant's having completed at least 1000 hours of combined training and experience;
3. A certified opinion from a certified public accountant stating that the applicant's records show at least 2 years of practice in acupuncture out of the past five years; and
4. A letter of recommendation, dated within 30 days of filing an application for licensure, signed by an acupuncturist permitted by law to practice in the United States or its districts or territories, attesting to the applicant's ability, qualifications, skills in sanitary techniques, and fitness to practice acupuncture.

C. The Board shall grant a license to an applicant who meets the requirements of this Section.

D. The Board shall deny licensure to an applicant for licensure by grandfathered rights who fails to meet the requirements of this Section. The applicant may appeal the denial of licensure in accordance with A.R.S. Title 41, Chapter 6, Article 10.

E. This Section is repealed on January 31, 2001.

R4-8-210. Minimum Competency Test for Grandfathered Rights

A. The minimum competency test for grandfathered rights is a written test.
1. The test measures the applicant's knowledge and competency in contraindications, sanitary techniques, and complications.
2. To pass the test, an applicant shall obtain a score of 75 on each part of the test.

B. Tests of applicants applying for licensure by grandfathered rights shall be held at a time, place, and date to be provided in writing to all applicants who have applications for licensure on file with the Board and pay their fees not less than 60 days before the test. The number of times an applicant may take the test is limited solely by the December 31, 2000 deadline for filing a complete application for licensure by grandfathered rights.

C. An applicant who fails the minimal competency test may appeal the failing score in accordance with A.R.S. Title 41, Chapter 6, Article 10.

D. This Section is repealed on January 31, 2001.

ARTICLE 3. TRAINING PROGRAMS AND CONTINUING EDUCATION

R4-8-301. Auricular Acupuncture Training Program Approval

A. To receive Board approval, a training program in acupuncture for the treatment of alcoholism, substance abuse, or chemical dependency shall submit to the Board evidence that:
1. The program is conducted in accordance with the "NADA Registered Trainer Resource Manual", 1999, published by the National Acupuncture Detoxification Association, 3220 N Street NW #275, Washington, D.C. 20007, which is incorporated by reference and on file with the Board and the Secretary of State. This incorporation includes no later edition or amendment; and
2. The program is approved by the NADA, another national certifying agency for acupuncture, or another state.

B. A program that is denied approval may appeal by requesting a hearing under A.R.S. Title 41, Chapter 6, Article 10.

R4-8-302. Clean Needle Technique Course Approval

A. To be approved by the Board, a person who proposes to conduct a clean needle technique course shall submit to the Board evidence that the course is conducted in accordance with "Clean Needle Technique Manual for Acupuncturists", 4th Edition, 1997, published by the National Acupuncture Foundation, 1718 M Street NW, Suite 195, Washington, D.C. 20036, which is incorporated by reference and on file with the Board and the Secretary of State. This incorporation includes no later edition or amendment.

B. A course that is denied approval may appeal by requesting a hearing under A.R.S. Title 41, Chapter 6, Article 10.

R4-8-303. Approval of Program of Acupuncture; Clinical Training

A. To obtain approval from the Board, an acupuncture program shall either:
1. Submit documentation that the acupuncture program is a candidate for accreditation or has accreditation through the ACAOM and provides a minimum of 1,850 hours of training, including not less than 800 hours of clinical training; or
2. Submit documentation of compliance with R4-8-304.

B. To obtain approval from the Board, an acupuncture clinical training program shall either:
1. Submit documentation that the clinical training program is part of an acupuncture program that is a candidate for accreditation or has accreditation through the ACAOM, or is itself a candidate for accreditation or has accreditation through ACAOM; or
2. Submit documentation of compliance with R4-8-304(B).

R4-8-304. Program of Acupuncture Standards

A. The Board shall approve a program of acupuncture that does not meet the standard at R4-8-303(A)(1) only if the program is for a minimum of 3 years and provides the following course content and hours:
1. 690 hours in Oriental medical theory, diagnosis, and treatment techniques in acupuncture and related studies;
2. 800 hours in clinical training; and
3. 360 hours in biomedical clinical sciences.

B. The Board shall approve an acupuncture training program that does not meet the standard at R4-8-303(B)(1) only if the clinical training program owns and operates an acupuncture clinic, provides at least 75% of clinical instruction in its clinic, and provides direct patient contact in the following:
1. Supervised observation of the clinical practice of acupuncture with case presentations and discussions;
2. Application of Eastern and Western diagnostic procedures in evaluating patients; and
3. Clinical treatment of a patient with acupuncture.

C. An acupuncture program shall comply with the 14 Essential Requirements and their attendant criteria in the "Accreditation Handbook", January 1998 Update, pages 9 through 41, published by the Accreditation Commission for Acupuncture and Oriental Medicine, 1010 Wayne Avenue, Suite 1270, Silver Spring, MD 20910, which is incorporated by reference and on file with the Board and the Secretary of State. This incorporation includes no later edition or amendment.

R4-8-305. Documentation Required for Approval

An acupuncture program or clinical training program seeking approval by the Board shall provide the Board with documents and other evidence requested by the Board to determine the nature and extent of the training offered, including but not limited to, catalogues, course description, curricula plans, and study bulletins.

R4-8-306. Denial or Revocation of Approval

A. The Board may deny approval to or revoke the approval of any acupuncture program or clinical training program for its failure to comply with the rules in this Chapter or A.R.S. Title 32, Chapter 39.

B. An acupuncture program or clinical training program that has approval denied may request a hearing in accordance with A.R.S. Title 41, Chapter 6, Article 10.

C. The Board shall conduct a hearing in accordance with A.R.S. Title 41, Chapter 6, Article 10, before revoking an acupuncture program or clinical training program approval.

R4-8-307. Acupuncture Program Monitoring; Records; Reporting

A. Every approved acupuncture program shall submit to the Board, within 60 days after the close of the program's fiscal year, a current course catalog with a letter outlining the following:
1. Any courses added, deleted, or substantially changed from the previous year's curriculum;
2. Any changes in program faculty, administration, or governing body; and
3. Any substantial changes in the program facility.

B. Representatives of the Board may conduct an on-site visit of an approved program to review and evaluate the status of the program. The approved program shall be required to reimburse the Board for direct costs incurred in conducting this review and evaluation.

C. All student records shall be maintained in English.

D. Each approved program of acupuncture shall, within 30 days, report to the Board any substantial changes to the facility, clinic, or curriculum.

R4-8-308. Approval of Continuing Education Course

A. To be approved by the Board, a continuing education course shall:
1. Be related to the knowledge or technical skills required to practice acupuncture; or
2. Be related to direct or indirect acupuncture patient care, including practice management or medical ethics; and
3. Include a method by which the course participants evaluate:

a. The extent to which the course met its stated objectives,
b. The adequacy of the instructor's knowledge of the course subject,
c. The use of appropriate teaching methods,
d. The applicability or usefulness of the course information, and
e. Other aspects of the course.

B. The Board shall not approve courses designed to be completed by an individual on an independent or home-study basis.

R4-8-309. Application for Continuing Education Course Approval

A. To obtain approval for a continuing education course, a course provider shall submit to the Board a request for course approval, in English, on a form provided by the Board, which includes the following information:
1. The provider's name, provider number, address, telephone number, and contact person;
2. Course title, date, location, and number of continuing education hours;
3. Method of instruction;
4. Educational objectives to be met and course outline;
5. Instructor information and qualifications; and
6. All proposed public advertisements that the provider intends to use to advertise the course. If the provider uses a public advertisement that is developed after the course is approved and that was not provided to the Board with the course approval request, the provider shall mail a copy of the advertisement to the Board within 10 days after its publication.

B. A provider shall obtain Board approval for every course that is offered for continuing education credit. If a previously approved course is repeated, the provider shall apply to the Board for approval of each subsequent administration of the course.

C. A provider shall submit a request for course approval to the Board at least 90 days before the course is offered.

R4-8-310. Denial or Revocation of Continuing Education Course Approval

A. The Board may revoke its approval of a continuing education course or deny approval for a continuing education course for causes that include, but are not limited to:
1. Failure to comply with any provision of these rules; and
2. Any material misrepresentation of fact by a provider.

B. The Board may revoke its approval of a course following a hearing conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10.

C. A provider may appeal the denial of approval of a course by filing a written request for hearing in accordance with A.R.S. Title 41, Chapter 6, Article 10.

ARTICLE 4. REGULATORY PROVISIONS

R4-8-401. Treatment of Patients by Acupuncture Students; Supervision

For an acupuncture student to treat a patient, the student and the student's supervisor shall comply with the following:
1. Obtain written evidence of informed consent in writing from a patient before treatment by an acupuncture student, indicating that the patient knows a student will be treating the patient;
2. Have a supervisor physically present during any treatment of a patient performed by an acupuncture student;
3. Have a supervisor physically present at all times during the diagnosis and treatment of a patient during a student's initial 235 hours of diagnosis, evaluation, and clinical practice;
4. Consult each other before and after each treatment; and
5. Maintain records for each patient treated in accordance with R4-8-402.

R4-8-402. Recordkeeping

An acupuncturist shall maintain legible and accurate records on each patient who is given acupuncture treatment, including but not limited to, history, treatment given, and progress made during acupuncture treatments.

ARTICLE 5. PUBLIC PARTICIPATION PROCEDURES

R4-8-501. Agency Record; Directory of Substantive Policy Statements

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

R4-8-502. Petition for Rulemaking; Review of Agency Practice or Substantive Policy Statement; Objection to Rule Based Upon Economic, Small Business, or Consumer Impact

A petition to adopt, amend, or repeal a rule or to review an existing agency practice or substantive policy statement that a petitioner alleges to constitute a rule under A.R.S. § 41-1033 or to object to a rule in accordance with A.R.S. § 41-1056.01 shall be filed with the Board as prescribed in this Section. Each petition shall contain:
1. The name and current address of the petitioner;
2. For the adoption of a new rule, the specific language of the proposed rule;

3. For the amendment of a current rule, the citation for the applicable Arizona Administrative Code number and rule title. The petition shall include the specific language of the current rule with any language to be deleted stricken through but legible, and any new language underlined;
4. For the repeal of a current rule, the citation for the applicable A.A.C. number and title of the rule proposed for repeal;
5. The reason a rule should be adopted, amended, or repealed, and if in reference to an existing rule, why the rule is inadequate, unreasonable, unduly burdensome, or otherwise not acceptable. The petitioner may provide additional supporting information, including:
   a. Any statistical data or other justification, with clear reference to an attached exhibit;
   b. An identification of what persons or segment of the public would be affected and how they would be affected; and
   c. If the petitioner is a public agency, a summary of relevant issues raised in any public hearing, or as written comments offered by the public;
6. For a review of an existing Board practice or substantive policy statement alleged to constitute a rule, the reason the existing Board practice or substantive policy statement is believed to constitute a rule and the proposed action requested of the Board.
7. For an objection to a rule based upon the economic, small business, or consumer impact, evidence that:
   a. The actual economic, small business, or consumer impact significantly exceeded the impact estimated in the economic, small business, and consumer impact statement submitted during the making of the rule; or
   b. The actual economic, small business, or consumer impact was not estimated in the economic, small business, and consumer impact statement submitted during the making of the rule and that actual impact imposes a significant burden on persons subject to the rule.
8. The signature of the person submitting the petition.

R4-8-503. Public Comments

A. On or before the date of the close of record, a person may comment upon a rule proposed by the Board by submitting written comments on the proposed rule or upon any other matter noticed for public comment by the Board in the Arizona Administrative Register.

B. The Board considers a written comment submitted on the date it is received by the Board, except if a comment is mailed, the postmarked date is considered the date of receipt.

C. The Board shall consider all written comments that conform with A.R.S. § 41-1023.

R4-8-504. Oral Proceedings

A. A person requesting an oral proceeding, as prescribed in A.R.S. § 41-1023(C), shall:
1. File the request with the Board;
2. Include the name and current address of the person making the request; and
3. Refer to the proposed rule and include, if known, the date and issue of the Arizona Administrative Register in which the notice of the proposed rule is published.

B. The Board shall record an oral proceeding either electronically or stenographically, and shall make any cassette tape, transcript, register, and written comment received part of the official record.

C. The presiding officer shall use the following guidelines to conduct an oral proceeding:
1. Registration of attendees. Registration of attendees is voluntary;
2. Registration of persons intending to speak. A person wishing to speak shall provide the person's name, representative capacity, if applicable, a notation of the person's position with regard to the proposed rule and the approximate length of time the person wishes to speak;
3. Opening of the record. The presiding officer shall open the proceeding by identifying the rule to be considered and the location, date, time, and purpose of the proceeding, and by presenting the agenda;
4. A statement by Board representative. A Board representative shall explain the background and general content of the proposed rule;
5. A public oral comment period. Any person may speak at an oral proceeding. A person who speaks shall ensure that all comments address the rule being considered. The presiding officer may limit the time allotted to each speaker and preclude undue repetition; and
6. Closing remarks. The presiding officer shall announce the location and last day for submitting written comments about the proposed rule.

R4-8-505. Petition for Delayed Effective Date

A. A person wanting to delay the effective date of a rule under A.R.S. § 41-1032 shall file a petition with the Board. The petition shall contain:
1. The name and current address of the person submitting the petition;
2. Identification of the proposed rule;

3. The need for the delay, specifying the undue hardship or other adverse impact that may result if the request for a delayed effective date is not granted, and the reasons why the public interest will not be harmed by the later date; and
4. The signature of the person submitting the petition.

B. The Board shall make a decision and notify the petitioner of the decision within 60 days of receipt of the petition.

R4-8-506. Written Criticism of Rule

A. Any person may file a written criticism of an existing rule with the Board.

B. The criticism shall clearly identify the rule and specify why the existing rule is inadequate, unduly burdensome, unreasonable, or otherwise improper.

C. The Board shall acknowledge receipt of any criticism within 15 days and shall place the criticism in the official record for review by the Board under A.R.S. § 41-1056.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 1. DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

PREAMBLE

1. Sections Affected **Rulemaking Action**

R9-1-412 Amend

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

Authorizing statute: A.R.S. §§ 36-132(A) and 36-136(F)

Implementing statute: A.R.S. §§ 36-405(A) and 36-406

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

Notice of Rulemaking Docket Opening: 2 A.A.R. 4264, October 11, 1996

Notice of Rulemaking Docket Opening: 5 A.A.R. 2999, September 3, 1999

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

Name: Tom Thliveris

Address: Department of Health Services
Assurance and Licensure Services
1647 E. Morten Avenue, Suite 110
Phoenix, Arizona 85020

Telephone: (602) 674-4360

Fax number: (602) 861-0463

or

Name: Kathleen Phillips

Address: Department of Health Services
1740 W. Adams, Suite 410
Phoenix, Arizona 85007

Telephone: (602) 542-1264

Fax number: (602) 542-1289

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

R9-1-412 incorporates by reference physical plant health and safety codes and standards including the Uniform Building Code, Uniform Mechanical Code, Uniform Plumbing Code, Guidelines for Design and Construction of Hospital and Healthcare Facilities, National Fire Codes, American National Standard Accessible and Usable Building and Facilities, and Uniform Fire Code. The Department refers to the codes and standards in R9-1-412 in Title 9, spe-

cifically in Chapter 5, Child Care Facilities; Chapter 8, Food, Recreational and Institutional Sanitation; Chapter 9, Health Care Institutions: Establishment, Modification; Chapter 10, Health Care Institutions: Licensure; Chapter 14, Laboratories; and Chapter 20, Behavioral Health Service Agencies: Licensure. In order to have requirements that reflect current industry standards and to maintain consistency with the codes and standards currently enforced by local jurisdictions, the Department is amending the rule to incorporate by reference in R9-1-412 the most current national codes and standards.

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

Not applicable

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

Not applicable

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

The current rule incorporates by reference specific publications of national codes and standards that establish physical plant requirements including the Uniform Building Code, the Uniform Mechanical Code, the Uniform Plumbing Code, Guidelines for Design and Construction of Hospital and Healthcare Facilities, the National Fire Code, the American National Standard Accessible and Usable Buildings and Facilities, and the Uniform Fire Code. The national organizations responsible for these codes and standards periodically review, revise, and republish the codes and standards in an effort to ensure greater safety and lower costs. The proposed rule amends the listed publications to ensure that the most current national codes and standards are incorporated by reference. The most current national codes and standards include changes in the requirements and a corresponding economic impact for the construction and modification of health care institutions and the installation of plumbing in food service establishments. The most current national codes and standards do not include any changes or economic impact for Child Care Facilities, Laboratories, and Behavioral Health Services Agencies. Local jurisdictions are using the most current national codes and standards.

The Department and local governments

Although amending the rule to incorporate by reference the most current national codes and standards will result in both a cost savings for and increased costs to the Department, the net effect will be a moderate increase in costs of approximately $1,800. Because local jurisdictions and industry professionals are using the most current national codes and standards, the Department's use of the most current national codes and standards will contribute to increased consistency and coordination and result in a minimal cost savings to the Department and local jurisdictions. Local fire departments may also realize substantial decreased costs as a result of fewer false alarms at affected institutions due to the application of new technology and fire detection devices required in the most current national codes and standards.

Health care institutions

Over the past 20 years, fire code requirements in the national codes and standards have shifted from the use of specific building materials to contain fires to the use of sprinkler systems to suppress fires. As a result the fire code now allows the use of materials that are not fire-rated and less costly. However, the fire code requirements for an electric door connected to an emergency generator will increase the installation cost of the electric door by approximately $200 per electric door.

The most current national codes and standards incorporated by reference in the proposed rule are more focused on preventive maintenance rather than replacement of materials. It is estimated that the use of protective plates on a nursing care institution's interior doors will increase the life of a door by three years, a cost savings of approximately $100 per door annually. In addition, allowing a nursing care institution to use battery-operated smoke detectors instead of hardwired smoke detectors in resident rooms will yield a savings of approximately $138 per smoke detector and will encourage the use of a resident's own bedding and furnishings instead of fire-rated institutional furnishings.

The proposed rule will decrease construction costs for health care institutions. The most current national codes and standards allow some interior corridors to be constructed with material that is not fire-rated and require fewer fire dampers, fire-rated doors, and lower-cost gypsum wall board resulting in decreased costs for interior corridors. The change in the most current national codes and standards requirements results in approximately a 25% decrease in the costs of gypsum wall board, $600 decrease for each toilet room, $250 decrease for each room for ventilation, and $300 decrease for each interior door.

Food service establishments

Plumbing code requirements in the most current national codes and standards establish standards for the production and installation of reverse osmosis drinking water units in food service establishments that many manufacturers already meet or exceed. A manufacturer who does not currently comply with the most current plumbing code requirements will incur increased costs of approximately $500 to install a reverse osmosis drinking water unit in a food service establishment in compliance with the plumbing code requirements in the most current national code and standards.

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

Name: Tom Thliveris

Address: Department of Health Services
Assurance and Licensure Services
1647 E. Morten, Suite 110
Phoenix, Arizona 85020

Telephone: (602) 674-4200

Fax number: (602) 861-0645

or

Name: Kathleen Phillips

Address: Department of Health Services
1740 W. Adams, Suite 410
Phoenix, Arizona 85007

Telephone: (602) 542-1264

Fax number: (602) 542-1289

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

The Department has not scheduled any oral proceedings on this rulemaking action. The Department will schedule oral proceedings if a person submits a written request for oral proceedings to an individual listed in paragraph 4 before 5:00 p.m., April 3, 2000, the date scheduled for the close of record.

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

Not applicable

12. Incorporations by reference and their locations in the rule:

American National Standard Accessible and Usable Buildings and Facilities, ANSI A117.1, 1998 edition, in R9-1-412(A)(6)

Guidelines for Design and Construction of Hospital and Healthcare Facilities, 1996-97 edition, in R9-1-412(A)(4)

International Mechanical Code and appendixes, 1997 edition, in R9-1-412(A)(2)

International Plumbing Code and appendixes, 1997 edition, in R9-1-412(A)(3)

National Fire Code - 1999 edition, Volumes 1 through 12 and 1999 Supplement Part 1 and Part 2, in R9-1-412(A)(5)

Uniform Building Code and appendixes, 1997 edition, Volumes 1 through 3, in R9-1-412(A)(1)

Uniform Fire Codes and appendixes, 1997 edition, Volumes 1 and 2, in R9-1-412(A)(7)

13. The full text of the rule follows:

TITLE 9. HEALTH SERVICES

CHAPTER 1. DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

ARTICLE 4. CODES AND STANDARDS REFERENCED

Section
R9-1-412. Physical Plant Health and Safety Codes and Standards

ARTICLE 4. CODES AND STANDARDS REFERENCED

R9-1-412. Physical Plant Health and Safety Codes and Standards

A. When this Section is referenced in a rule contained in Title 9, the following physical plant health and safety codes and standards are incorporated by reference and on file with the Department and the Office of Secretary of State~~,~~. ~~and~~ This incorporation by reference contains no future additions or amendments ~~or editions shall apply:~~.

1. Uniform Building Code and appendixes - ~~1994~~1997 edition, Volumes 1 through 3; published by the International Conference of Building Officials, 5360 Workman Mill Road, Whittier, ~~California~~CA 90601-2298 (formerly R9-1-412(A)).
2. Uniform Mechanical Code and appendixes - ~~1994~~1997 edition; published by the International Conference of Building Officials; 5360 Workman Mill Road, Whittier, ~~California~~CA 90601-2298 (formerly R9-1-412(C)).
3. Uniform Plumbing Code and appendixes - ~~1994~~1997 edition; published by the ~~International Association of Plumbing and Mechanical Officials, 20001 South Walnut Drive, Walnut, CA 91789-2825~~ International Conference of Building Officials; 5360 Workman Mill Road, Whittier, CA 90601-2298 (formerly R9-1-412(D)).
4. Guidelines for Design and Construction ~~and Equipment~~ of Hospital and ~~Medical~~ Healthcare Facilities, ~~1992-93~~1996-97 edition; published by The American Institute of Architects Press, 1735 New York Avenue, N.W., Washington, D.C. 20006 (formerly R9-1-412(F)).
5. National Fire Codes - ~~1995~~1999 ~~editions~~ edition, Volumes 1 through 12 and ~~1995~~1999 Supplement Part 1 and Part 2, published by the National Fire Protection Association, Batterymarch Park, Quincy, MA 02269-9101 (formerly R9-1-412(G) and includes the former R9-1-412(B), Life Safety Code, NFPA 101 and the former R9-1-412(E), National Electrical Code, NFPA 70).
6. American National Standard Accessible and Usable Buildings and Facilities, ANSI A117.1 - ~~1992~~ 1998 edition; published by Council of American Building Officials, 5203 Leesburg Pike, #708, Falls Church, VA 22041 (formerly R9-1-412(H)).
7. Uniform Fire Code and appendixes - ~~1994~~1997 edition, Volumes 1 and 2; published by the International Fire Code Institute, 9300 Jollyville Road, Suite 105, Austin, TX 78759-7455 (formerly R9-1-412(I)).

B. ~~A person shall not be subject to~~ The Department shall not assess any penalty or fee specified in the physical plant health and safety codes and standards that are incorporated by reference in this Section.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

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

PREAMBLE

1. Sections Affected	**Rulemaking Action**
R9-22-101	Amend
R9-22-105	Amend
R9-22-106	Amend
R9-22-110	Amend
R9-22-114	Amend
R9-22-116	Amend
R9-22-204	Amend
R9-22-205	Amend
R9-22-206	Amend

R9-22-209	Amend
R9-22-213	Amend
R9-22-216	Amend
R9-22-402	Amend
R9-22-711	Amend
R9-22-1608	Amend
R9-22-1609	Amend
R9-22-1610	Amend
R9-22-1611	Amend
R9-22-1616	Amend
R9-22-1701	Amend
R9-22-1704	Amend

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

Authorizing statutes: A.R.S. § § 36-2903.01(G), (H), and (K); 36-2904(D); and 36-2906(C).

Implementing statutes: A.R.S. § § 11-297; 36-2903(C)(12), (N), (R), and (S); 36-2904(E) and (F); 36-2905; 36-2907; 36-2907.04; and 36-2921(A)(1).

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

Notice of Rulemaking Docket Opening: 6 A.A.R. 607, February 4, 2000

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

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 East Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

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

The Administration is proposing changes to 9 A.A.C. 22 to conform to federal law and changes made to state statute and session law by Laws 1999, Ch. 313, § 32. The Administration made other changes to provide additional clarity and conciseness to existing rule language.

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

Not applicable

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

Not applicable

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

The Administration is proposing the changes primarily to conform rule to state statute and federal law and the Administration anticipates no substantive impact. The Administration made other changes to expedite the eligibility referral process and this will benefit certain parties by making the language easier to use.

The small business community as a whole will not be impacted by the changes. AHCCCS providers that meet the definition of small business in A.R.S. § 41-1001(19) will benefit from the additional clarity and conciseness of the rule language.

The following entities will also benefit from the changes:

• The Administration;

• AHCCCS health plans and providers;

• County eligibility staff; and

• AHCCCS members.

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

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS, Office of Policy Analysis and Coordination
801 East Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

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

Date: April 3, 2000

Time: 10:00 a.m.

Location: AHCCCS
Turquoise Room
701 East Jefferson
Phoenix, AZ 85034

Location: ALTCS: Arizona Long-Term Care System
110 South Church, Suite 3250
Tucson, AZ 85701

Location: Arizona Long-Term Care System
3480 East Route 66
Flagstaff, AZ 86004

Nature: Video Conference Oral Proceeding

The Administration will accept written comments until 5:00 p.m., April 3, 2000. Please submit comments to the following person:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS, Office of Policy Analysis and Coordination
801 East Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

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

Not applicable

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

Incorporation	Date	Location
42 CFR 455.101	September 30, 1986	R9-22-106(1)
42 U.S.C. 1396d(r)(5)	April 1, 1990	R9-22-213(8)
42 CFR 433 Subpart D	October 1, 1995	R9-22-402(A)(11)
42 CFR 434.6(b)	October 1, 1995	R9-22-402(A)(12)
42 CFR 447.50 through 447.58	October 1, 1995	R9-22-402(A)(18)
42 CFR 434 Subpart C	October 1, 1995	R9-22-402(B)

13. Was this rule previously adopted as an emergency rule?

No

14. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

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

ARTICLE 1. DEFINITIONS

Section
R9-22-101. Location of Definitions
R9-22-105. General Provisions and Standards Related Definitions
R9-22-106. Request for Proposals (RFP) Related Definitions
R9-22-110. 1st- and 3rd-Party Liability Related Definitions
R9-22-114. Title IV-A Related Definitions
R9-22-116. State-Only Eligibility Related Definitions

ARTICLE 2. SCOPE OF SERVICES

Section
R9-22-204. Inpatient General Hospital Services
R9-22-205. Physician and Primary Care Physician and Practitioner Services
R9-22-206. Organ and Tissue Transplantation Services
R9-22-209. Pharmaceutical Services
R9-22-213. Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)
R9-22-216. ~~Nursing Facility Services~~ NF, Alternative HCBS Setting, or HCBS

ARTICLE 4. CONTRACTS, ADMINISTRATION, AND STANDARDS

Section
R9-22-402. Contracts

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-711. Copayments

ARTICLE 16. STATE-ONLY ELIGIBILITY

Section
R9-22-1608. County Responsibility for Completion of MI/MN Eligibility Determination
R9-22-1609. MI/MN Timeliness Requirements
R9-22-1610. Forwarding Applications to Obtain Categorical or Title XIX Eligibility
R9-22-1611. Eligibility for Medicare Beneficiaries

ARTICLE 17. ENROLLMENT

ARTICLE 1. DEFINITIONS

R9-22-101. Location of Definitions

A. Location of definitions. Definitions applicable to Chapter 22 are found in the following:

Definition	Section or Citation
1. "210"	R9-22-114
2. "1931"	R9-22-114
3. "1-time income"	R9-22-116
4. "1st-party liability"	R9-22-110
5. "3-month income period"	R9-22-116
6. "3rd-party"	R9-22-110
7. "3rd-party liability"	R9-22-110
8. "Accommodation"	R9-22-107
9. "Act"	R9-22-114
10. "Acute mental health services"	R9-22-112
11. "Adequate notice"	R9-22-114
12. "ADHS"	R9-22-112
13. "Administration"	~~R9-22-106, R9-22-114, and~~ A.R.S. § 36-2901
14. "Adverse action"	R9-22-114
15. "AEC"	R9-22-117
16. "Affiliated corporate organization"	R9-22-106
17. "Aged"	~~R9-22-115~~ 42 U.S.C. 1382c(a)(1)(A)
18. "Aggregate"	R9-22-107
19. "AHCCCS"	R9-22-101
20. "AHCCCS-disqualified dependent"	R9-22-101
21. "AHCCCS-disqualified spouse"	R9-22-101
22. "AHCCCS hearing officer"	R9-22-108
23. "AHCCCS inpatient hospital day or days of care"	R9-22-107
24. "Ambulance"	R9-22-102
25. "Ancillary department"	R9-22-107
26. "Annual enrollment choice"	R9-22-117
27. "Appeal"	R9-22-108
28. "Appellant"	R9-22-114
29. "Applicant"	R9-22-101
30. "Application"	R9-22-101
31. "Assignment"	R9-22-101
32. "Assistance unit"	R9-22-114
33. "Authorized representative"	R9-22-114
34. "Auto-assignment algorithm"	R9-22-117
35. "Baby Arizona"	R9-22-114
36. "Behavior management services"	R9-22-112
37. "Behavioral health paraprofessional"	R9-22-112
38. "Behavioral health professional"	R9-22-112
39. "Behavioral health service"	R9-22-112
40. "Behavioral health technician"	R9-22-112
41. "BHS"	R9-22-114
42. "Billed charges"	R9-22-107
43. "Blind"	R9-22-115
44. "Board-eligible for psychiatry"	R9-22-112

45.	"Bona fide funeral agreement"	R9-22-114
46.	"Burial plot"	R9-22-114
47.	"Capital costs"	R9-22-107
48.	"Capped fee-for-service"	R9-22-101
49.	"Caretaker relative"	R9-22-114
50.	"Case management services"	R9-22-112
51.	"Case record"	R9-22-101
52.	"Cash assistance"	R9-22-114
53.	"Categorically eligible"	A.R.S. § 36-2901(4)(b) and 36-2934
54.	"Certification"	R9-22-109
55.	"Certification error"	R9-22-109
56.	"Certification period"	R9-22-115 and R9-22-116
57.	"Certified psychiatric nurse practitioner"	R9-22-112
~~58.~~	~~"Child welfare agency"~~	~~R9-22-114~~
~~59~~ 58.	"Clean claim"	A.R.S. § 36-2904
~~60~~ 59.	"Clinical supervision"	R9-22-112
~~61~~ 60.	"CMDP"	R9-22-117
~~62~~ 61.	"Continuous stay"	R9-22-101
~~63~~ 62.	"Contract"	R9-22-101
~~64~~ 63.	"Contractor"	R9-22-101
~~65~~ 64.	"Contractor of record"	R9-22-101
~~66~~ 65.	"Copayment"	R9-22-107
~~67~~ 66.	"Corrective action plan"	R9-22-109
~~68~~ 67.	"Cost-to-charge ratio"	R9-22-107
~~69~~ 68.	"Countable income"	R9-22-116
~~70~~ 69.	"County eligibility department"	R9-22-109
~~71~~ 70.	"County eligibility staff"	R9-22-116
~~72~~ 71.	"Covered charges"	R9-22-107
~~73~~ 72.	"Covered services"	R9-22-102
~~74~~ 73.	"CPT"	R9-22-107
~~75~~ 74.	"CRS"	R9-22-114
~~76~~ 75.	"Date of determination"	R9-22-116
~~77~~.	~~"Date of discontinuance"~~	~~R9-22-116~~
~~78~~ 76.	"Date of enrollment action"	R9-22-117
~~79~~ 77.	"Day"	R9-22-101
~~80~~ 78.	"DCSE"	R9-22-114
~~81~~ 79.	"Deductible medical expense"	R9-22-116
~~82~~ 80.	"Deemed application date"	R9-22-116
~~83~~ 81.	"De novo hearing"	R9-22-112
~~84~~ 82.	"Dentures"	R9-22-102
~~85~~ 83.	"Department"	R9-22-114
~~86~~ 84.	"Dependent child"	R9-22-114 and R9-22-116
~~87~~ 85.	"DES"	R9-22-101
~~88~~ 86.	"Determination"	R9-22-116
~~89~~ 87.	"Diagnostic services"	R9-22-102
~~90~~ 88.	"Disabled"	R9-22-115
~~91~~ 89.	"Discontinuance"	R9-22-116
~~92~~ 90.	"Discussions"	R9-22-106
~~93~~ 91.	"Disenrollment"	R9-22-117
~~94~~ 92.	"District Medical Consultant"	R9-22-114
~~95~~ 93.	"DME"	R9-22-102
~~96~~ 94.	"DRI inflation factor"	R9-22-107
~~97~~ 95.	"E.P.S.D.T. services"	R9-22-102
~~98~~ 96.	"EAC"	~~R9-22-101~~ A.R.S. § 36-2905.03(B)
~~99~~ 97.	"Earned income"	R9-22-116

~~100~~ 98. "Educational income" R9-22-116
~~101~~ 99. "ELIC" ~~R9-22-101~~
A.R.S. § 36-2905.03(C) and (D)
~~102. "Eligibility determination date" R9-22-114~~
~~103. "Eligible assistance children" A.R.S. § 36-2905.03(B)~~
~~104~~ 100. "Eligible applicant" A.R.S. § 36-2901(4)
~~105. "Eligible low income children" A.R.S. § 36-2905.03(C) and (D)~~
~~106~~ 101. "Emancipated minor" R9-22-116
~~107~~ 102. "Emergency medical condition" 42 U.S.C. 1396b(v)
~~108~~ 103. "Emergency medical services" R9-22-102
~~109~~ 104. "Encounter" R9-22-107
~~110~~ 105. "Enrollment" R9-22-117
~~111~~ 106. "Enumeration" R9-22-101
~~112~~ 107. "Equity" R9-22-101
~~113~~ 108. "Evaluation" R9-22-112
~~114~~ 109. "Expressly emancipated minor" R9-22-116
~~115~~ 110. "FAA" ~~or "Family Assistance Administration"~~ R9-22-114
~~116~~ 111. "Facility" R9-22-101
~~117~~ 112. "Factor" R9-22-101
~~118~~ 113. "FBR" R9-22-101
~~119. "Federal Benefit Rate" R9-22-101~~
~~120. "Federal emergency services program" R9-22-101~~
~~121~~ 114. "FESP" R9-22-101
~~122~~ 115. "Foster care maintenance payment" ~~R9-22-114~~
41 U.S.C. 675(4)(A)
~~123. "Foster child" R9-22-114~~
~~124~~ 116. "FPL" R9-22-114
~~125~~ 117. "FQHC" R9-22-101
~~126~~ 118. "Fraudulent information" R9-22-109
~~127~~ 119. "Grievance" R9-22-108
~~128~~ 120. "GSA" R9-22-101
~~129~~ 121. "Guardian" R9-22-116
~~130~~ 122. "Head-of-household" R9-22-116
~~131~~ 123. "Hearing aid" R9-22-102
~~132~~ 124. "Home health services" R9-22-102
~~133~~ 125. "Homebound" R9-22-114
~~134~~ 126. "Hospital" R9-22-101
~~135~~ 127. "Hospitalized" R9-22-116
~~136~~ 128. "ICU" R9-22-107
~~137~~ 129. "IHS" R9-22-117
~~138~~ 130. "IMD" R9-22-112
~~139~~ 131. "Income" R9-22-114 and R9-22-116
~~140~~ 132. "Income-in-kind" R9-22-116
~~141~~ 133. "Indigent" A.R.S. § 11-297
~~142~~ 134. "Inmate of a public institution" 42 CFR 435.1009
~~143~~ 135. "Inpatient psychiatric facilities for individuals under age 21" R9-22-112
~~144~~ 136. "Interested party" R9-22-106
~~145~~ 137. "Interim change" R9-22-116
~~146~~ 138. "JTPA" ~~or "Job Training Partnership Act"~~ R9-22-114
~~147~~ 139. "License" or "licensure" R9-22-101
~~148. "Liquid assets" R9-22-114 and~~ R9-22-116
~~149~~ 140. "Liquid resources" R9-22-116

~~150~~ 141.	"Lump-sum income"	R9-22-116
~~151~~ 142.	"Mailing date"	R9-22-114
~~152~~ 143.	"Medical education costs"	R9-22-107
~~153~~ 144.	"Medical record"	R9-22-101
~~154~~ 145.	"Medical review"	R9-22-107
~~155~~ 146.	"Medical services"	R9-22-101
~~156~~ 147.	"Medical supplies"	R9-22-102
~~157~~ 148.	"Medical support"	R9-22-114
~~158~~ 149.	"Medically necessary"	R9-22-101
~~159~~ 150.	"Medicare claim"	R9-22-107
~~160~~ 151.	"Medicare HMO"	R9-22-101
152.	"Member"	R9-22-101
~~161~~ 153.	"Mental disorder"	R9-22-112
~~162~~ 154.	"MI/MN"	A.R.S. § 36-2901(4)(a) and (c)
~~163~~ 155.	"Minor parent"	R9-22-114
~~164~~ 156.	"Month of determination"	R9-22-116
~~165~~ 157.	"New hospital"	R9-22-107
158.	"NF"	R9-22-101
~~166~~ 159.	"NICU"	R9-22-107
~~167~~ 160.	"Noncontracting provider"	A.R.S. § 36-2931
~~168~~ 161.	"Nonliquid resources"	R9-22-116
~~169~~ 162.	"Nonparent caretaker relative"	R9-22-114
~~170.~~	~~"NF"~~	~~42 U.S.C. 1396r(a)~~
~~171~~ 163.	"Occupational therapy"	R9-22-102
~~172~~ 164.	"Offeror"	R9-22-106
~~173~~ 165.	"Operating costs"	R9-22-107
~~174~~ 166.	"Outlier"	R9-22-107
~~175~~ 167.	"Outpatient hospital service"	R9-22-107
~~176~~ 168.	"Ownership change"	R9-22-107
~~177~~ 169.	"Partial Care"	R9-22-112
~~178~~ 170.	"Peer group"	R9-22-107
~~179~~ 171.	"Pharmaceutical service"	R9-22-102
~~180~~ 172.	"Physical therapy"	R9-22-102
~~181~~ 173.	"Physician"	R9-22-102
~~182~~ 174.	"Post-stabilization services"	42 CFR 438.114
~~183~~ 175.	"Practitioner"	R9-22-102
~~184~~ 176.	"Pre-enrollment process"	R9-22-114
~~185~~ 177.	"Prescription"	R9-22-102
~~186~~ 178.	"Primary care provider"	R9-22-102
~~187~~ 179.	"Primary care provider services"	R9-22-102
~~188~~ 180.	"Prior authorization"	R9-22-102
~~189~~ 181.	"Private duty nursing services"	R9-22-102
~~190~~ 182.	"Proposal"	R9-22-106
~~191.~~	~~"Proposal of discontinuance"~~	~~R9-22-116~~
~~192.~~	~~"Prospective rate year"~~	~~R9-22-107~~
~~193~~ 183.	"Prospective rates"	R9-22-107
184.	"Prospective rate year"	R9-22-107
~~194~~ 185.	"Prudent layperson standard"	42 U.S.C. 1396u-2
~~195~~ 186.	"Psychiatrist"	R9-22-112
~~196~~ 187.	"Psychologist"	R9-22-112
~~197~~ 188.	"Psychosocial rehabilitation"	R9-22-112
~~198~~ 189.	"Public assistance"	R9-22-116
~~199~~ 190.	"Quality control case analysis"	R9-22-109
~~200~~ 191.	"Quality control sample review"	R9-22-109
~~201~~ 192.	"Quality management"	R9-22-105
~~202~~ 193.	"Radiology services"	R9-22-102
~~203~~ 194.	"RBHA"	R9-22-112
~~204~~ 195.	"Rebasing"	R9-22-107

~~205~~ 196. "Recipient"	R9-22-114
~~206~~ 197. "Redetermination"	R9-22-116
~~207~~ 198. "Referral"	R9-22-101
~~208~~ 199. "Rehabilitation services"	R9-22-102
~~209~~ 200. "Reinsurance"	R9-22-107
~~210~~ 201. "Resources"	R9-22-114 and R9-22-116
~~211~~ 202. "Respiratory therapy"	R9-22-102
~~212~~ 203. "Responsible offeror"	R9-22-106
~~213~~ 204. "Responsive offeror"	R9-22-106
~~214~~ 205. "Review"	R9-22-114
~~215~~ 206. "RFP"	~~R9-22-105 and~~ R9-22-106
~~216~~ 207. "Scope of services"	R9-22-102
~~217~~ 208. "Screening"	R9-22-112
~~218~~ 209. "SDAD"	R9-22-107
~~219~~ 210. "Separate property"	A.R.S. § 25-213
~~220~~ 211. "Service location"	R9-22-101
~~221~~ 212. "Service site"	R9-22-101
~~222~~ 213. "SESP"	R9-22-101
~~223~~ 214. "S.O.B.R.A."	R9-22-101
~~224~~ 215. "Specialist"	R9-22-102
~~225~~ 216. "Specified relative"	R9-22-114 and R9-22-116
~~226~~ 217. "Speech therapy"	R9-22-102
~~227~~ 218. "Spendthrift restriction"	R9-22-114
~~228~~ 219. "Spouse"	R9-22-101
~~229~~ 220. "SSA"	P.L. 103-296, Title I
~~230~~ 221. "SSI"	R9-22-101
~~231~~ 222. "SSN"	R9-22-101
~~232~~ 223. "State alien"	R9-22-101
~~233. "State emergency services program"~~	~~R9-22-101~~
~~234~~ 224. "Sterilization"	R9-22-102
~~235~~ 225. "Subcontract"	R9-22-101
~~236~~ 226. "Substance abuse"	R9-22-112
~~237~~ 227. "SVES" ~~or "State Verification and Exchange System"~~	R9-22-114
~~238~~ 228. "Tier"	R9-22-107
~~239~~ 229. "Tiered per diem"	R9-22-107
~~240~~ 230. "Title IV-A"	R9-22-114
~~241~~ 231. "Title IV-D"	R9-22-114
~~242~~ 232. "Title IV-E"	R9-22-114
~~243~~ 233. "Title XIX"	42 U.S.C. 1396
~~244~~ 234. "TMA"	R9-22-114
~~245~~ 235. "Total inpatient hospital days"	R9-22-107
~~246~~ 236. "Treatment"	R9-22-112
~~247~~ 237. "Unearned income"	R9-22-116
~~248~~ 238. "Utilization management"	R9-22-105

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

1. "AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to an eligible person.
2. "AHCCCS-disqualified dependent" means a dependent child of an AHCCCS-disqualified spouse who resides in the same household of an AHCCCS-disqualified spouse.
3. "AHCCCS-disqualified spouse" means the spouse of an MI/MN applicant, who is ineligible for MI/MN benefits because the value of that spouse's separate property, when combined with the value of other resources owned by household members, exceeds the allowable resource limit.
4. "Applicant" means a person who submits or whose representative submits, a written, signed, and dated application for AHCCCS benefits that has not been approved or denied.

5. "Application" means an official request for medical assistance made under this Chapter.
6. "Assignment" means enrollment of an eligible person with a contractor by the Administration.
7. "Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific AHCCCS covered service and equipment provided to an eligible applicant. A payment is made in accordance with an upper, or capped, limit established by the Director.
8. "Case record" means the file and all documents in the file that are used to establish eligibility.
9. "Categorically eligible" means a person who is eligible as defined by A.R.S. §§ 36-2901(4)(b) and 36-2934.
10. "Continuous stay" means the period of time during which an eligible person receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.
11. "Contract" means a written agreement entered into between a person, an organization, or other entity and the Administration, to provide health care services to a member under A.R.S. Title 36, Chapter 29, and these rules.
12. "Contractor" means a person, an organization, or an entity that agrees through a direct contracting relationship with the Administration, to provide goods and services specified by the contract under the requirements of the contract and these rules.
13. "Contractor of record" means an organization or an entity in which a person is enrolled for the provision of AHCCCS services.
14. "Day" means a calendar day unless otherwise specified in the text.
15. "DES" means the Department of Economic Security.
16. "EAC" means eligible assistance children defined by A.R.S. § 36-2905.03(B).
17. "ELIC" means eligible low-income children defined by A.R.S. § 36-2905.03(C) and (D).
~~18. "Eligible assistance children" means the children defined by A.R.S. § 36-2905.03(B).~~
~~19. "Eligible low income children" means the children defined by A.R.S. § 36-2905.03(C) and (D).~~
~~20~~ 18. "Eligible applicant" means the applicant defined in A.R.S. § 36-2901(4).
~~21~~ 19. "Enumeration" means the assignment of a specific 9-digit identification number to a person by the Social Security Administration.
~~22~~ 20. "Equity" means the county assessor full cash or market value of a resource minus valid liens, encumbrances, or both.
~~23~~ 21. "Facility" means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution, under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related services.
~~24~~ 22. "Factor" means an organization, a collection agency, a service bureau, or a person who advances money to a provider for accounts receivable that the provider assigns, sells, or otherwise transfers, including transfers through the use of a power of attorney, to the organization, the collection agency, the service bureau, or the person that receives an added fee or a deduction of a portion of the face value of the accounts receivable in return for the advanced money. The term "factor" does not include a business representative, such as a billing agent or an accounting firm described within these rules, or a health care institution.
~~25~~ 23. "FBR" means Federal Benefit Rate, ~~defined in R9-22-101(B)26~~ the maximum monthly Supplemental Security Income payment rate for an eligible person or a married couple.
~~26. "Federal Benefit Rate" means the maximum monthly Supplemental Security Income payment rate for an eligible person or a married couple.~~
~~27. "Federal emergency services program" means a program designed to provide emergency medical services covered under 42 U.S.C. 1396b(v), to treat an emergency medical condition for a categorically eligible person who is determined eligible under A.R.S. § 36-2903.03.~~
~~28~~ 24. "FESP" means federal emergency services ~~program.~~ program which is designed to provide emergency medical services covered under 42 U.S.C. 1396b(v), to treat an emergency medical condition for a categorically eligible person who is determined eligible under A.R.S. § 36-2903.03.
~~29~~ 25. "FQHC" means federally qualified health center.
~~30~~ 26. "GSA" means a geographical service area designated by the Administration within which a contractor of record provides, directly or through a subcontract, a covered health care service to a member enrolled with that contractor of record.
~~31~~ 27. "Hospital" means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined to meet the requirements of certification.
~~32~~ 28. "Indigent" means meeting eligibility criteria under A.R.S. § 11-297.
~~33~~ 29. "Inmate of a public institution" means a person defined by 42 CFR 435.1009.
~~34~~ 30. "License" or "licensure" means a nontransferable authorization that is based on established standards in law, is issued by a state or a county regulatory agency or board, and allows a health care provider to render a health care service lawfully.

~~35~~ 31. "Medical record" means all documents that relate to medical and behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that are kept at the site of the provider.

~~36~~ 32. "Medical services" means health care services provided to an eligible person by a physician, a practitioner, a dentist, or by a health professional and technical personnel under the direction of a physician, a practitioner, or a dentist.

~~37~~ 33. "Medically necessary" means a covered service provided by a physician or other licensed practitioner of the healing arts and within the scope of practice under state law to:

a. Prevent disease, disability, and other adverse health conditions or their progression; or

b. Prolong life.

~~38~~ 34. "Medicare HMO" means a health maintenance organization that has a current contract with the Health Care Financing Administration (HCFA) for participation in the Medicare program under 42 CFR 417(L).

35. "Member" is defined in A.R.S. § 36-2901.

~~39~~ 36. "MI/MN" means medically indigent and medically needy defined in A.R.S. § 36-2901(4)(a) and (c).

~~40~~ 37. ~~"Nursing facility"~~ "NF" means a nursing facility defined in 42 U.S.C. 1396r(a).

~~41~~ 38. "Noncontracting provider" means the provider defined in A.R.S. § 36-2931.

~~42~~ 39. "Referral" means the process by which an eligible person is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

~~43~~ 40. "Separate property" means property defined in A.R.S. § 25-213.

~~44~~ 41. "Service location" means any location at which a member obtains any health care service provided by a contractor of record under the terms of a contract.

~~45~~ 42. "Service site" means a location designated by a contractor of record as the location at which a person is to receive health care services.

~~46~~ 43. "SESP" means state emergency services ~~program.~~ program which is designed to provide emergency medical services identified as covered under R9-22-217 to treat an emergency medical condition for a person who is determined eligible under A.R.S. § 36-2905.05

~~47~~ 44. "S.O.B.R.A." means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(ii)(IX), July 1, 1988.

~~48~~ 45. "Spouse" means the husband or wife who has entered into a contract of marriage, recognized as valid by Arizona.

~~49~~ 46. "SSA" means Social Security Administration defined in P.L. 103-296, Title I.

~~50~~ 47. "SSI" means Supplemental Security Income under Title XVI of the Social Security Act, as amended.

~~51~~ 48. "SSN" means social security number.

~~52~~ 49. "State alien" means an unqualified alien ~~described in~~ under A.R.S. § 36-2903.03(C) who was residing in the United States under color of law on or before August 21, 1996, who was receiving AHCCCS services through eligibility for SSI, and who would be eligible for coverage under 9 A.A.C. Article 15 except for United States citizenship or legal alienage requirements.

~~53. "State emergency services program" means a program designed to provide emergency medical services identified as covered under R9-22-217 to treat an emergency medical condition for a person who is determined eligible under A.R.S. § 36-2905.05.~~

~~54~~ 50. "Subcontract" means an agreement entered into by a contractor with any of the following:

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

b. A marketing organization; or

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

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

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

1. "Quality management" means a methodology and activities used by professional health personnel through a formal program involving multiple organizational components and committees to:
   a. Assess the degree of conformance to desired medical standards and practices and;
   b. Improve or maintain quality service and care.

~~2. "RFP" means a request for proposals which is a document prepared by the Administration that describes the services required and that instructs prospective offerors how to prepare a response (proposal).~~

~~3~~ 2. "Utilization management" means a methodology used by professional health personnel that assesses the medical indications, appropriateness, and efficiency of care provided.

R9-22-106. Request for Proposals (RFP) Related Definitions

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

~~1. "Administration" means the Arizona Health Care Cost Containment System Administration, its agents, employees, and designated representatives.~~

~~2~~ 1. "Affiliated corporate organization" means any organization that has ownership or management interests as defined in 42 CFR 455.101, and includes a parent and subsidiary corporation relationships. 42 CFR 455.101, September 30, 1986, is incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

~~3~~ 2. "Discussions" means an oral or written exchange of information or any form of negotiation.

~~4~~ 3. "Interested party" means an actual or prospective offeror whose economic interest may be directly affected by the issuance of an RFP, the award of a contract, or by the failure to award a contract.

~~5~~ 4. "Offeror" means a person or other entity that submits a proposal to the Administration in response to an RFP.

~~6~~ 5. "Proposal" means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.

~~7~~ 6. "Responsible offeror" means a person or entity who has the capability to perform the contract requirements and which will ensure good faith performance.

~~8~~ 7. "Responsive offeror" means a person or entity that submits a proposal that conforms in all material respects to an RFP.

~~9~~ 8. "RFP" means Request for Proposals, including all documents, whether attached or incorporated by reference, which are used by the Administration for soliciting a proposal under Article 6.

R9-22-110. 1st- and 3rd-Party Liability Related Definitions

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

1. "1st-party liability" means the resources available from any insurance or other coverage obtained directly or indirectly by a member ~~or eligible person~~ that provides benefits directly to the member ~~or eligible person~~ and is liable to pay all or part of the expenses for medical services incurred by the Administration, a contractor, ~~a member,~~ or ~~an eligible person.~~ a member.
2. ~~"3rd party"~~ "3rd-party" means an individual, entity, or program that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an ~~applicant, eligible person,~~ applicant or member.
3. "3rd-party liability" means the resources available from an individual, entity, or program that is or may be, by agreement, circumstance, or otherwise, liable to pay all or part of the medical expenses incurred by an ~~applicant, eligible person,~~ applicant or member.

R9-22-114. Title IV-A Related Definitions

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

1. "210" means 42 CFR 435.210.
2. "1931" means Section 1931 of the Social Security Act.
3. "Act" means the Social Security Act.
4. "Adequate notice" means a notice that explains the action the Department intends to take, the reason for the action, the specific authority for the action, the recipient's appeal rights, right to medical assistance pending appeal, and that is mailed before the effective date of the action.

~~5. "Administration" means the AHCCCS Administration.~~

~~6~~ 5. "Adverse action" means an action taken by the Department to deny, discontinue, or reduce medical assistance.

~~7~~ 6. "Appellant" means an applicant or recipient of medical assistance who is appealing an adverse action by the Department.

~~8~~ 7. "Assistance unit" means a group of persons whose needs, income, and resources are considered as a unit for purposes of determining eligibility for medical assistance.

~~9~~ 8. "Authorized representative" means a person who is authorized by the applicant, recipient, or legally responsible person to act on behalf of the applicant or recipient.

~~10~~ 9. "Baby Arizona" means the public/private partnership program that provides a pregnant woman an opportunity to apply for medical assistance at a Baby Arizona provider's office through a streamlined eligibility process.

~~11~~ 10. "BHS" means Behavioral Health Services, Arizona Department of Health Services.

~~12~~ 11. "Bona fide funeral agreement" means a prepaid plan that specifically covers only funeral-related expenses as evidenced by a written contract.

~~13~~ 12. "Burial plot" means a space reserved in a cemetery, crypt, vault, or mausoleum for the remains of a deceased person.

~~14~~ 13. "Caretaker relative" means a parent or relative who maintains a family setting for a dependent child and who exercises responsibility for the day-to-day physical care, guidance, and support of that child.
~~15~~ 14. "Cash assistance" means a program administered by the Department that provides assistance to needy families with dependent children under 42 U.S.C. 601 et seq.
~~16. "Child welfare agency" means any agency or institution defined in A.R.S. § 8-501(A)(1).~~
~~17~~ 15. "CRS" means Children Rehabilitation Services.
~~18~~ 16. "DCSE" means the Division of Child Support Enforcement, which is the division within the Department that administers the Title IV-D program and includes a contract agent operating a child support enforcement program on behalf of the Department.
~~19~~ 17. "Department" means the Arizona Department of Economic Security.
~~20~~ 18. "Dependent child" means a child defined at A.R.S. § 46-101(7).
~~21~~ 19. "District Medical Consultant" means a licensed physician whom the Department employs to review medical records for the purpose of determining physical or mental incapacity.
~~22. "Eligibility determination date" means the date the Department makes the decision described in R9-22-1414 and issues the eligibility decision notice.~~
~~23~~ 20. "FAA" ~~or "Family Assistance Administration"~~ means the Family Assistance Administration, the administration within the Department's Division of Benefits and Medical Eligibility with responsibility for providing cash and food stamp assistance to an eligible person and for determining eligibility for medical assistance.
~~24~~ 21. "Foster care maintenance payment" means a monetary amount defined in ~~Section 475(4)(A) of the Social Security Act~~ 42 U.S.C. 675(4)(A).
~~25. "Foster child" means a child placed in a foster care setting.~~
~~26~~ 22. "FPL" means the federal poverty level guidelines published annually by the United States Department of Health and Human Services.
~~27~~ 23. "Homebound" means a person who is confined to the home because of physical or mental incapacity.
~~28~~ 24. "Income" means earned and unearned income combined.
~~29~~ 25. "JTPA" ~~or "Job Training Partnership Act"~~ means the Job Training Partnership Act program authorized by 29 U.S.C. 1501 et seq. which prepares youth and unskilled adults for entry into the labor force and affords special job training.
~~30. "Liquid assets" means cash or another financial instrument that is readily convertible to cash.~~
~~31~~ 26. "Mailing date", when used in reference to a document sent 1st class, postage prepaid, through the United States mail, means the date:
a. Shown on the postmark;
b. Shown on the postage meter mark of the envelope, if there is no postmark; or
c. Entered on the document as the date of its completion, if there is no legible postmark or postage meter mark.
~~32~~ 27. "Medical support" means an obligation of a natural or adoptive parent to provide health care coverage in the form of health insurance or court-ordered payment for medical care.
~~33~~ 28. "Minor parent" means a person meeting the age requirements of R9-22-1401(B)(1) who is also a parent.
~~34~~ 29. "Nonparent caretaker relative" means a person, other than a parent, who is related by blood, marriage, or lawful adoption to the dependent child and who maintains a family setting for the dependent child and exercises responsibility for the day to day care of the dependent child.
~~35~~ 30. "Pre-enrollment process" means the process that provides an applicant the opportunity to choose an AHCCCS health plan before the determination of eligibility is completed.
~~36~~ 31. "Recipient" means a person who is approved for and receiving medical assistance under this Article.
~~37~~ 32. "Resources" means real and personal property including liquid assets.
~~38~~ 33. "Review" means a review of all factors affecting an assistance unit's eligibility.
~~39~~ 34. "Specified relative" means a person defined in R9-22-1418(B).
~~40~~ 35. "Spendthrift restriction" means a legal restriction on the use of a resource that prevents a payer or beneficiary from alienating the resource.
~~41~~ 36. "SVES" ~~or "State Verification and Exchange System"~~ means the State Verification and Exchange System, a system through which the Department exchanges income and benefit information with the Internal Revenue Service, Social Security Administration, State Wage, and Unemployment Insurance Benefit data files.
~~42~~ 37. "Title IV-A" means the relevant provisions, specified in Section 1931 of the Social Security Act, of the Aid to Families With Dependent Children program that was in place in the state's Title IV-A State Plan as of July 1996.
~~43~~ 38. "Title IV-D" of the Social Security Act means 42 U.S.C. 651-669, the statutes establishing the child support enforcement and establishment of paternity program.
~~44~~ 39. "Title IV-E" of the Social Security Act means 42 U.S.C. 670-679, the statutes establishing the foster care and adoption assistance programs.
~~45~~ 40. "TMA" means Transitional Medical Assistance.

R9-22-116. State-Only Eligibility Related Definitions

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

1. "1-time income" means income that a person may receive only once. Examples are:
   a. The total of gifts received during the 3-month income period for a birthday, wedding, anniversary, graduation, religious event, or birth;
   b. The total of single payment death benefits; or
   c. The total of single payment insurance or legal settlements resulting from 1 accident.
2. "3-month income period" means the 91 or 92 days immediately preceding the application date. The 3-month income period is 92 days only if:
   a. A household member regularly receives a monthly or 2-times-a-month payment, and
   b. The household member received the 3rd of 3 monthly payments on the 92nd day preceding the application date, or
   c. The household member received the 6th of 6 2-times-a-month payments on the 92nd day preceding the application date.
3. "Certification period" means the period of time for which a person is certified under A.R.S. § 36-2901(4)(a), (c), (h), and (j) as eligible for AHCCCS benefits.
4. "Countable income" means gross income, less amounts that are disregarded under R9-22-1626(D) and amounts that are deducted under R9-22-1626(E).
5. "County eligibility staff" means a county employee designated to conduct eligibility interviews and determinations for AHCCCS or conduct related business.
6. "Date of determination" means the date on which a decision of an applicant's eligibility or ineligibility as a medically indigent, medically needy person, eligible low- income child, or state emergency services person is communicated by the county to the applicant by a Notice of Action and, for eligible applicants, to the Administration as specified in R9-22-1618.
7. ~~"Date of discontinuance" means the last day of MI/MN, ELIC, SESP, or EAC coverage when there is a discontinuance.~~
8 7. "Deductible medical expense" means the cost of:
   a. A medically necessary service or supply that would be covered if provided to an AHCCCS member of any age under Articles 2 and 12;
   b. A medically necessary service or supply that would be covered if provided to an ALTCS member under 9 A.A.C. 28, Articles 2 and 11;
   c. Other medically necessary services that are provided by a licensed practitioner or physician;
   d. Assistance with daily living provided under prescription by a licensed physician or practitioner except when provided by the spouse of a patient or the parent of a minor patient;
   e. Care in a licensed nursing home, supervisory care facility, adult foster home, or in another residential care facility licensed by the Arizona Department of Health Services;
   f. Purchasing and maintaining a dog guide or service dog for the assistance of the applicant or member; or
   g. Health insurance premiums if the insured is a household member.
9 8. "Deemed application date" means the 30th day following either the original application date or a previously deemed application date, whichever is later.
10 9. "Dependent child" means an unborn child, an unemancipated minor, or an 18-year-old, if all of the following 3 conditions exist:
   a. The 18-year-old is a full-time student in a secondary school, or in a vocational, technical, or trade school that grant credits to be applied toward secondary school graduation;
   b. The 18-year-old is reasonably expected to graduate before reaching age 19; and
   c. The 18-year-old resides with 1 or both parents or a specified relative.
11 10. "Determination" means the process by which an applicant is approved or denied for coverage as an indigent or medically needy person, an eligible low-income child, or a state emergency services applicant.
12 11. "Discontinuance" means an action taken by county eligibility staff or the Administration to terminate a person's eligibility under MI/MN, ELIC, or SESP.
13 12. "Earned income" means money or its equivalent received by a household member in exchange for:
   a. Labor;
   b. Professional service or entrepreneurship, including income from the rental of real or personal property;
   c. Vacation pay;
   d. Sick pay;
   e. Tips; and
   f. Gratuities.

~~14~~ 13. "Educational income" means income received as a scholarship or grant by a student for the purpose of paying tuition, fees, and related expenses, excluding room and board expenses.
~~15~~ 14. "Emancipated minor" means a minor who is married or divorced, in military service, or the subject of a court order declaring the minor to be emancipated.
~~16~~ 15. "Expressly emancipated minor" means a minor whose parent has or parents have signed a notarized affidavit indicating that the minor is no longer under parental support and control, and that the parent has or parents have surrendered claim to the state and federal tax dependency deductions provided that the minor is not living with a parent or a specified relative who is the legal guardian or acting as guardian, and a court has not ordered custody with another person or agency.
~~17~~ 16. "Guardian" means a guardian, conservator, executor, or public fiduciary appointed by a court or other protective order to manage the affairs of a minor or incapacitated person.
~~18~~ 17. "Head-of-household" means the family household member who assumes the responsibility for providing AHCCCS eligibility information for the family household members under Article 16.
~~19~~ 18. "Hospitalized" means in a hospital as an inpatient at the time of application or at any time from the application date through the date of determination.
~~20~~ 19. "Income" means money or other liquid resource that:
a. Is received or deemed received by a person under R9-22-1626(C);
b. Becomes available for a person's legal unrestricted use;
c. Is used by a person; or
d. Is due to a person but paid to someone else on the person's behalf, including monies paid from a trust to which the person is a beneficiary if the trust is excluded as a resource.
~~21~~ 20. "Income-in-kind" means any noncash item or service received that is not deducted from other income to which the recipient is entitled.
~~22~~ 21. "Interim change" means either a change occurring after the application date and before the eligibility decision or a change occurring during the certification period.
~~23~~ 22. "Liquid assets" means all property and resources readily convertible to cash.
~~24~~ 23. "Liquid resources" means ~~liquid assets~~ all property and resources readily convertible to cash.
~~25~~ 24. "Lump-sum income" means income received in a single payment instead of regularly occurring installments over a period of time.
~~26~~ 25. "Month of determination" means the calendar month during which the date of determination occurs.
~~27~~ 26. "Nonliquid resources" means all resources that are not readily convertible to cash.
~~28. "Proposal of discontinuance" means a notice sent to a person informing the person that AHCCCS benefits will terminate on a specified date unless the person provides proof of eligibility within 15 days following the date of the notice.~~
~~29~~ 27. "Public assistance" means benefits provided to a person, either directly or indirectly by a city, county, state, federal, or governmental agency, based on financial needs.
~~30~~ 28. "Redetermination" means the process by which an eligible person under A.R.S. §§ ~~36-2901.4(a),~~ 36-2901(4)(a), (c), or (h) applies for a new eligibility certification period before expiration of the current certification period.
~~31~~ 29. "Resources" means property of any kind, real or personal, that can be converted to food, clothing, shelter, medical care, or money.
~~32~~ 30. "Specified relative" means a nonparent caretaker of a dependent child who is a grandmother, grandfather, sister, brother, stepmother, stepfather, stepbrother, stepsister, aunt, uncle, 1st cousin, niece, nephew, or person of preceding generations whose relationship to the child is described by any of these terms preceded by a single "great" or "grand". A specified relative shall be at least 18 years old to apply on behalf of a dependent child, unless a court has awarded custody of the dependent child to the specified relative.
~~33~~ 31. "Unearned income" means all income defined in subsection (20) except income which is defined as earned income in subsection (11).

ARTICLE 2. SCOPE OF SERVICES

R9-22-204. Inpatient General Hospital Services

A. Inpatient services provided in a general hospital shall be covered by contractors or provided by fee-for-service providers or noncontracting providers and shall include:
1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
a. Maternity care including labor; delivery and recovery rooms; birthing centers; newborn nursery; and related centers;
b. Neonatal intensive care (NICU);
c. Intensive care (ICU);
d. Surgery including surgical suites and recovery rooms;
e. Nursery and related services;

f. Routine care; and
g. Behavioral health (psychiatric) care.
i. ~~Emergency~~ Behavioral health emergency crisis ~~behavioral health~~ stabilization services may be provided for up to 3 days per acute episode and a maximum of 12 days per AHCCCS contract year for each member ~~or eligible person~~ unless services are provided under Article 12.
ii. For purposes of this Section, the AHCCCS contract year shall be October 1 through September 30.

2. Ancillary services as specified by the Director and included in contract:
~~a. Labor, delivery and recovery rooms, and birthing centers;~~
~~b. Surgery and recovery rooms;~~
~~c~~ a. Laboratory services;
~~d~~ b. Radiological and medical imaging services;
~~e~~ c. Anesthesiology services;
~~f~~ d. Rehabilitation services;
~~g~~ e. Pharmaceutical services and prescribed drugs;
~~h~~ f. Respiratory therapy;
~~i~~ g. Blood and blood derivatives; and
~~j~~ h. Central supply items, appliances, and equipment not ordinarily furnished to all patients and which are customarily reimbursed as ancillary ~~services;~~ services.
~~k. Maternity services; and~~
~~l. Nursery and related services.~~

B. The following limitations apply to general inpatient hospital services that are provided by fee-for-service providers and for which the Administration is financially responsible:
1. The cost of inpatient hospital accommodation for an eligible person shall be incorporated into the rate paid for the level of care as specified in subsection (A)(1).
2. Prior authorization shall be obtained from the Administration for the following inpatient hospital services provided to an eligible person:
a. Nonemergency and elective admission, including psychiatric hospitalization, shall be authorized prior to the scheduled admission;
b. Elective surgery, with the exception of voluntary sterilization procedures, shall be authorized prior to the surgery;
c. An emergency hospitalization that exceeds 3 days or an intensive care unit admission that exceeds 1 day;
d. Hospitalization beyond the number of days initially authorized shall be covered only if determined medically necessary through AHCCCS Administration concurrent team review;
e. Services or items furnished to cosmetically reconstruct appearance after the onset of trauma or serious injury shall be authorized prior to service delivery; and
f. Behavioral health services for an eligible person who is 18, 19, or 20 years of age that are provided on an emergency basis for crisis stabilization, and exceed 3 days per episode, or 12 days per contract year.

R9-22-205. Physician and Primary Care Physician and Practitioner Services

A. Primary care provider services shall be furnished by a physician or practitioner and shall be covered for members when rendered within the provider's scope of practice under A.R.S. Title 32. An eligible person may receive these services through an attending physician or practitioner. Primary care provider services may be provided in an inpatient or outpatient setting and shall include at a minimum:
1. Periodic health examinations and assessments;
2. Evaluations and diagnostic work-ups;
3. Medically necessary treatment;
4. Prescriptions for medications and medically necessary supplies and equipment;
5. Referrals to specialists or other health care professionals when medically necessary;
6. Patient education;
7. Home visits when determined medically necessary;
8. Covered immunizations; and
9. Covered preventive health services.

B. The following limitations and exclusions apply to physician and practitioner services and primary care provider services:
1. Specialty care and other services provided to a member upon referral from a primary care provider or to an eligible person upon referral from the attending physician or practitioner shall be limited to the services or conditions for which the referral is made, or for which authorization is given, unless referral is waived by the Administration;
2. If a physical examination is performed with the primary intent to accomplish 1 or more of the objectives listed in subsection (A), it shall be covered by the member's contractor, or the Administration, except if there is an additional or alternative objective to satisfy the demands of an outside public or private agency. Alternative objectives may include physical examinations and resulting documentation for:

a. Qualification for insurance;
b. Pre-employment physical evaluation;
c. Qualification for sports or physical exercise activities;
d. Pilot's examination (FAA);
e. Disability certification for establishing any kind of periodic payments;
f. Evaluation for establishing 3rd-party liabilities; or
g. Physical ability to perform functions that have no relationship to primary objectives listed in subsection (A).

~~4~~3. Orthognathic surgery shall be covered only for members and eligible persons who are less than 21 years of age;

~~5~~4. The following services shall be excluded from AHCCCS coverage:
a. Infertility services, reversal of surgically induced infertility (sterilization), and sex change operations;
b. Abortion counseling services;
c. Abortions, unless authorized under federal or state law;
d. Services or items furnished solely for cosmetic purposes; and
e. Hysterectomies unless determined to be medically necessary.

~~6~~5. Prior authorization from the Administration shall be required for fee-for-service providers to render the following services to eligible persons:
a. Elective or scheduled surgeries with the exception of voluntary sterilization procedures;
b. Services or items provided to reconstruct or improve personal appearance after an illness or injury.

R9-22-206. Organ and Tissue Transplantation Services

A. ~~The following organ~~ As specified in A.R.S. § 36-2907, organ and tissue transplantation services shall be covered for a member ~~or eligible person as specified in A.R.S. § 36-2907~~ if prior authorized and coordinated with the member's contractor, or the ~~Administration for eligible persons:~~ Administration.
~~1. Kidney transplantation;~~
~~2. Cornea transplantation;~~
~~3. Heart transplantation;~~
~~4. Liver transplantation;~~
~~5. Autologous and allogeneic bone marrow transplantation;~~
~~6. Lung transplantation;~~
~~7. Heart-lung transplantation;~~
~~8. Other organ transplantation if the transplantation is required by federal law for a categorically eligible person or member less than the age of 21 years and if other statutory criteria are met; and~~
~~9. Immunosuppressant medications, chemotherapy, and other related services.~~

~~**B.** The following limitations shall apply to organ and tissue transplantation services:~~
~~1. Artificial or mechanical hearts and xenografts are not covered services.~~
~~2. Organ or tissue transplantation services specified in subsection (A) are covered for a member or eligible person who is medically indigent or medically needy or for eligible assistance children and eligible low-income children only if funding is available as specified in A.R.S. § 36-2907;~~
~~3. Organ and tissue transplantation services are not covered during the fee-for-service emergency services only period for a member or eligible person who is medically indigent or medically needy or for eligible assistance children and eligible low-income children, except for persons eligible for services under Laws 1995, 3rd Special Session, Ch. 1, § 5; and~~
~~4. Organ and tissue transplantation services are not covered under the state and federal emergency services programs.~~

B. Organ and tissue transplantation services are not covered during the fee-for-service emergency services only period for an MN/MI or ELIC member except for persons under A.R.S. § 36-2907.10 and 11. There is no fee-for-service emergency services only period for an EAC member under A.R.S. § 2905.03.

C. Organ and tissue transplantation services are not covered for members of SESP under A.R.S. § 36-2905.05 or FESP under A.R.S. § 36-2903.03.

R9-22-209. Pharmaceutical Services

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

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

C. Pharmaceutical services shall be covered if prescribed for a member by the member's primary care provider or dentist, or if prescribed by a specialist upon referral from the primary care provider unless referral is waived by the Administration or upon authorization by the contractor or its designee. Pharmaceutical services provided for an eligible person shall be covered if prescribed by the attending physician, practitioner, or dentist.

D. The following limitations shall apply to pharmaceutical services:

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

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

R9-22-213. Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)

A. The following EPSDT services shall be covered for a member ~~or eligible person~~ less than 21 years of age:
1. Screening services including:
   a. Comprehensive health and developmental history;
   b. Comprehensive unclothed physical examination;
   c. Appropriate immunizations according to age and health history;
   d. Laboratory tests; and
   e. Health education, including anticipatory guidance;
2. Vision services including:
   a. Diagnosis and treatment for defects in vision;
   b. Eye examinations for the provision of prescriptive lenses; and
   c. Provision of prescriptive lenses;
3. Hearing services including:
   a. Diagnosis and treatment for defects in hearing;
   b. Testing to determine hearing impairment; and
   c. Provision of hearing aids;
4. Dental services including:
   a. Emergency dental services as specified in R9-22-207;
   b. Preventive services including screening, diagnosis, and treatment of dental disease; and
   c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
5. Orthognathic surgery;
6. Nutritional assessment and nutritional therapy as specified in contract to provide complete daily dietary requirements or supplement a member's daily nutritional and caloric intake;
~~6~~7. Behavioral health services under Article 12;
~~7~~8. Other necessary health care, diagnostic services, treatment and measures required by 42 U.S.C. 1396d(r)(5), April 1, 1990, incorporated by reference and on file with the Administration and the Office of Secretary of State. This incorporation by reference contains no future editions or amendments.

B. All providers of EPSDT services shall meet the following standards:
1. Provide services by or under the direction of, the member's primary care provider or dentist, or the eligible person's attending physician, practitioner, or dentist.
2. Perform tests and examinations in accordance with the AHCCCS Administration Periodicity Schedule.
   a. Refer members and eligible persons as necessary for dental diagnosis and treatment, and necessary specialty care.
   b. Refer members and eligible persons as necessary for behavioral health evaluation and treatment services.

C. Contractors shall meet the following additional conditions for EPSDT members:
1. Provide information to members and their parents or guardians concerning EPSDT services;
2. Notify members and their parents or guardians regarding the initiation of EPSDT screening and subsequent appointments according to the AHCCCS Administration Periodicity Schedule; and
3. Offer and provide, if requested, necessary assistance with transportation to and from providers, in accordance with R9-22-211, and with scheduling appointments for services.

D. Members and eligible persons with special health care needs ~~may~~ shall be referred to ~~the Children's Rehabilitative Service program.~~ CRS.

R9-22-216. ~~Nursing Facility Services~~ NF, Alternative HCBS Setting, or HCBS

A. ~~Nursing facility services including room and board~~ NF, alternative HCBS setting, or HCBS as defined in 9 A.A.C. 28, Article 2 shall be covered for a maximum of 90 days per contract year if ~~the~~ a medical condition of a member ~~or eligible person~~ is such that, if ~~nursing facility services~~ NF, alternative HCBS, or HCBS are not provided, hospitalization of the individual would result.

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

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

C. Each admission shall be prior authorized by the Administration for eligible persons.

ARTICLE 4. CONTRACTS, ADMINISRATION, AND STANDARDS

R9-22-402. Contracts

A. Each contract between the Administration and a contractor shall be in writing and contain at least the following information:

1. The method and amount of compensation or other consideration to be received by the contractor.
2. The name and address of the contractor.
3. The population to be covered by the contract.
4. The amount, duration, and scope of medical services to be provided, or for which compensation will be paid.
5. The term of the contract, including the beginning and ending dates, as well as methods of extension, renegotiation, and termination.
6. A provision that the Director or the Secretary of the U.S. Department of Health and Human Services may evaluate, through inspection or other means, the quality, appropriateness, or timeliness of services performed under the contract.

7. A description of patient, medical, and cost recordkeeping systems and a provision that the Director or the Secretary of the U.S. Department of Health and Human Services may audit and inspect any of the contractor's records that pertain to services performed and determinations of amounts payable under the contract. These records shall be maintained by the contractor for 5 years from the date of final payment or, for records relating to costs and expenses to which the Administration has taken exception, 5 years after the date of final disposition or resolution of the exception.
8. A provision to retain of a specified percentage of periodic payments to contractors, have a reserve fund, or use another means to adjust the payments made to contractors, based on utilization efficiency, including incentives for maintaining quality care and minimizing unnecessary inpatient services. This provision applies only to capped fee-for-service and AHCCCS-assembled network contractors and providers that participate in a risk retention fund in accordance with R9-22-714.
9. A provision that contractors maintain all forms, records, and statistical information required by the Director for purposes of audit and program management. This material, including files, correspondence, and related information pertaining to services rendered or claims for payments shall be subject to inspection and copying by the Administration and the U.S. Department of Health and Human Services during normal business hours at the place of business of the person or organization maintaining the records.
10. A provision that the contractor safeguard information.
11. Any activities to be performed by the contractor affecting categorically eligible persons and members that are related to ~~third-party~~ 3rd-party liability requirements prescribed in 42 CFR 433, Subpart D, as of October 1, 1995, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
12. Functions that may be subcontracted, including a provision that any subcontract meets the requirements of 42 CFR 434.6(b), as of October 1, 1995, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
13. A provision that the contractor arrange for the collection of any required co-payment.
14. A provision that the contractor will not bill or attempt to collect from a member for any covered service except as may be authorized by statute or these rules.
15. A provision that the contract will not be assigned or transferred without the prior approval of the Director.
16. Procedures for enrollment or re-enrollment of the covered population.
17. Procedures and criteria for terminating the contract.
18. A provision that any cost sharing requirements imposed for services furnished to members are in accordance with 42 CFR 447.50 through 447.58, as of October 1, 1995, which are incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
19. A provision that specifies the actuarial basis for computation of capitation fees.
20. Procedures for terminating enrollment and choice of health professional.
21. A provision that a contractor provide for an internal grievance procedure that:
    a. Is approved in writing by the Administration;
    b. Provides for prompt resolution; and
    c. Ensures the participation of individuals with authority to require corrective action.
22. A provision that the contractor maintain an internal quality-management-system consistent with AHCCCS rules.
23. A provision that the contractor submit marketing plans, procedures, and materials to the Administration for approval in accordance with R9-22-505 before implementation.
24. A statement that all representations made by contractors or authorized representatives are truthful and complete to the best of their knowledge.
25. A provision that the contractor is responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage, for itself and its employees, and that the Administration has no responsibility or liability for any of the taxes or insurance coverage.
26. A provision that the contractor agrees to comply with all applicable statutes and rules.
27. A provision that the contractor complies with the requirements regarding laboratory tests as specified in A.R.S. § 36-2903(R) and (S).

B. Each contract shall include all provisions necessary to ensure compliance with the applicable requirements of 42 CFR 434, Subpart C, as of October 1, 1995, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-711. Copayments

A. Contractors shall be responsible for collecting copayments from members. The following are excluded from copayment requirements:

1. Prenatal care including all obstetrical visits;
2. Well-baby, EPSDT care;
3. Care in nursing facilities and intermediate care facilities for the mentally retarded;
4. Visits scheduled by a primary care physician or practitioner, and not at the request of a member; ~~and~~
5. Drugs and medications beginning October 1, 1985~~.~~; and
6. Family planning services as specified in 42 U.S.C. 1396o.

B. Except as provided in subsection (A), contractors and members shall comply with the following copayment schedules:

1. Categorically eligible members:

Covered Services	Copayment
Doctor's office or home visit and all diagnostic and rehabilitative x-ray and laboratory services associated with the visit.	$1.00 per visit
Nonemergency surgery	$5.00 per procedure
Nonemergency use of the emergency room	$5.00 per visit

2. Indigent, medically needy, eligible assistance children, and eligible low-income children members:

Covered Services	Copayment
Doctor's office or home visit and all diagnostic and laboratory services associated with the visit.	$5.00 per visit
Nonemergency surgery	$5.00 per procedure
Nonemergency use of the emergency room	$5.00 per visit

C. A contractor shall ensure that a member is not denied services because of the member's inability to pay a copayment.

ARTICLE 16. STATE-ONLY ELIGIBILITY

R9-22-1608. County Responsibility for Completion of MI/MN Eligibility Determination

A. Provision of space. The county eligibility staff shall provide sufficient space and materials for the head-of-household to complete the application forms.

B. Provision of assistance. The county eligibility staff or a person authorized by the eligibility staff shall assist the head-of-household in completing the application forms if assistance is requested.

1. The person providing the assistance shall indicate on the form that assistance was provided.
2. The person providing assistance may provide assistance before or during the face-to-face interview.

C. Face-to-face interview. The county eligibility staff shall complete the face-to-face interview when the head-of-household is present at the scheduled appointment time. During a face-to-face interview, the county eligibility staff shall:

1. Inform the head-of-household of:
   a. The MI/MN eligibility requirements defined in this Article;
   b. The responsibilities of the head-of-household specified in R9-22-1605;
   c. The confidential nature of information received;
   d. The timeframes for completion of the application specified in R9-22-1609;
   e. The date coverage begins for approved applicants and the enrollment process;
   f. The length of certification period, under R9-22-1615, that may apply to approved household members;
   g. The E.P.S.D.T. benefits specified in R9-22-102, if there are children in the household; and
   h. The right to appeal specified in R9-22-802;
2. Present the Statement of Truth and obtain the head-of-household's signature under R9-22-1606;
3. Explain the requirement to screen for S.O.B.R.A. and other categorical eligibility under R9-22-1610 and provide each applicant with the appropriate screening form;
4. Obtain the head-of-household's signature on the Intent to Cooperate form and assist the head-of-household in the completion of additional forms for required applications under R9-22-1610;
5. Review each question on the application forms and supplements with the head-of-household and ensure that answers are recorded on the forms. Unless the applicant requests assistance in the completion of the application forms as provided in subsection (B), the county eligibility staff shall add information in the designated areas only; and
6. Request verification of information required under this Article.

D. Telephone interviews. The county eligibility staff may conduct a telephone interview if:

1. The person on whose behalf the application was initiated is a patient who is hospitalized:

a. Outside of the patient's county of residence, or
b. In the county of residence in medical isolation and there is no head-of-household in the county of residence who may apply on the patient's behalf; or

2. The head-of-household lives in a geographically isolated area identified by the Director; or
3. The person is an applicant with a disability and requests a reasonable accommodation, such as a sign language interpreter.

E. Eligibility worker responsibility during telephone interview. During the telephone interview, the eligibility worker shall:

1. Read the Statement of Truth to the head-of-household at the beginning of the telephone interview and determine the head-of-household's understanding;
2. Obtain demographic information about all household members and enter the information on the application forms;
3. Ask all questions on the application forms and obtain and record the answers;
4. Request the information and complete the screening form to identify potential S.O.B.R.A. and categorical eligibility under R9-22-1610;
5. Inform the head-of-household that verification of all information received during the telephone interview is required prior to the eligibility determination;
6. Inform the head-of-household of all factors listed in subsections (C)(1)(a) through (C)(1)(h);
7. Obtain confirmation of the household's mailing address and inform the head-of-household that all forms requiring signatures will be sent to that address and, except as provided in subsection (F), shall be signed and returned to the county eligibility staff within 30 days following the date of the application; and
8. Establish, by mutual agreement, follow-up arrangements to obtain verifications of all factors of eligibility and to obtain the required signatures.

F. Extension of 30-day timeframe. The county eligibility staff may extend the 30-day timeframe in subsection (E)(7) if the head-of-household remains incapacitated and unable to complete the application process. The extension ends when the conditions of either subsection (D)(1)(a) or (b) no longer apply.

G. Requirement to complete face-to-face interview. Except as permitted in subsection (D), the county eligibility staff shall complete an interview with the head-of-household before making an eligibility determination. After the interview, the county eligibility staff shall:

1. Complete any appropriate worksheets and other necessary forms to justify eligibility decisions;
2. Obtain the head-of-household's signature and date for any additional entries on the application;
3. Compare information received during and after the interview with existing case information to identify differences and to determine their effect on the eligibility determination;
4. Notify the Administration under R9-22-1618 if a household member is eligible;
5. Issue a Notice of Action under R9-22-1617;
6. Refer the head of household to apply for categorical or Title XXI eligibility if screened as potentially eligible and concurrent application was not required under R9-22-1610.
~~6~~7. Discontinue eligibility under R9-22-1617 and R9-22-1618 if a telephonic interview has been approved and after 30 days there have been no extensions or the end of the extension as specified in subsection (F); and:
   a. The county eligibility staff has not received the required verification, or
   b. The head-of-household has not signed and returned the required forms.

H. Statement of Completion. The Administration shall publish a Statement of Completion to be signed by the eligibility staff certifying completion of the application process.

1. The statement shall include the eligibility staff's confirmation that the eligibility worker has:
   a. Advised the person of:
      i. The right to appeal any eligibility decision,
      ii. The obligation to report all changes affecting eligibility, and
      iii. The penalties for fraud, misrepresentation, and intentional omissions;
   b. Requested and received confirmation that the person fully understands these rights, obligations, and penalties; and
   c. Completed the investigation of the AHCCCS eligibility required by law.
2. The county eligibility staff shall sign the Statement of Completion at the time of the eligibility decision except when the application is denied because an interview is not completed.

R9-22-1609. MI/MN Timeliness Requirements

A. Requirement for counties. Except for determinations for an applicant whose complete MI/MN-S.O.B.R.A. dual application has been forwarded to DES under R9-22-1610, the county eligibility staff shall make the eligibility determination within the 30 days following the application date. This 30-day limit may be extended under subsection (C).

B. Requirement for the head-of-household. The head-of-household shall provide the county eligibility staff with verification ~~of~~ or information requested by the county eligibility staff under this Article by the ~~30th day following the application date~~ 10th day following the date the county eligibility staff requests the information in writing. The county eligibility staff

shall, upon request by the head-of-household, extend the 10-day timeframe. The county eligibility staff shall not extend the timeframe beyond the 30th day following the date of application, except as specified in subsection (C).

C. Extension of an allotted time. The county eligibility staff shall extend the ~~time period allotted~~ 30-day timeframe in subsections (A) and (B) 1 time, by 30 days, if the head-of-household requests additional time to obtain or provide ~~the requested~~ verification ~~and complies with subsection (D).~~ required by the county eligibility staff to determine MI/MN eligibility.

D. Informed consent. The county eligibility staff shall inform the head-of-household in writing that the requested extension may result in a delay or lapse in AHCCCS coverage. The county eligibility staff shall not extend the 30-day timeframe in subsections (A) and (B) unless the head-of-household ~~shall agree~~ agrees in writing to the extension and acknowledge the potential delay or lapse in AHCCCS coverage.

E. Extending time period. The county eligibility staff shall not extend the time period unless the county eligibility staff receives the signed agreement within the initial 30-day period.

F. Processing an untimely application. When processing an untimely application, for the purpose of counting income under R9-22-1626, the county eligibility staff shall base the 3-month income period on a deemed application date instead of the original application date.

R9-22-1610. Forwarding Applications to Obtain Categorical or Title XXI **Eligibility**

A. Screening requirement. During or before the face-to-face interview, the county eligibility staff shall use the screening form required by A.R.S. §§ 36-2905, 36-2905.03, and 11-297 to screen all applications to ~~determine~~ identify each household member's potential for categorical and Title XXI eligibility as defined in R9-31-101.

B. ~~A concurrent application~~ Application for categorical eligibility. ~~The head-of-household of a~~ Under A.R.S. §36-2905(H), if a household that includes 1 or more of the ~~following shall also apply at the same time for~~ following, who the county identified under subsection (A) as having potential categorical or Title XXI eligibility, the county shall submit the application to the Department of Economic Security or the Administration for determination of categorical ~~coverage~~ or Title XXI eligibility for the household member, unless the household member is already ~~categorically eligible:~~ eligible for categorical or Title XXI coverage.

1. A pregnant woman under R9-22-1406(I);
2. A dependent child born on or after October 1, 1983 under R9-22-1406(J);
3. A nonpregnant hospitalized person ~~applicant, not listed in subsections (B)(1) or (2),~~ who is:
   a. A dependent child born before October 1, 1983;
   b. The parent or specified relative of a dependent child if;
      i. The child resides with a parent or specified relative, and
      ii. Deprivation exists under R9-22-1424; ~~or~~
4. A nonhospitalized person not listed in subsections (B)(1) or (2) applying for SESP under R9-22-1613 who:
   a. Is listed in subsection (B)(3)(a),
   b. Is age 65 or older, or
   c. Claims blindness or disability as defined by 42 U.S.C. 1382c(a)(2) and (3).
5. Any person who is determined eligible for MI/MN under this Article.

C. Required cooperation. The head-of-household and household members listed in subsection (B) shall cooperate with the application process for categorical eligibility and shall sign a statement of Intent to Cooperate. The statement shall be on a form prescribed by the Administration and shall explain:

1. The requirement to concurrently apply for categorical eligibility, and
2. That failure to cooperate shall result in denial or discontinuance of eligibility.

D. Application forwarding requirements. ~~If the household includes 1 or more persons who are listed in subsection (B), the county eligibility staff and the head-of-household shall complete the following:~~ If the county eligibility staff assists the head-of-household in completing the application:

~~1. The county eligibility staff shall assist the head-of-household for an applicant listed in subsections (B)(1) or (2) in completing an application for S.O.B.R.A. at the same time as completing the MI/MN application unless a pending S.O.B.R.A. application exists with DES. The county eligibility staff shall send the S.O.B.R.A. application to DES within 30 days following the date the county eligibility staff receives the signed application.~~

~~2~~ 1. ~~The county eligibility staff shall assist the head-of-household for an applicant listed in subsections (B)(3), or (B)(4)(a) to complete an application for medical assistance under R9-22-1407(D).~~ The county eligibility staff shall forward the application and all available documentation and verification to DES for categorical eligibility or the Administration for Title XXI eligibility under subsection ~~(D)(4)~~ (D)(2).

~~3. The head-of-a-household that includes an applicant listed in subsection (B)(4)(b) or (c) shall apply for SSI-linked FESP for that person. The county eligibility staff shall forward the application forms, available documentation, and verification to the Administration under subsection (D)(4).~~

~~4~~ 2. The county eligibility staff shall forward documents in subsections ~~(D)(2) and (3)~~ (D)(1) by:

   a. The 30th day after the date the county eligibility staff receives the signed application; or
   b. The 3rd day after the county completes the determination of eligibility, whichever date occurs 1st.

~~5~~ 3. After the county eligibility staff forwards an application to DES or the Administration, the county eligibility staff shall not request additional verification from the household if that verification is necessary solely for determination of categorical eligibility other than S.O.B.R.A. The county eligibility staff shall continue to receive and forward it to DES or the Administration any verification that was requested prior to forwarding the application or that was requested for the MI\MN determination.

~~6~~ 4. Application forwarding requirements are waived if:

a. The applicant listed in subsection (B) has an application for medical assistance pending determination by DES, or

b. The applicant listed in subsection (B)(4) has an application for medical assistance pending determination by the Administration.

5. Waiver of application forwarding requirements under subsection (D)(4) does not waive the applicant's requirement to cooperate.

E. Conditions for approval. If the county eligibility staff forwards an application for an applicant listed in subsections (B)(1) through (4) to DES or the Administration under subsection (D), the county eligibility staff shall not approve that applicant for coverage unless the applicant meets the requirements for eligibility under this Article and:

1. The applicant is hospitalized;
2. DES or the Administration denies the applicant's application for categorical eligibility for a reason other than refusal to cooperate; or
3. The applicant is listed in subsection (B)(1) or (2); and:
   a. The applicant meets the citizenship or alien status requirement for MI/MN eligibility under R9-22-1624;
   b. The county eligibility staff forwards a complete application with all required documentation and verification to DES under subsection (D)(1); and
   c. DES has not, within 10 working days following DES' receipt of the forwarded application, completed a determination of the applicant's eligibility for categorical eligibility.

F. County requirement to inform. Whenever the county eligibility staff is required to forward an application to another agency under this Article, the county eligibility worker shall explain to the head-of-household during the face-to-face interview:

1. That the application will be forwarded to another agency or agencies and the name or names of the agency or agencies,
2. What additional actions the head-of-household shall be required to take in order to establish eligibility,
3. The penalties for refusal to cooperate, and
4. The potential for delay in a determination of eligibility.

G. Other referrals. If a person does not meet the requirements of this Chapter but is potentially eligible for categorical coverage or Title XXI under the screening requirements in subsection (A), and does not apply concurrently under subsection (B), the county eligibility staff shall refer the person to DES for categorical eligibility or to the Administration for Title XXI eligibility.

R9-22-1611. Eligibility for Medicare Beneficiaries

A. Exceptions. This Section does not apply to a person who:

1. Has had an ~~organ~~ transplant ~~requiring prescribed immunosuppressant drugs;~~ as specified in A.R.S § 36-2905(K); or
2. May not be enrolled in a Medicare HMO because:
   a. The person resides in a ~~county~~ location where no Medicare HMO ~~operates~~ is geographically available or
   b. The person has a preexisting medical condition or receives Medicare hospice services.

B. Eligibility restriction. A recipient of Medicare benefits is ineligible for MI/MN coverage if:

1. The person is enrolled in a Medicare HMO, or
2. The person voluntarily discontinued Part B Medicare benefits after being found ineligible for MI/MN under this Section.

C. Eligibility limitation. An applicant who is not enrolled in a Medicare HMO but is eligible or may be eligible to be enrolled in a Medicare HMO may receive MI/MN coverage, if eligible, with the following restrictions:

1. An ~~person~~ applicant who has Medicare Parts A and B may receive MI/MN coverage for no longer than the month of certification plus the 2 following calendar months.
2. An ~~person~~ applicant who ~~receives~~ meets the requirements for Medicare Part A benefits, but who does not receive Medicare Part B benefits, may receive MI/MN coverage only:
   a. Until the date that Medicare Part B benefits are available; or
   b. Until the date Medicare Part B would be available if the person had applied for Medicare Part B benefits during the 1st Medicare general enrollment period following approval for MI/MN coverage.
      i. Medicare general enrollment periods and resulting dates of Medicare Part B coverage are specified in 42 CFR 406 and 407.

ii. For this subsection, the Medicare general enrollment period ends if less than 1 month of the Medicare general enrollment period remains.

3. If an person becomes eligible for Medicare while MI/MN eligible, the county eligibility staff shall:
   a. At the time of approval of MI/MN, advise the person to apply for those benefits during the initial Medicare enrollment period as specified in 42 CFR 406 and 407; and
   b. Not approve a person for MI/MN coverage again, after the Medicare Part A and Part B benefits are effective, or would be effective if the person had applied for Medicare Part B benefits during the initial enrollment period.
4. The county eligibility staff shall provide the person a minimum of 2 months from the last day of the initial enrollment period to enroll in a Medicare HMO.

D. Undue Hardship. The Administration shall determine that a person has undue hardship if the applicant:
1. Meets all requirements for MI/MN benefits under this Article; and
2. Is determined ineligible for the Qualified Medicare Beneficiary, ~~and~~ Specified Low Income Medicare Beneficiary ~~program~~ and Qualifying Individuals 1 programs, as defined in A.R.S. § 36-2971 et seq., due solely to excess income and either:
   a. Received Medicare Part A benefits as specified in 42 CFR 406 and 407 prior to July 1, 1996, and did not have Medicare Part B coverage as of July 1, 1996, or has applied to receive Medicare Part B; or
   b. Received Medicare Part A and B or Medicare Part A benefits only and all Medicare HMOs operating ~~in the applicant's~~ which are geographically available to the applicant charge a monthly premium.

E. Undue hardship payment:
1. The Administration shall reimburse the Medicare Part B premiums paid by the person who is subject to undue hardship under subsection (D)(2)(a).
2. The Administration shall pay Medicare HMO premiums directly to the Medicare HMO or reimburse Medicare premiums paid by the person who is subject to undue hardship under subsection (D)(2)(b). The Administration shall not pay:
   a. More than the lowest Medicare HMO monthly premium available if there is more than 1 Medicare HMO ~~in the applicant's county of residence~~ geographically available to the applicant, or
   b. If coverage from a premium-free Medicare HMO becomes geographically available ~~in the applicant's county of residence~~ to the applicant.
3. Once every 6 months, the Administration shall review the status of each person who receives payments or on whose behalf payments are made for undue hardship under this Section. The Administration may approve an additional 6-month extension of the payments, provided the person continues to meet the requirements in subsection (D).

R9-22-1616. Denial or Discontinuance of MI/MN Eligibility

A. Ineligibility of households. The county eligibility staff shall send a denial or discontinuance notice for all household members under any of the following circumstances:
1. The household's annual income, determined under R9-22-1626, exceeds the limits specified in A.R.S. §§ 11-297 and 36-2905. The county eligibility staff shall not deny or discontinue eligibility if:
   a. A household member is incurring medical expenses that are eligible for deduction under R9-22-1626(F), and
   b. The household is expected to reach the allowable income limit within the 30 days following the application date.
2. The household's total countable liquid resources determined under R9-22-1627 exceed the $5,000 limit specified in A.R.S. §§ 11-297 and 36-2905.
3. The household's total countable resources determined under R9-22-1627 exceed the $50,000 limit specified in A.R.S. §§ 11-297 and 36-2905.
4. A household member transfers resources under R9-22-1628 for the purpose of meeting the resource limits specified in A.R.S. §§ 11-297 and 36-2905.
5. The head-of-household fails, within the timeframes as specified in R9-22-1609 or R9-22-1630, to provide information or verification required to determine eligibility. The county eligibility staff shall not deny or discontinue eligibility for this reason unless the required information or verification has been requested in writing by the county eligibility staff and the head-of-household has been given a minimum of 10 days from the date of a written request to provide the information or verification.
6. The head-of-household refuses to cooperate in providing information or verification that is required under this Article.
7. The head-of-household does not sign the application forms when required under this Article.
8. The head-of-household fails to participate in the face-to-face interview, under R9-22-1602, R9-22-1603, or R9-22-1631.
9. The head-of-household fails or refuses to cooperate with the application process under R9-22-1605.
10. The head-of-household requests a withdrawal of an application or discontinuance of all household members' eligibility for the program.

11. The head-of-household fails or refuses to cooperate with the Administration's eligibility quality control review or analysis.
12. The head-of-household refuses to assign health or accident benefits to the Administration as specified in R9-22-1605.
13. The applicant applying for the household is a dependent child, except as permitted under R9-22-1601(D).

B. Ineligibility of an individual household member. The county eligibility staff shall send a denial or discontinuance notice for an applicant under any of the following circumstances:

1. The person's whereabouts are unknown.
2. The person is not a resident of Arizona as defined in A.R.S. § 36-2903.01 and R9-22-1623.
3. The person is a dependent child whose application is not filed by a qualified applicant.
4. The person an inmate in a public institution.
5. The person is a patient of a public mental hospital.
6. The person is deceased. If the applicant dies and, within 2 days following the date of death, the county eligibility staff determines the applicant met all other eligibility requirements, the county eligibility staff shall approve the deceased applicant for MI/MN, ELIC, or SESP. The county eligibility staff shall then immediately discontinue the deceased applicant's MI/MN eligibility. This action will result in the availability of coverage under R9-22-1620, beginning 2 days before the date of determination and ending on the date of death.
7. The person is not a citizen of the United States or an alien under R9-22-1624.
8. The person is ineligible for coverage as specified in R9-22-1611.
9. The person is not a household member as specified R9-22-1625.
10. The person is eligible for medical assistance under Title XIX or Title XXI of the Social Security Act.
11. The person is an AHCCCS-disqualified spouse or an AHCCCS-disqualified dependent.
12. The person is ineligible for MI/MN, ELIC, or SESP coverage due to a refusal to cooperate with the Title XIX or Title XXI eligibility process ~~as required by state law.~~ under A.R.S. §§ 36-2905(H).
13. The head-of-household requests a discontinuance of the applicant's coverage.
14. The person is an adult and requests a discontinuance of the applicant's coverage.

ARTICLE 17. ENROLLMENT

R9-22-1701. Enrollment of a Member with an AHCCCS Contractor

A. General Enrollment Requirements

1. The Administration shall not enroll an applicant with a contractor if an applicant:
   a. Resides in an area not served by a contractor;
   b. Is eligible for the Federal Emergency Services (FES) program as defined in R9-22-101 or the State Emergency Services Program defined in R9-22-1613;
   c. Is eligible for a period less than 30 days from the date the Administration receives notification of a member's eligibility, except for a member who is enrolled with CMDP or IHS as specified in this Section;
   d. Is eligible only for a prior quarter period as defined in R9-22-1432, except for a member who is enrolled with IHS as specified in this Section; or
   e. Is eligible only for a retroactive period of eligibility, except for a member who is enrolled with IHS as specified in this Section.
2. The Administration shall enroll a member with:
   a. A contractor serving the member's geographical service area (GSA) except as provided in subsection (C); or
   b. The member's most recent contractor of record, if available, if the member's period of ineligibility and disenrollment from the contractor of record is for a period of less than 90 days except if:
      i. The member no longer resides in the contractor's GSA,
      ii. The contractor's contract is suspended or terminated,
      iii. The member was previously enrolled with CMDP but at the time of re-enrollment the member is not a foster care child,
      iv. The member chooses another contractor during the annual enrollment choice period, or
      v. The member was previously enrolled with a contractor but at the time of re-enrollment the member is a foster care child.

B. Fee-for-service coverage.

1. A member not enrolled with a contractor under subsection (A)(1) shall obtain covered medical services from an AHCCCS registered provider on a fee-for-service basis as provided in 9 A.A.C. 7~~.~~ :
2. An incarcerated member shall be disenrolled from the contractor effective with the date of incarceration. Covered medical services performed by a AHCCCS registered provider for an incarcerated member shall be covered on a fee-for-service basis as provided in 9 A.A.C. 22, Article 7, from the date of incarceration to the date the Administration takes action to terminate eligibility based on notification received from the eligibility source.

C. Foster care child. The Administration shall enroll a member with CMDP if the member is a foster care child under A.R.S.§ 8-512.

D. Categorical, EAC, ELIC, and state alien member.
1. Except as provided in subsections (A)(1), (2)(b), and (C), a categorical, EAC, ELIC, or state alien member residing in an area served by more than 1 contractor shall have freedom of choice in the selection of an contractor.
2. A Native American member may select IHS or another available contractor.
3. If the member does not make a choice, the Administration shall auto-assign the member to:
   a. A contractor based on;
      i Family continuity, or
      ii The auto-assignment algorithm; or
   b. IHS, if the member is a Native American living on reservation.

E. MI/MN member.
1. A MI/MN member, including Native Americans, shall not receive freedom of choice in the selection of an AHCCCS contractor, except as specified in subsection (G).
2. Except as provided in subsection (A)(2)(b), the Administration shall auto-assign a member as specified in subsection (D)(3).

F. Family Planning Services Extension Program. A member eligible under the Family Planning Services Extension Program, as defined in R9-22-1435, shall remain enrolled with the member's contractor of record.

G. Enrollment changes for a member.
1. A member may change contractors during the annual enrollment choice period.
2. The Administration may approve the transfer for an enrolled member from 1 contractor to another as specified in 9 A.A.C. 5, or as determined by the Director.
3. The Administration shall approve a change in contractor for any member if the change is a result of a grievance, resolved through the grievance process specified in 9 A.A.C. 8.
4. A categorical, EAC, ELIC, or state alien member may choose a different contractor if the member moves into a GSA not served by the current contractor or if the contractor is no longer available. If the member does not select a contractor, the Administration shall auto-assign the member as provided in subsection (D)(3).
5. The Administration shall auto-assign an MI/MN member to a different contractor as specified in subsection (E)(2), if the member moves into a GSA not served by the member's current contractor.

H. Newborn enrollment. A newborn shall be initially enrolled with a contractor as specified in R9-22-1703.

I. IHS. The provisions of subsections (A)(1)(a), (2)(a), and (b)(iv), (D), (E), (F), (G), and (H) apply if IHS is the contractor.

J. CMDP. The provisions of subsections (A)(1)(d) and (e) and (H) apply if CMDP is the contractor.

R9-22-1704. Categorical and EAC Guaranteed Enrollment Period

A. General.
1. The Administration shall grant a guaranteed enrollment period as provided in this Section to a categorical or EAC member if the member meets the following conditions:
   a. Becomes ineligible before receiving 5 full calendar months of enrollment with a contractor as specified in 42 U.S.C. 1396a(e)(2),
   b. If the date of ineligibility does not precede or equal the date of initial enrollment,
   c. Did not receive 5 full calendar months of categorical enrollment during a previous categorically eligible period,
   d. Did not receive 5 full calendar months of EAC enrollment during a previous EAC eligible period, and
   e. Does not meet any of the conditions listed in subsection (B).
2. The member may receive a separate guaranteed enrollment:
   a. For a maximum of 1 time if the member is a categorical member, and
   b. For a maximum of 1 time if the member is an EAC.
3. The guaranteed enrollment period shall begin on the effective date of the member's initial enrollment with the contractor and shall continue for not less than 5 full calendar months.

B. Exceptions to guaranteed period. The Administration shall not grant a guaranteed enrollment period or shall terminate a guaranteed enrollment period as provided in subsection (C), if the member:
1. Is an inmate of a public institution as defined in 42 CFR 435.1009 except as provided in 9 A.A.C. 12,
2. Dies,
3. Moves out-of-state,
4. Voluntarily withdraws from the AHCCCS program,
5. Is adopted,
6. Is an EAC eligible and age 14, or
7. Is an EAC and fails or refuses to cooperate with the Title XIX eligibility process.

C. Disenrollment effective date. The Administration shall terminate any guaranteed enrollment period for which the member is not entitled effective on:

1. The date the member is admitted to a public institution specified in subsection (B)~~,~~ ; ~~if known, or the date the Administration receives notification from the eligibility agency of the member's admission to a public institution;~~.
2. The member's date of death;
3. The last day of the month in which the Administration receives notification from the eligibility agency that a member has moved out-of-state;
4. The date the Administration receives written notification of the member's voluntary withdrawal from the AHCCCS program;
5. The date adoption proceedings are initiated through a private party, if known, or on the last day of the month in which the Administration receives notification of the proceedings;
6. The last day of the month in which an EAC becomes age 14; or
7. The date the Administration receives notification from the eligibility agency that EAC eligibility will terminate because the responsible member fails or refuses to cooperate with the Title XIX eligibility process.

D. Retroactive adjustments. The Administration shall adjust the member's eligibility and enrollment retroactively as specified in subsection (C).

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

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

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-28-101	Amend
R9-28-102	Amend
R9-28-103	Amend
R9-28-104	Amend
R9-28-107	Amend

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

Authorizing statute: A.R.S. § 36-2932(M)

Implementing statutes: A.R.S. § § 36-2901 and 36-2931 establish statutory definitions; this Section adds to those definitions.

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

Notice of Rulemaking Docket Opening: 6 A.A.R. 608, February 4, 2000

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

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 East Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

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

Changes are made to provide additional clarity and conciseness to existing definitions.

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

Not applicable

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

Not applicable

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

The changes will not directly impact the small business community. It is anticipated that the changes will benefit all parties that use rules including:

The Administration:

ALTCS contractors;

ALTCS providers; and

ALTCS members.

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

Name:	Cheri Tomlinson, Federal and State Policy Administrator
Address:	AHCCCSA, Office of Policy Analysis and Coordination 801 East Jefferson, Mail Drop 4200 Phoenix, AZ 85034
Telephone:	(602) 417-4198
Fax:	(602) 256-6756

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

Date:	April 3, 2000
Time:	10:00 a.m.
Location:	AHCCCS 701 East Jefferson Phoenix, AZ 85034 Turquoise Room
Location:	ALTCS: Arizona Long-Term Care System 110 South Church, Suite 3250 Tucson, AZ 85701
Location:	Arizona Long-Term Care System 3480 East Route 66 Flagstaff, AZ 86004
Nature:	Video Conference Oral Proceeding

The Administration will accept written comments until 5:00 p.m., April 3, 2000. Please submit comments to the following person:

Name:	Cheri Tomlinson, Federal and State Policy Administrator
Address:	AHCCCSA, Office of Policy Analysis and Coordination 801 East Jefferson, Mail Drop 4200 Phoenix, AZ 85034
Telephone:	(602) 417-4198
Fax:	(602) 256-6756

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

Not applicable

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

None

13. Was this rule previously adopted as an emergency rule?

No

14. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

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

ARTICLE 1. DEFINITIONS

Section

ARTICLE 1. DEFINITIONS

R9-28-101. General Definitions

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

Definition	Section or Citation
1. "211"	~~R9-28-104~~ 42 CFR 435.211
2. "217"	~~R9-28-104~~ 42 CFR 435.217
3. "236"	~~R9-28-104~~ 42 CFR 435.236
4. "Administration"	A.R.S. § 36-2931
5. "ADHS"	R9-28-111
~~6. "AFDC"~~	~~R9-22-101~~
~~7~~ 6. "Aggregate"	R9-22-107
~~8~~ 7. "AHCCCS"	R9-22-101
~~9~~ 8. "AHCCCS hearing officer"	R9-22-108
~~10~~ 9. "Algorithm"	R9-28-104
~~11~~ 10. "ALTCS"	A.R.S. § 36-2932
~~12~~ 11. "ALTCS acute care services"	R9-28-104
~~13~~ 12. "Alternative HCBS setting"	R9-28-101
~~14~~ 13. "Ambulance"	R9-22-102
~~15~~ 14. "Appeal"	R9-22-108
~~16~~ 15. "Bed hold"	R9-28-102
~~17~~ 16. "Behavior intervention"	R9-28-102
~~18~~ 17. "Behavior management services"	R9-28-111
~~19~~ 18. "Behavioral health para-professional"	R9-28-111
~~20~~ 19. "Behavioral health professional"	R9-28-111
~~21~~ 20. "Behavioral health service"	R9-28-111
~~22~~ 21. "Behavioral health technician"	R9-28-111
~~23~~ 22. "Billed charges"	R9-22-107
~~24~~ 23. "Board eligible for psychiatry"	R9-28-111
~~25~~ 24. "Capped fee-for-service"	R9-22-101
~~26~~ 25. "Case management plan"	R9-28-101
~~27~~ 26. "Case management services"	R9-28-111
~~28~~ 27. "Case manager"	R9-28-101
~~29~~ 28. "Case record"	R9-22-101
~~30~~ 29. "Categorically eligible"	A.R.S. § 36-2934
~~31~~ 30. "Certification"	R9-28-105

~~32~~ 31.	"Certified psychiatric nurse practitioner"	R9-28-111
~~33~~ 32.	"CFR"	R9-28-101
~~34~~ 33.	"Clean claim"	A.R.S. § 36-2904
~~35~~ 34.	"Clinical supervision"	R9-28-111
~~36~~ 35.	"Community Spouse"	R9-28-104
~~37. "Community Spouse Resource Deduction"~~		~~R9-28-104~~
~~38~~ 36.	"Contract"	R9-22-101
~~39~~ 37.	"Contractor"	R9-22-101
~~40~~ 38.	"County of fiscal responsibility"	R9-28-107
~~41~~ 39.	"Covered services"	R9-22-102
~~42~~ 40.	"CPT"	R9-22-107
~~43~~ 41.	"CSRD"	R9-28-104
~~44~~ 42.	"Day"	R9-22-101
~~45~~ 43.	"De novo hearing"	R9-28-111
~~46~~ 44.	"DES Division of Developmental Disabilities"	A.R.S. § 36-551
~~47~~ 45.	"Developmental disability"	A.R.S. § 36-551
~~48~~ 46.	"Diagnostic services"	R9-22-102
~~49~~ 47.	"Disenrollment"	R9-22-117
~~50~~ 48.	"DME"	R9-22-102
~~51~~ 49.	"Eligible person"	A.R.S. § 36-2931
~~52~~ 50.	"Emergency medical services"	R9-22-102
~~53~~ 51.	"Encounter"	R9-22-107
~~54~~ 52.	"Enrollment"	R9-22-117
~~55~~ 53.	"Estate"	A.R.S. § 14-1201
~~56~~ 54.	"Evaluation"	R9-28-111
~~57~~ 55.	"Facility"	R9-22-101
~~58~~ 56.	"Factor"	R9-22-101
~~59~~ 57.	"Fair consideration"	R9-28-104
~~60~~ 58.	"FBR"	R9-22-101
~~61~~ 59.	"Grievance"	R9-22-108
~~62~~ 60.	"GSA"	R9-22-101
~~63~~ 61.	"Guardian"	R9-22-116
~~64~~ 62.	"HCBS"	A.R.S. §§ 36-2931 and 36-2939
~~65~~ 63.	"Home"	R9-28-101
~~66~~ 64.	"Home health services"	R9-22-102
~~67~~ 65.	"Hospital"	R9-22-101
~~68~~ 66.	"ICF-MR" ~~R9-28-101~~	42 CFR 435.1009 and 440.150
~~69~~ 67.	"IHS"	R9-28-101
~~70~~ 68.	"IMD"	42 CFR 435.1009
~~71~~ 69.	"Indian"	P.L. 94-437
~~72~~ 70.	"Inpatient psychiatric facilities for individuals under age 21"	R9-28-111
~~73~~ 71.	"Institutionalized"	R9-28-104
~~74~~ 72.	"Interested Party"	R9-28-106
~~75~~ 73.	"JCAHO"	R9-28-101
~~76~~ 74.	"License" or "licensure"	R9-22-101
~~77~~ 75.	"Medical record"	R9-22-101
~~78~~ 76.	"Medical services"	R9-22-101
~~79~~ 77.	"Medical supplies"	R9-22-102
~~80~~ 78.	"Medically eligible"	R9-28-104
~~81~~ 79.	"Medically necessary"	R9-22-101
~~82~~ 80.	"Member"	A.R.S. § 36-2931
~~83~~ 81.	"Mental disorder"	R9-28-111
~~84~~ 82.	"MMMNA"	R9-28-104

~~85~~ 83.	"NF"	42 U.S.C. 1396r(a)
~~86~~ 84.	"Noncontracting provider"	A.R.S. § 36-2931
~~87~~ 85.	"Occupational therapy"	R9-22-102
~~88~~ 86.	"Partial care"	R9-28-111
~~89~~ 87.	"PAS"	R9-28-103
~~90~~ 88.	"PASARR"	R9-28-103
~~91~~ 89.	"Pharmaceutical service"	R9-22-102
~~92~~ 90.	"Physical therapy"	R9-22-102
~~93~~ 91.	"Physician"	R9-22-102
~~94~~ 92.	"Post-stabilization services"	42 CFR 438.114
~~95~~ 93.	"Practitioner"	R9-22-102
~~96~~ 94.	"Primary care provider"	R9-22-102
~~97~~ 95.	"Primary care provider services"	R9-22-102
~~98~~ 96.	"Prior authorization"	R9-22-102
~~99~~ 97.	"Prior period coverage"	R9-28-101
~~100~~ 98.	"Prior-quarter period"	R9-28-101
~~101~~ 99.	"Private duty nursing services"	R9-22-102
~~102~~ 100.	"Program contractor"	A.R.S. § 36-2931
~~103~~ 101.	"Provider"	A.R.S. § 36-2931
~~104~~ 102.	"Prudent layperson standard"	42 U.S.C. 1396u-2
~~105~~ 103.	"Psychiatrist"	R9-28-111
~~106~~ 104.	"Psychologist"	R9-28-111
~~107~~ 105.	"Psychosocial rehabilitation"	R9-28-111
~~108~~ 106.	"Quality management"	R9-22-105
~~109~~ 107.	"RBHA"	R9-28-111
~~110~~ 108.	"Radiology"	R9-22-102
~~111~~ 109.	"Reassessment"	R9-28-103
~~112~~ 110.	"Redetermination"	R9-28-104
~~113~~ 111.	"Referral"	R9-22-101
~~114~~ 112.	"Reinsurance"	~~R9-22-107~~ R9-22-101
~~115~~ 113.	"Representative"	R9-28-104
~~116~~ 114.	"Respiratory therapy"	R9-22-102
~~117~~ 115.	"Respite care"	R9-28-102
~~118~~ 116.	"RFP"	~~R9-22-105~~ R9-22-106
~~119~~ 117.	"Room and board"	R9-28-102
~~120~~ 118.	"Scope of services"	R9-22-102
~~121~~ 119.	"Screening"	R9-28-111
~~122~~ 120.	"Speech therapy"	R9-22-102
~~123~~ 121.	"Spouse"	R9-28-104
~~124~~ 122.	"SSA"	P.L. 103-296, Title I
~~125~~ 123.	"SSI"	R9-22-101
~~126~~ 124.	"Subcontract"	R9-22-101
~~127~~ 125.	"Substance abuse"	R9-28-111
~~128~~ 126.	"Treatment"	R9-28-111
~~129~~ 127.	"Utilization management"	R9-22-105
~~130~~ 128.	"Ventilator dependent"	R9-28-102

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

1. "AHCCCS" is defined in 9 A.A.C. 22, Article 1.
2. "ALTCS" means the Arizona Long-Term Care System as authorized by A.R.S. § 36-2932.
3. "Alternative HCBS setting" means a living arrangement approved by the Director and licensed or certified by a regulatory agency of the state, where a member may reside and receive HCBS including:
    a. For a person with a developmental disability (DD) specified in A.R.S. § 36-551:
        i. Community residential setting defined in A.R.S. § 36-551;
        ii. Group home defined in A.R.S. § 36-551;
        iii. State-operated group home defined in A.R.S. § 36-591;

iv. Family foster home defined in 6 A.A.C. 5, Article 58;
v. Group foster home defined in 6 A.A.C. 5, Article 59;
vi. Licensed residential facility for a person with traumatic brain injury specified in ~~A.R.S. § 36-2939(C)~~ A.R.S. § 36-2939; and
vii. Behavioral health service agency specified in A.R.S. § 36-2939(B)(2) and 9 A.A.C. 20, Articles 6, 7, and 8 for Levels I, II, or III;

b. For a person who is elderly or physically disabled (EPD), and the facility, setting, or institution is registered with AHCCCS:
i. Adult foster care homes defined in A.R.S. § 36-401; and as authorized in A.R.S. § 36-2939; and an assisted living home or residential unit, as defined in A.R.S. § 36-401, and as authorized in A.R.S. § 36-2939.
ii. Licensed residential facility for a person with a traumatic brain injury specified in A.R.S. § 36-2939(C); and
iii. Behavioral health service agency specified in A.R.S. § 36-2939(C) and 9 A.A.C. 20, Articles 6, 7, and 8 for Levels I and II.
iv. Alzheimer's treatment assistive living facility demonstration pilot project as specified in Laws 1999, Ch. 313, § 35.

4. "Capped fee-for-service" is defined in 9 A.A.C. 22, Article 1.
~~4~~ 5. "Case management plan" means a service plan developed by a case manager that involves the overall management of a member's ~~or an eligible person's~~ care, and the continued monitoring and reassessment of the member's ~~or the eligible person's~~ need for services.
~~5~~ 6. "Case manager" means a person who is either a degreed social worker, a licensed registered nurse, or a person with a minimum of 2 years of experience in providing case management services to a person who is elderly and physically disabled or has developmental disabilities.
7. "Case record" is defined in 9 A.A.C. 22, Article 1.
~~6~~ 8. "CFR" means Code of Federal Regulations, unless otherwise specified in this Chapter.
~~7~~ 9. "Contract" is defined in 9 A.A.C. 22, Article 1.
~~8~~ 10. "Day" is defined in 9 A.A.C. 22, Article 1.
~~9~~ 11. "DES Division of Developmental Disabilities" is defined in A.R.S. § 36-551.
~~10~~ 12. "Disenrollment" is defined in 9 A.A.C. 22, Article 1.
~~11~~ 13. "Eligible person" is defined in A.R.S. § 36-2931.
~~12~~ 14. "Enrollment" is defined in 9 A.A.C. 22, Article 1.
~~13~~ 15. "Facility" is defined in 9 A.A.C. 22, Article 1.
~~14~~ 16. "Factor" is defined in 9 A.A.C. 22, Article 1.
17. "FBR" means Federal Benefit Rate and is defined in 9 A.A.C. 22, Article 1.
~~15~~ 18. "HCBS" means home and community based services defined in A.R.S. §§ 36-2931 and 36-2939.
~~16~~ 19. "Home" means a residential dwelling that is owned, rented, leased, or occupied at no cost to a member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion and any of these, licensed or certified by a regulatory agency of the state as a:
a. Health care institution defined in A.R.S. § 36-401;
b. Residential care institution defined in A.R.S. § 36-401;
c. Community residential facility defined in A.R.S. § 36-551; or
d. Behavioral health service facility defined in 9 A.A.C. 20, Articles 6, 7, and 8.
~~17~~ 20. "Hospital" is defined in 9 A.A.C. 22, Article 1.
~~18~~ 21. "GSA" is defined in 9 A.A.C. 22, Article 1.
~~19~~ 22. "ICF-MR" means an intermediate care facility for the mentally retarded and is defined in 42 CFR 435.1009 and 440.150.
~~20~~ 23. "IHS" means the Indian Health Services.
~~21~~ 24. "Indian" is defined in P.L. 94-437.
~~22~~ 25. "JCAHO" means the Joint Commission on Accreditation of Healthcare Organizations.
~~23~~ 26. "License" or "licensure" is defined in 9 A.A.C. 22, Article 1.
~~24~~ 27. "Medical record" is defined in 9 A.A.C. 22, Article 1.
~~25~~ 28. "Medical services" is defined in 9 A.A.C. 22, Article 1.
~~26~~ 29. "Medically necessary" is defined in 9 A.A.C. 22, Article 1.
~~27~~ 30. "Member" is defined in A.R.S. § 36-2931.
~~28~~ 31. "NF" means nursing facility ~~and is defined in 9 A.A.C. 22, Article 1~~ defined in 42 U.S.C. 1396r(a).
~~29~~ 32. "Noncontracting provider" is defined in A.R.S. § 36-2931.
~~30~~ 33. "Prior period coverage" means the period of time from the 1st day of the month of application or the 1st eligible month whichever is later to the day a member is enrolled with the program contractor. The program contractor receives notification from the Administration of the member's enrollment.

~~31~~ 34. "Prior-quarter period" means the 3 calendar months immediately preceding the month of application during which a member may be eligible for services covered under this Chapter, retroactively under federal law and under A.R.S. § 36-2937.
~~32~~ 35. "Program contractor" is defined in A.R.S. § 36-2931.
~~33~~ 36. "Provider" is defined in A.R.S. § 36-2931.
~~34~~ 37. "Referral" is defined in 9 A.A.C. 22, Article 1.
38. "Reinsurance" is defined in 9 A.A.C. 22, Article 1.
~~35~~ 39. "SSA" means Social Security Administration defined in P.L. 103-296, Title I.
~~36~~ 40. "SSI" is defined in 9 A.A.C. 22, Article 1.
~~37~~ 41. "Subcontract" is defined in 9 A.A.C. 22, Article 1.

R9-28-102. Covered Services Related Definitions

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

1. "Ambulance" is defined in 9 A.A.C. 22, Article 1.
2. "Bed hold" means a 24 hour per day unit of service that is authorized by an ALTCS case manager or designee during a period of short-term hospitalization or therapeutic leave that meets the requirement specified in 42 CFR 483.12.
3. "Behavior intervention" means the planned interruption of ~~an eligible person's or~~ a member's inappropriate behavior using techniques such as reinforcement, training, behavior modification, and other systematic procedures intended to result in more acceptable behavior.
4. "Covered services" is defined in 9 A.A.C. 22, Article 1.
5. "Diagnostic services is defined in 9 A.A.C. 22, Article 1.
6. "DME" means durable medical equipment and is defined in 9 A.A.C. 22, Article 1.
7. "Emergency medical services" is defined in 9 A.A.C. 22, Article 1.
8. "Home health services" is defined in 9 A.A.C. 22, Article 1.
9. "Medical supplies" is defined in 9 A.A.C. 22, Article 1.
10. "Occupational therapy" is defined in 9 A.A.C. 22, Article 1.
11. "Pharmaceutical service" is defined in 9 A.A.C. 22, Article 1.
12. ~~"Physician" is defined in 9 A.A.C. 22, Article 1.~~
~~13.~~12. "Physical therapy" is defined in 9 A.A.C. 22, Article 1.
13. "Physician" is defined in 9 A.A.C. 22, Article 1.
14. "Practitioner" is defined in 9 A.A.C. 22, Article 1.
15. "Primary care provider" is defined in 9 A.A.C. 22, Article 1.
16. "Primary care provider services" is defined in 9 A.A.C. 22, Article 1.
17. "Prior authorization" is defined in 9 A.A.C. 22, Article 1.
18. "Private duty nursing services" is defined in 9 A.A.C. 22, Article 1.
19. "Radiology ~~services~~" is defined in 9 A.A.C. 22, Article 1.
20. "Respiratory therapy" is defined in 9 A.A.C. 22, Article 1.
21. "Respite care" means a short-term service provided in a NF or a home and community based service setting to an individual when necessary to relieve a family member or other person caring for the individual.
22. "Room and board" means lodging and meals.
23. "Scope of services" is defined in 9 A.A.C. 22, Article 1.
24. "Speech therapy" is defined in 9 A.A.C. 22, Article 1.
25. "Ventilator dependent" for purposes of ALTCS eligibility, means an individual is medically dependent on a ventilator for life support at least 6 hours per day and has been dependent on ventilator support as an inpatient in a hospital, NF, or ICF-MR for 30 consecutive days.

R9-28-103. Preadmission Screening Related Definitions

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

1. "Case record" is defined in 9 A.A.C. 22, Article 1.
2. "Developmental disability" means a disability described in A.R.S. § 36-551.
3. "Guardian" is defined in 9 A.A.C. 22, Article 1.
4. ~~"Minor" is defined in 9 A.A.C. 22, Article 1.~~
~~5.~~4. "PAS" means preadmission screening, which is the process of determining an individual's risk of institutionalization at a NF or ICF-MR level of care, as specified in Article 3 of this Chapter.
~~6.~~5. "PASARR" means preadmission screening and annual resident review, which is the 2-step screening process for mental illness and mental retardation ~~according to~~ as described in A.R.S. § 36-2936. The level I screening is used to identify potentially mentally ill (MI) or mentally retarded (MR) individuals before nursing facility admission. The level II

screening used to make an in-depth assessment of potentially MI or MR individuals referred through the level I screening and to determine the appropriateness of nursing facility care and the need for special services for the MI or MR individual.

~~7.~~6. "Reassessment" means the process of redetermining PAS eligibility for ALTCS services on an annual or periodic basis, as appropriate, for all members ~~and eligible persons~~.

R9-28-104. Eligibility and Enrollment Related Definitions

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

1. "211" ~~means~~ is defined in 42 CFR 435.211.
2. "217" ~~means~~ is defined in 42 CFR 435.217.
3. "236" ~~means~~ is defined in 42 CFR 435.236.
4. "ALTCS acute care services" means services, under 9 A.A.C. 22, Articles 2 and 12, that are provided to a person who meets ALTCS eligibility requirements in 9 A.A.C. 28, Article 4 but who lives in an acute care living arrangement described in ~~R9-28-406(B)~~ R9-28-406 or who is not eligible for long-term benefits, described in ~~R9-28-409(D)~~ R9-28-409, due to a transfer without receiving equal compensation.
5. "Algorithm" means a mathematical formula used by the Administration to assign a member to an EPD program contractor when the member does not make a choice and does not meet the assignment-decision process.
6. "Community spouse" means the husband or wife of an institutionalized person who has entered into a contract of marriage, recognized as valid by Arizona, and who does not live in a medical institution.
7. ~~"Community Spouse Resource Deduction" means the amount of a married couple's resources that are excluded in the eligibility determination to prevent impoverishment of the community spouse, determined under R9-28-410(B).~~
8 7. "CSRD" means Community Spouse Resource ~~Deduction defined in R9-28-104(7)~~ Deduction, the amount of a married couple's resources that are excluded in the eligibility determination to prevent impoverishment of the community spouse, determined under R9-28-410.
9 8. "Fair consideration" means income, real or personal property, services, or support and maintenance equal to the fair market value of the income or resources that were transferred.
10 9."Institutionalized" means residing in a medical institution or receiving or expecting to receive HCBS that prevent the person from being placed in a medical institution determined by the ALTCS Pre-Admission Screening (PAS) under R9-28-103.
11 10. "Medically eligible" means meeting the ALTCS medical eligibility criteria under 9 A.A.C. 28, Article 3.
12 11. "MMMNA" means Minimum Monthly Maintenance Needs Allowance.
13 12. "Redetermination" means a periodic review of all eligibility factors for a recipient.
14 13. "Representative" means a person other than a spouse or a parent of a dependent child, who applies for ALTCS on behalf of another person.
15 14. "Spouse" means either someone who is legally married under Arizona law, a person who is eligible for Social Security benefits as the spouse of another person, or a person who lives with another person of the opposite sex and the couple represents themselves in their community as husband and wife.

R9-28-107. Standards for Payments Related Definitions

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

1. "Aggregate" is defined in 9 A.A.C. 22, Article 1.
2. "Billed charges" is defined in 9 A.A.C. 22, Article 1.
3. "Capped fee-for-service" is defined in 9 A.A.C. 22, Article 1.
4. "Clean claim" is defined in 9 A.A.C. 22, Article 1.
5. "CPT" is defined in 9 A.A.C. 22, Article 1.
6. "County of fiscal responsibility" means the county that is financially responsible for the state's share of ALTCS funding.
7. "Encounter" is defined in 9 A.A.C. 22, Article 1.
8. ~~"Reinsurance" is defined in 9 A.A.C. 22, Article 1.~~